GROW-WI
GATHERING THE RURAL OB WORKFORCE IN WI

Project ECHO®

Gathering the **R**ural **O**B **W**orkforce in **WI**
GROW-WI ECHO Program

How to Join:
https://iecho.org/public/program/PRGM17425658124325CC96FHKX3

For attendance purposes, please text the code PEHROZ to 608-260-7097.

Session Date: April 22, 2025
Facilitator: Jillian Landeck, MD

	Topic	**Presenter**
Case Presentation	Undiagnosed pregnancy presents for delivery	Rachel Hartline, MD, FM OB, Upland Hills Health, Dodgeville, WI
Educational Presentation	Substance Use in Pregnancy and Neonatal Withdrawal Syndromes	Rachel Hartline, MD, FM OB, Upland Hills Health, Dodgeville, WI Jillian Landeck, MD, FM OB UW Dept of Family Medicine and Community Health

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Agenda:

7:30 – 7:35 AM – Welcome and Introductions
-Text-in your attendance, even if you do not plan to claim Continuing Education credits.

7:35 – 8:00 AM – Case Presentation

8:00 – 8:30 AM – Educational Presentation

Continuing Education Credits:
To claim CE credit, **you must complete the evaluation form after each session**.
ICEP will email you a link to the evaluation form after texting in for attendance.

Interprofessional Continuing Education Partnership
UNIVERSITY OF WISCONSIN-MADISON

GROW-WI ECHO (Gathering the Rural OB Workforce in WI)
2025-2026
Substance Use in Pregnancy and Neonatal Withdrawal Syndromes
April 22, 2025
Rachel Hartline, MD; Jillian Landeck, MD

Provided by the University of Wisconsin–Madison Interprofessional Continuing Education Partnership (ICEP)

Intended Audience:
MD/DO, RN, APRN, Physician Assistants, Certified Nurse Midwives, Students

Objectives:
1. Demonstrate perinatal and newborn impact of substance use in pregnancy
2. Evaluate potential options for management of substance use in pregnancy
3. Explain neonatal withdrawal symptoms and diagnosis

Policy on Disclosure
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** **Ineligible companies** are those whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients. The ACCME does not consider providers of clinical service directly to patients to be ineligible companies.*

Name	Role	Financial Relationship Disclosures	Discussion of unlabeled/unapproved uses of drugs/devices in presentation	COI completion date
Jillian Landeck, MD	Presenter	No relevant financial relationships with ineligible companies to disclose.	No	4/4/2025
Rachel Hartline, MD	Presenter	No relevant financial relationships with ineligible companies to disclose.	No	4/15/2025
Jillian Landeck, MD	RSS Chair	No relevant financial relationships with ineligible companies to disclose.	NA	3/25/2025
Jenny White	RSS Coordinator	No relevant financial relationships with ineligible companies to disclose.	NA	3/27/2025
Korina Bauer, RN, CPM, LM	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	3/25/2025
Bonnie Brown, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	4/8/2025
Jensena Carlson, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	3/27/2025
Lee Dresang, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	4/17/2025
Rachel Hartline, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	4/15/2025
Ryan Luellwitz, DO	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	3/26/2025
Rebecca Pfaff, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	4/6/2025
Allegra Ponshock, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	3/29/2025
Ryan Spencer, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	3/31/2025
Shannan Stephens, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	4/10/2025

Accreditation Statement

In support of improving patient care, the University of Wisconsin–Madison ICEP is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC) to provide continuing education for the healthcare team.

Credit Designation Statements

The University of Wisconsin-Madison ICEP designates this live activity for a maximum of 1.0 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

The University of Wisconsin–Madison ICEP designates this live activity for a maximum of 1.0 ANCC contact hour(s).

The University of Wisconsin–Madison ICEP, as a member of the University Professional & Continuing Education Association (UPCEA), authorizes this program for 0.1 CEUs or 1.0 hour.

Welcome!

We will get started shortly.

Feel free to share your name, title, and/or organization in the chat.

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The University of Wisconsin–Madison ICEP designates this live activity for a maximum of 1 ANCC contact hour.

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- The planning committee has no conflicts of interest to disclose.

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Continuing Ed Credit

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1. Log your attendance (as above)
   - Create an ICEP account if you don't already have one.

2. Fill out the session evaluation form to receive credit – **REQUIRED for credit**.
   - A link to the evaluation will be sent after you text the code.

