EVIDENCE-BASED CARE FOR MATERNAL-INFANT DYADS AFFECTED BY SUBSTANCE USE DISORDER RESOURCE WORKBOOK

MISSOURI PQC Perinatal Quality Collaborative | MHA

Acknowledgements

Improving the health outcomes of maternal and infant populations is a critical priority in Missouri. The Missouri Perinatal Quality Collaborative serves as a statewide convener, resource, and change agent to support decreased variations in care and outcomes, support optimized use of evidence-based practice, and support clinical-community integration — all noted gaps in achieving equitable and improved health.

These efforts would not be possible without the collective vision and collaboration of the Missouri Department of Health and Senior Services, Missouri Hospital Association, and members of the Missouri Maternal-Child Learning and Action Network. MC LAN members represent a diverse group of stakeholders from clinical backgrounds, professional associations, government agencies, community-based organizations and community representatives who have committed support to reducing maternal morbidity and mortality in Missouri, including the March of Dimes, Missouri Section of the American College of Obstetricians and Gynecologists, Missouri Chapter of the American Academy of Pediatrics, Missouri Primary Care Association, Missouri DHSS, Missouri Department of Social Services MO HealthNet Division, Missouri Foundation for Health, Missouri Chapter of the Association of Women's Health, Obstetric and Neonatal Nurses, Nurse Practitioners in Women's Health Association, Missouri Chapter of the Amniotic Fluid Embolism Foundation, Generate Health, St. Louis Integrated Health Network, Bootheel Perinatal Network, Healthy Blue MO, Home State Health, United Healthcare, Nurture KC, Promise 1000, M-Brace Birthing, SafiMoms365, the Doula Foundation and Simply Strategy. These partners successfully aligned efforts to bring Alliance for Innovation on Maternal Health initiatives to Missouri in 2019 and connect directly to the Missouri Pregnancy-Associated Mortality Review Board, which identifies leading causes of morbidity and mortality.

The MO PQC also acknowledges the contributions of AIM, the national, cross-sector commitment designed to lead in developing and implementing patient safety bundles to promote safe care for every U.S. birth. Founded in 2014 through a cooperative agreement funded by the Health Services Resources Administration, and executed by ACOG, the AIM program provides expert technical support and capacity building to multidisciplinary state-based teams, most often perinatal quality collaboratives, leading targeted rapid-cycle quality improvement via implementation of patient safety bundles. An AIM patient safety bundle is a structured way of improving the process of care and patient outcomes: a small, straightforward set of evidence-based practices that, when performed collectively and reliably, have been proven to improve patient outcomes. Patient safety bundles are developed by expert multidisciplinary working groups, supported by the AIM staff at ACOG. Working groups include representatives appointed by professional member organizations, known experts and researchers specializing in the clinical topic, and patients with lived experience. The bundle development process includes design of measure and metrics for implementation and multiple levels of review from engaged stakeholders.[1,2]

The MO PQC leverages AIM patient safety bundles as one option to support implementation of evidence-based practice and care delivery redesign for birthing units, providers, and communities throughout the state.

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The Evidence

This section contains information on key evidence-based practices for improving the care of maternal-infant dyads affected by substance use disorder.

ACOG, the Society for Maternal-Fetal Medicine and the Substance Abuse and Mental Health Services Administration recommend universal SUD screening with a validated verbal screening tool for all pregnant and postpartum people that follows the screening, brief intervention and referral to treatment process. The SBIRT process gives providers the opportunity to work with a patient to identify substance misuse and SUD early, and connect individuals to appropriate treatment and services to achieve positive maternal-infant outcomes.[3,4,5] Links to validated screening tools are included in the Resources section of this document.

Universal biologic testing for substances, such as urine drug testing, is not recommended, as these laboratory tests do not identify sporadic substance use, do not identify all substances, and could prevent pregnant people from obtaining and continuing to participate in prenatal care. Additionally, positive test results do not always indicate a person has SUD. Organizations should develop specific, equitable biologic testing policies and ensure informed consent is obtained prior to testing.[4,5] A urine drug testing guidance document is included in the Resources section of this document.