**Continuing Education Units with the Midwifery Education Accreditation Council are coming!

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Planning Team

Korina Bauer, RN, CPM, LM – WI Guild of Midwives, Iola, WI

Bonnie Brown, MD – UW DFMCH

Jensena Carlson, MD – UW DFMCH

Lee Dresang, MD – UW DFMCH

Rachel Hartline, MD* – FMOB, Upland Hills Health, Dodgeville, WI

Jillian Landeck, MD* – UW DFMCH

Ryan Luellwitz, MD – UW OB GYN

Rebecca Pfaff, MD – FMOB, Forks Community Hosp, Forks, WA

Allegra Ponshock, MD* – FMOB, Mile Bluff Med Ctr, Mauston, WI

Ryan Spencer, MD – UW OB GYN

Shannan Stephens, MD – Gundersen OB GYN, La Crosse, WI

Jenny White* – UW DFMCH

*Thanks to Gretchen Spicer, CPM, LM for her contributions to planning

* Core Facilitation Team

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Friendly Reminders

- Video appreciated
- Use chat function to ask questions or raise hand if able
- Mute microphone when not speaking
- Maintain confidentiality, no PHI
- Didactic will be recorded
- Mission is to empower those working in rural settings
- Our diversity of perspectives, specialties, practice scopes are our strength
- **"Coming together is a beginning. Keeping together is progress. Working together is success."** - Henry Ford

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Announcements

Please join us next month!

Tuesday May 27th, 7:30-8:30AM

Scope of Practice of Licensed Midwives in WI

- Korina Bauer, RN, CPM, LM, Co-President of Wisconsin Guild of Midwives

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Interested in sharing a case?

Email jennifer.white@fammed.wisc.edu

- Slide template shared, 10 min for details of case
- Priority to cases from rural and resource-limited settings
- No PHI
- Include on CV as a state presentation

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A Review of a Harrowing Obstetric and Newborn Case

Rachel Hartline

Upland Hills Health

April 22, 2025

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Disclosures & Disclaimers

- No relevant financial disclosures
- Rachel is an ALSO instructor and thinks it is great
- We think obstetric care and substance use care are both critically important

- PATIENT RELATIONSHIP DISCLAIMER
  - PLEASE NOTE that Project ECHO® case consultations do not create or otherwise establish a provider-patient relationship between any clinician and any patient whose case is being presented in a Project ECHO® setting.

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Case Introduction

- One-liner (including age, G&Ps, GA if applicable):
- call from the ER: 37 year old female with presenting with abdominal pain is pregnant–unsure gestation, maybe 22 weeks—with a bulging amniotic sac on sterile speculum exam

- Primary question for discussion:
  - What are considerations for an undiagnosed pregnancy presenting in labor in a rural setting?

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Obstetrical/Prenatal History:

- chili dog → n/v and abdominal pain 3-4 d ago
- worsening crampy pain, now severe, BLQ with radiation to her back
- limited PO and UOP today with recurrent n/v x 4
- no other urinary or bowel sx
- LMP one month ago, was normal from the 4th-8th, typically she has light periods every month

Past Medical History:

- ADHD, not on meds
- Very limited past interaction with healthcare system

Exam:

T:97.4 °F (36.3 °C)
HR: 99
RR: 24
BP: 148/75
O2: 98 %

Pertinent initial exam:

- Tearful; tachycardic
- Abdominal: protuberant, firm, nontender, decreased BS
- GU exam - sterile speculum - amniotic sac membrane noted

- FH→well above umbilicus
- Doptones quite audible and easily traced

Labs & Imaging:

COVID neg
CBC with 16.6 WBC with L shift
CMP remarkable for alk phos 214
Urine HCG +
Quant 6027
Normal lipase
u/a + for 40 ketones, small bili, 30 protein
Blood type B+

Bedside US by ED: appears >20 weeks gestation

- u/s tech arrives, limited measurements consistent with 34-35 weeks
- Breech position