Medications for opioid use disorder like buprenorphine and methadone are the recommended treatment for pregnant and postpartum people. Because of the potential for poor outcomes, medically supervised withdrawal is not recommended for pregnant and postpartum people.[3,4,5] SAMHSA announced the removal of the X-waiver requirement in 2023. All practitioners with a current Drug Enforcement Administration registration may now prescribe buprenorphine for opioid use disorder.[6] As of June 27, 2023, those new or renewing DEA registrants are required to complete eight hours of training on SUD.[7] Specific requirements can be found on SAMHSA's website. Educational resources related to the DEA requirements and guides for buprenorphine initiation are included in the Resources section of this document.

Developed by staff at Yale New Haven Children's Hospital, the Eat, Sleep, Console model of care is an evidence-based functional assessment tool for infants experiencing neonatal abstinence syndrome. This tool promotes the approach that the birthing person is the primary and greatest intervention for managing NAS. The approach fosters bonding between the infant and birthing person, or other identified caregiver, through nonpharmacologic interventions to support feeding, sleeping and calming infants with NAS symptoms. If or when these interventions become ineffective, pharmacologic interventions are recommended, which may or may not require admission to a higher level of care.[8,9] The Missouri NAS Collaborative, which included 14 birthing facilities across the state, implemented the ESC model of care and demonstrated a 23.9% reduction in transfer rates for NAS-diagnosed infants or infants at risk for withdrawal.[10] ESC resources are included in the Resources section of this document.

Missouri NAS Collaborative Outcomes, November 2020 - December 2022

The transfer rate of NAS-diagnosed infants or infants at risk for withdrawal was reduced by 23.9% (30.1% to 22.9%).	↓ 23.9% (30.1% to 22.9%)	
The rate of NAS-diagnosed infants or infants at risk for withdrawal receiving nonpharmacologic treatment as a first-line intervention increased by 17.9% (84.1% to 99.1%).	↑ 17.9% (84.1% to 99.1%)	
The rate of NAS-diagnosed infants or infants at risk for withdrawal receiving pharmacologic treatment was reduced by 13.1% (30.8% to 26.8%).	↓ 13.1% (30.8% to 26.8%)	
The rate of maternal patients screened for OUD/SUD during prenatal care increased by 47.9% (66.9% to 99%), and upon birth admission increased by 67.3% (57.5% to 96.2%).	↑ 47.9% (66.9% to 99%)	↑ 67.3% (57.5% to 96.2%)
Participants increased the rate of NAS-diagnosed infants receiving a safe plan of care by 36.8% (71.2% to 97.4%) and the rate of maternal patients receiving a safe plan of care by 144.4% (37% to 90.5%) (supports care coordination and SDOH mitigation).	↑ 36.8% (71.2% to 97.4%)	↑ 144.4% (37% to 90.5%)

The Comprehensive Addiction and Recovery Act of 2016 amended the Child Abuse Prevention and Treatment Act to include the requirement that a plan of safe care be created that addresses the health care and SUD treatment of both the infant, parent/caregiver and family. CARA amendments make clear that infants born affected by prenatal substance exposure, experiencing withdrawal symptoms or having fetal alcohol spectrum disorder have a POSC implemented so families can gain access to needed services.[11] A POSC is a requirement of the newborn crisis assessment that is completed by Children's Division when a report is made to the Child Abuse/Neglect Hotline.[12]

In order to support early engagement in recovery treatment models, the POSC, also termed family care plan, should be initiated early in the prenatal period; shared with the multidisciplinary team across the care continuum; be rooted in evidence-based practices; and maintain focus on addressing the family's needs, including social drivers of health, to ensure positive health and well-being for the infant, individual(s) and family unit.[11,13] Resources regarding plans of safe care or family care plans, including templates and eLearning options, are included in the Resources section of this document.