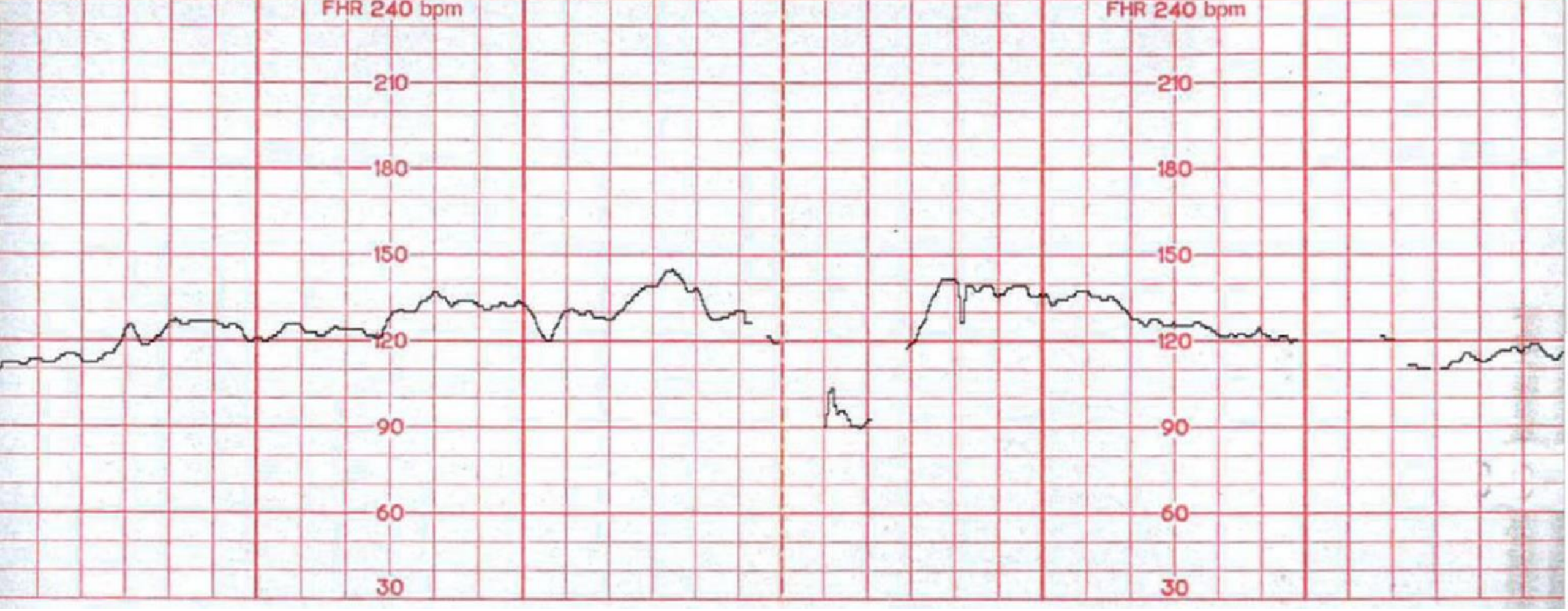
- Pt increasingly uncomfortable and pushy
- FP hospitalist partner checked patient and complete→ OR staff notified to come for potential section

Proposed diagnoses/management plan:

- Vaginal Breech delivery vs C/S

CAREFUL Mnemonic for Breech Delivery

- **C**heck presentation, dilation, and cord
- **A**wait umbilicus
- **R**otate for arms
- **E**nter for Mauriceau-Smellie-Veit (MSV) maneuver
- **F**lex the fetal head
- Back **U**p (sacrum anterior)
- **L**ift baby onto mother



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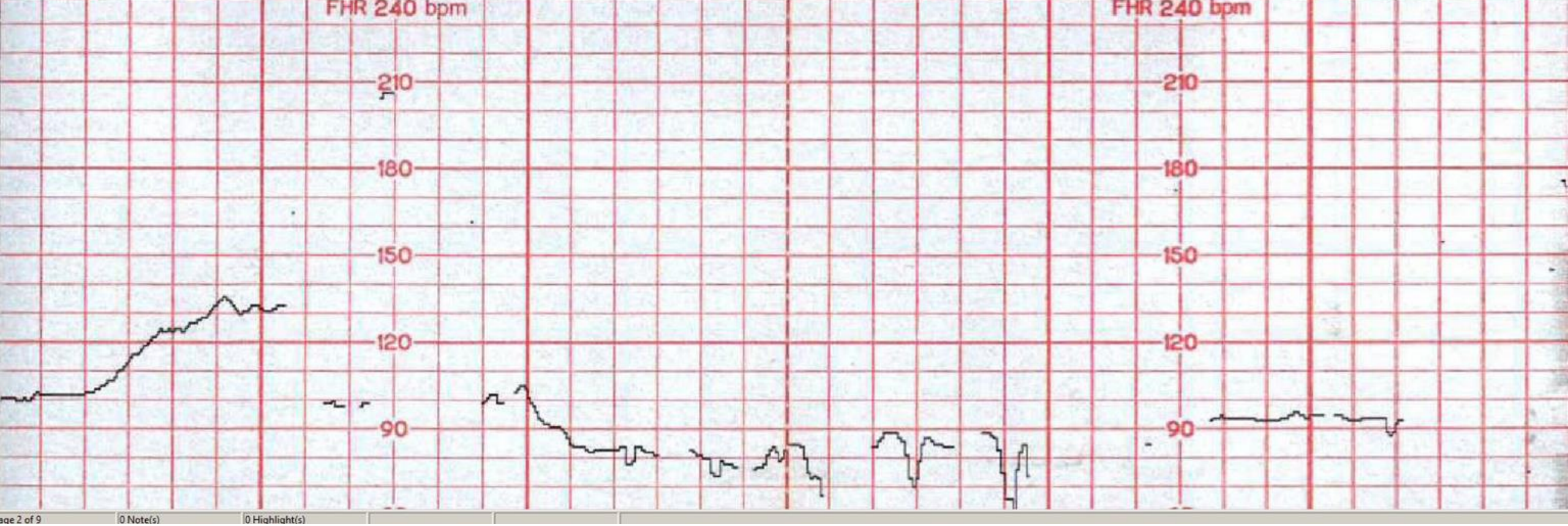