Finally, and most importantly, it is critical for all stakeholders working with maternal patients with SUD to understand that SUD is a chronic medical condition with evidence-based care guidelines. Although there are established and effective treatments for SUD, similar to other chronic conditions such as diabetes and hypertension, pregnant people with SUD confront a vastly different health care experience. Pregnant people with SUD commonly face stigma, discrimination and legal penalties when seeking care. Many may not seek prenatal or postnatal care at all for fear of this discrimination and child custody concerns. This poor treatment is unjustly experienced at higher rates by pregnant people of color and the underprivileged. The AIM Care for Pregnant and Postpartum People with SUD patient safety bundle is a collection of best practice recommendations designed to improve the care experienced by those with SUD to realize positive and equitable outcomes for all.[14,15] AIM CPPPSUD bundle components are included in this booklet, and resources for key process implementation are included in the Resources section of this document.

Missouri's Call to Action

The Missouri PAMR Board reviews all deaths of women and birthing people while pregnant or within one year of the end of the pregnancy. Pregnancy-associated death is the overarching term used when referring to maternal deaths. Within this broad categorization are more specific terms to describe the cause of death including, pregnancy-related death, pregnancy-associated, but not related (PANR) death and pregnancy-associated, but unable to determine relatedness.[17] See definitions below.

Pregnancy-related death: Death occurring during or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiological effects of pregnancy[16]

PANR: Death during or within one year of pregnancy from a cause that is not related to pregnancy[16] (e.g., pregnant person who dies in a natural disaster)

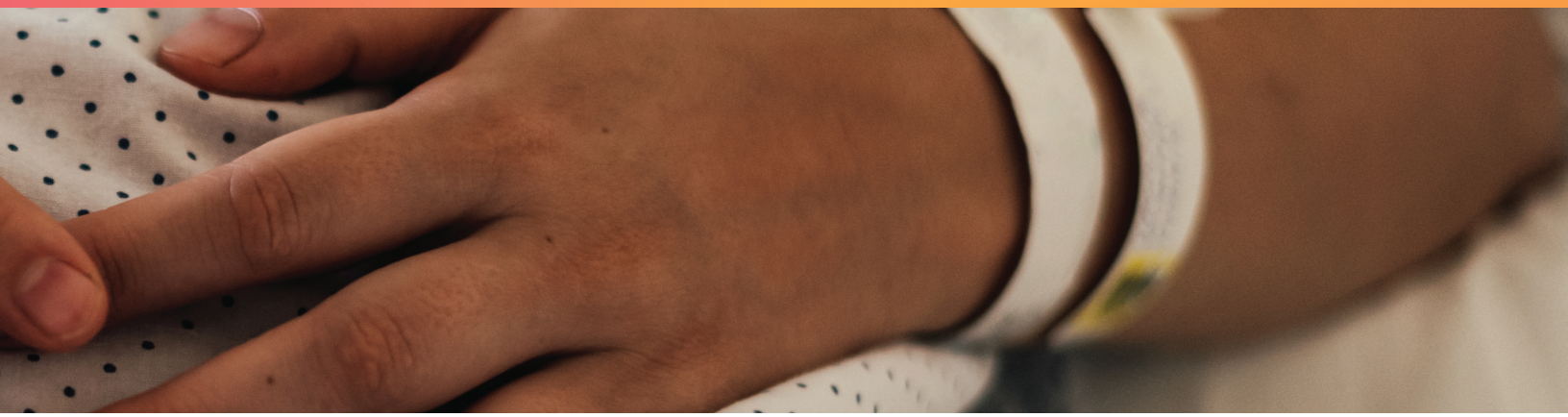
Pregnancy-associated, but unable to determine relatedness: Cases when the board was unable to determine if a death was pregnancy-related or PANR[16]

Maternal morbidity: Unexpected negative outcomes of childbirth resulting in short- or long-term health impacts.[16]

Maternal mortality: The World Health Organization defines a maternal death as "a death while pregnant or within 42 days of the end of the pregnancy from any cause related to or aggravated by pregnancy or its management, but not from accidental or incidental causes."[17] In Missouri, the term maternal mortality is used to describe deaths that occur during pregnancy, at delivery and up to one year after the end of a pregnancy.[16]

SUD is a chronic disease with lasting effects for the birthing person, infant, family and community. Worsening rates of maternal SUD have been perpetuated by the global opioid epidemic, including use of unnecessary prescribing practices for this population, and further is impacted by the "pair of ACEs" — the combined effects of adverse traumatic life events and social determinants of health.

The 2023 Missouri PAMR report, reviewing maternal deaths from 2018 to 2020, found mental health conditions, including SUD, were the primary underlying cause of pregnancy-related deaths. Forty-nine percent of pregnancy-related deaths occurred between 43 and 365 days postpartum — calling for interventions across the care continuum, especially during the postpartum period when care often ends at six weeks postbirth. Additionally, disparate health outcomes were noted for Black birthing persons and those with Medicaid insurance.



Perhaps of critical concern is that ***all*** pregnancy-related deaths due to mental health conditions, including SUD, were found to be preventable.[16]

The MO PQC has determined that implementing a mother/birthing person-infant dyadic model of care will serve to promote healthier outcomes for both, while ensuring inclusion of the father/partner, support person(s) and family. Initiation of family care plans (also known as plans of safe care) early in the prenatal period supports resource and care access and a greater opportunity to maintain the mother/birthing person-infant dyad.[18]

Much of the AIM CPPPSUD bundle serves to close the noted gaps in Missouri, as applied through the 3As Framework — acceptability, availability and accessibility.[18]

Acceptability — Health care workers, social support providers and communities must take steps to both recognize and mitigate their own stigma and implicit bias against persons with SUD and mental health diagnoses, both chronically referenced in multiple literature sources. System-level strategies are necessary to address institutional racism and discrimination. Eliminating these system-level and individual barriers through the provision of respectful, inclusive and safe environments for pregnant and postpartum people and their chosen support networks allows a safe space for disclosure of substance use, the receipt of recommended medical care and treatment and connection to needed resources.[18]

Availability and Accessibility — Supportive policies and funding mechanisms are needed to increase the availability and accessibility of care, as well. Missouri lacks mental health and SUD services in many parts of the state, especially those serving the perinatal population.[19] Providers should assess their capacity and competency in serving maternal populations with SUD to strengthen access to medication therapies and behavioral health resources, specifically in rural areas. Leveraging community-based roles, such as peer recovery specialists, community health workers and doulas, also may strengthen the recovery support network. Early patient engagement in medical and social care and resource referrals increases opportunities to educate the patient, results in fewer conflicts in care needs at the time of birth, improves patient-provider relationships and produces better overall health outcomes.[18]

Missouri perinatal care providers now can enroll in the Missouri Maternal Health Access Project. MHAP is a statewide perinatal psychiatry access program developed to offer health care providers with the tools and support to recognize and effectively treat perinatal mental and behavioral health conditions, including SUD. Contact musompsychiatrymh1@missouri.edu for more information and enroll in MHAP.[20]

AIM Bundle Components[21]

Readiness — Every Unit

- ☐ Provide education to pregnant and postpartum people related to SUDs, naloxone use, harm reduction strategies and care of infants with in-utero substance exposure.*
- ☐ Develop trauma-informed protocols and anti-racist training to address health care team member biases and stigma related to SUDs.
- ☐ Provide clinical and nonclinical staff education on optimal care for pregnant and postpartum people with SUD, including federal, state and local notification guidelines for infants with in-utero substance exposure and comprehensive family care plan requirements.*
- ☐ Engage appropriate partners to assist pregnant and postpartum people and families in the development of family care plans, starting in the prenatal setting.*
- ☐ Establish a multidisciplinary care team to provide coordinated clinical pathways for people experiencing 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 supports for pregnant and postpartum families for social determinants of health needs, behavioral health supports and SUD treatment.

Recognition & Prevention — Every Patient

- ☐ 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.

*See CPPPSUD Element Implementation Details.

Response — Every Event

- ☐ Assist pregnant and postpartum people with SUD to receive evidence-based, person-directed SUD treatment that is welcoming and inclusive in an intersectional manner and discuss readiness to start treatment, as well as referral for treatment with warm hand-off and close follow-up.*
- ☐ 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 and Systems Learning — Every Unit

- ☐ 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 payer as able.*
- ☐ Convene inpatient and outpatient providers and community stakeholders, including those with lived experience in an ongoing way, to share successful strategies and identify opportunities to improve outcomes and system-level issues.*

Respectful, Equitable, and Supportive Care — Every Unit/Provider/Team Member

- ☐ Engage in open, transparent and empathetic communication with the pregnant and postpartum persons and their identified support network to understand diagnosis, options and treatment plans.*
- ☐ Integrate pregnant and postpartum persons as part of the multidisciplinary care team to establish trust and ensure informed, 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.*[21]

*See CPPPSUD Element Implementation Details.

Resources Section

General

AIM: Care for Pregnant and Postpartum People with Substance Use Disorder Patient Safety Bundle
AIM: CPPPSUD Element Implementation Details
AIM: CPPPSUD Patient Safety Bundle Implementation Resources
AIM: CPPPSUD Change Package
SAMHSA: Advisory: Evidence-Based, Whole Person Care of Pregnant People Who Have Opioid Use Disorder
SAMHSA: Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants
National Harm Reduction Coalition: Pregnancy and Substance Use: A Harm Reduction Toolkit

Education

MHA and Addiction Technology Transfer Center: Optimizing Care of the Mother-Baby Dyad Affected by Substance Use Disorder
ACOG: CPPPSUD PSB Learning Module

Screening Tools

National Institutes of Health/National Institute on Drug Abuse: Screening and Assessment Tools Chart
NTI Upstream: The 4P's Plus© Screening Instrument
Illinois Perinatal Quality Collaborative: The 5Ps Prenatal Substance Abuse Screen for Alcohol and Drugs

Urine Drug Testing

MO PQC: Perinatal Urine Drug Testing Guidance

Buprenorphine/Naloxone Initiation in Pregnancy

Institute for Healthcare Improvement and AIM: Buprenorphine/Naloxone Initiation in Pregnancy - Appendix B of AIM CPPPSUD Change Package

SAMSHA Recommended Resources for Substance Use Disorder Training for DEA Registrants

Coalition of Physician Education in SUD: Substance Use Disorder Curriculum and Resources
University of California San Francisco Smoking Cessation Leadership Center: National Center of Excellence for Tobacco-Free Recovery
NIH: Training Resources
Providers Clinical Support System: Medications for Opioid Use Disorders Training
U.S. Food & Drug Administration: Opioid Analgesic Risk Evaluation and Mitigation Strategy (REMS)
Centers for Disease Control and Prevention: Training for Healthcare Professionals
SAMHSA: Evidence-Based Practices Resource Center
DEA: DEA Specific Guidance

Missouri Training

Missouri Telehealth Network/Show-Me ECHO: OUD ECHO
Missouri Telehealth Network/Show-Me ECHO: Pain Management ECHO
Missouri Telehealth Network/Show-Me ECHO: Mothers, Infants & NAS ECHO

Eat, Sleep, Console

NIH: Eat, Sleep, Console Approach: A Family-Centered Model for the Treatment of Neonatal Abstinence Syndrome
Boston Medical Center Corporation, Dr. Matthew Grossman and Children's Hospital at Dartmouth-Hitchcock: ESC NAS Care Tool — See appendices for care tool and treatment algorithms.
California Perinatal Quality Care Collaborative: Eat, Sleep, Console (ESC)
SAMHSA: Clinical Guidance for Treating Pregnant and Parenting Women with OUD and Their Infants

- Infant care information starts on page 76.
- Screening and assessment for NAS starts on page 78.
- Management of NAS starts on page 84.

MHA: Reducing Neonatal Abstinence Syndrome by Improving Care of the Maternal-Infant Dyad Affected by Substance Use Disorder: Transitioning Models of Care: An Implementation Guide

Plans of Safe Care or Family Care Plan

MO PQC: Plans of Safe Care and Family Care Plans Guidance Document
Oklahoma Department of Mental Health and Substance Abuse Services: Family Care Plan eLearning module
American Academy of Pediatrics: Family Care Plan Template
National Center on Substance Abuse and Child Welfare: Plan of Safe Care Expert Video Series
Legislative Analysis and Public Policy Association: Model Substance Use During Pregnancy and Family Care Plans Act

Stigma/Bias and Respectful Care Resources

Association of State and Territorial Health Officials: Stigma Reinforces Barriers to Care for Pregnant and Postpartum Women with SUD
NIH: Your Words Matter — Language Showing Compassion and Care for Women, Infants, Families and Communities Impacted by SUD
March of Dimes: Beyond Labels: Do Your Part to Reduce Stigma
ACOG: Respectful Care eModules
AIM: Respectful Care Education for Providers: Options for How to Start Making Progress webinar recording – A full resource list is available at the end of the presentation.

Examples

Peripartum Care Protocol for Post-Cesarean Pain Management for Patients on Opioid Maintenance Treatment
EPIC TAPS Screening Tool Build Example

References

1. Health Resources & Services Administration. (n.d.). Alliance for innovation on maternal health (AIM) capacity. Retrieved November 10, 2023, from https://www.hrsa.gov/grants/find-funding/HRSA-23-066
2. American College of Obstetricians & Gynecologists. (n.d.). AIM patient safety bundles. Retrieved November 10, 2023, from https://saferbirth.org/patient-safety-bundles/
3. Mascola, M. A., Borders, A. E., & Terplan, M. (2017). Committee opinion no. 711: Opioid use and opioid use disorder in pregnancy. *Obstetrics & Gynecology, 130*(2), e81-e94. https://doi.org/10.1097/AOG.0000000000002235
4. Ecker, J., Abuhamad, A., Hill, W., Bailit, J., Bateman, B. T., Berghella, V., Blake-Lamb, T., Guille, C., Landau, R., Minkoff, H., Prabhu, M., Rosenthal, E., Terplan, M., Wright, T. E., & Yonkers, K. A. (2019). Substance use disorders in pregnancy: Clinical, ethical, and research imperatives of the opioid epidemic: A report of a joint workshop of the Society for Maternal-Fetal Medicine, American College of Obstetricians and Gynecologists, and American Society of Addition Medicine. *American Journal of Obstetrics & Gynecology, 221*(1), B5-B28. https://doi.org/10.1016/j.ajog.2019.03.022
5. Substance Abuse and Mental Health Services Administration. (2024). Evidence-based, whole-person care for pregnant people who have opioid use disorder [PDF]. *Advisory.* Publication No. PEP23-02-01-002. https://store.samhsa.gov/sites/default/files/whole-person-care-pregnant-people-oud-pep23-02-01-002.pdf
6. Substance Abuse and Mental Health Services Administration. (2023, October 10). Waiver elimination (MAT Act). https://www.samhsa.gov/medications-substance-use-disorders/waiver-elimination-mat-act
7. Substance Abuse and Mental Health Services Administration. (2023, April 24). Recommendations for curricular elements in substance use disorders training. https://www.samhsa.gov/medications-substance-use-disorders/provider-support-services/recommendations-curricular-elements-substance-use-disorders-training
8. Hussey, K. (2020). Reducing Neonatal Abstinence Syndrome by improving care for the maternal-infant dyad affected by substance use disorder: Transitioning models of care: An implementation guide. Missouri Hospital Association. https://www.mhanet.com/mhaimages/SQI/Maternal_Health/NAS_workbook.pdf
9. Grossman, M. R., Berkwitt, A. K., Osborn, R. R., Xu, Y., Esserman, D. A., Shapiro, E. D., & Bizzarro, M. J. (2017). An initiative to improve the quality of care of infants with neonatal abstinence syndrome. *Pediatrics, 139*(6), e1-e8. https://doi.org/10.1542/peds.2016-3360
10. Williams, A. (2023). Missouri Neonatal Abstinence Syndrome collaborative evaluation: Implementation of the Eat, Sleep, Console model of care. Missouri Perinatal Quality Collaborative, Missouri Hospital Association. https://www.mhanet.com/mhaimages/QSR/MO_NAS_Collaborative_Evaluation.pdf
11. Quality Improvement Center Collaborative Community Court Teams (n.d.). Plans of safe care: An issue brief for judicial officers. https://cffutures.b-cdn.net/wp-content/uploads/2020/05/Judicial_Officers_POSC_Brief-1.pdf
12. Missouri Department of Social Services. (n.d.). Newborn crisis assessments. Child Welfare Manual. Retrieved March 25, 2024, from https://dssmanuals.mo.gov/child-welfare-manual/section-2-chapter-4-non-child-abuse-neglect-referrals-subsection-4-newborn-crisis-assessments/#:~:text=A%20Newborn%20Crisis%20Assessment%20is,a%20newborn%20from%20the%20hospital
13. Legislative Analysis and Public Policy Association. (2023, March). Model substance use during pregnancy and family care plans act. https://legislativeanalysis.org/wp-content/uploads/2023/03/Model-Substance-Use-During-Pregnancy-and-Family-Care-Plans-Act.pdf
14. Mather, C., & Goodman, D. (n.d.). Care for pregnant and postpartum people with substance use disorder change package. Retrieved March 25, 2024, from https://saferbirth.org/wp-content/uploads/SUD__CP_Final_V1_2022-2.pdf
15. Bogard, N. (2022). Confronting pregnancy criminalization: A practical guide for health care providers, lawyers, medical examiners, child welfare workers, and policymakers. National Advocates for Pregnant Women. https://www.pregnancyjusticeus.org/wp-content/uploads/2023/09/1.Confronting-Pregnancy-Criminalization_6.22.23.pdf
16. Missouri Department of Health and Senior Services. (2023, July). Missouri Pregnancy Associated Mortality Review 2018-2020 Annual Report. Retrieved from https://health.mo.gov/data/pamr/pdf/2020-annual-report.pdf
17. Hoyert, D. L. (2023). Maternal mortality rates in the United States, 2021. NCHS Health E-Stats. https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.htm#ref1
18. Williams, A. (2021). Missouri AIM: Care for pregnant and postpartum people with substance use disorder. Missouri Hospital Association. https://www.mhanet.com/mhaimages/SQI/Maternal_Health/2021_AIM_Report_REVLR.pdf
19. The Uplift Connection. (2023). Missouri's Perinatal SUD Resource Map. Retrieved from https://www.theupliftconnection.org/sud-resources
20. Missouri Department of Social Services. (2024, March). MHAP enrollment flyer — March 2024. https://mydss.mo.gov/media/pdf/mhap-enrollment-flyer-march-2024
21. American College of Obstetricians and Gynecologists. (2022). Alliance for innovation on maternal health: Care for pregnant and postpartum people with substance use disorder patient safety bundle. https://saferbirth.org/wp-content/uploads/U2-FINAL_AIM_Bundle_CPPPSUD.pdf

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