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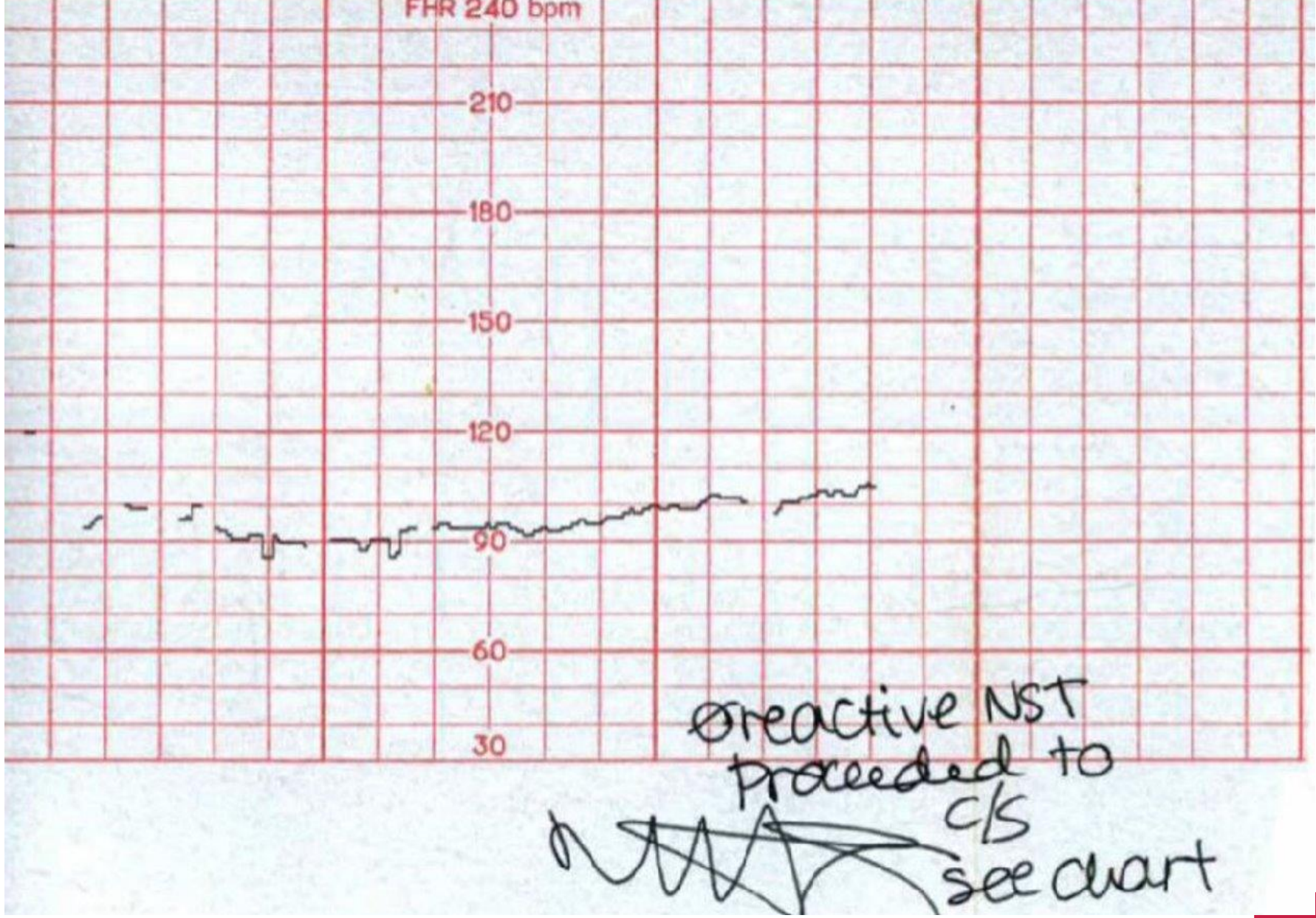

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Social History

- Endorsed occasional and fairly recent cocaine use
- Tobacco (chewing)
- THC
- Some alcohol use during pregnancy
- Denied other substances

Amphetamines Screen Urine NEGATIVE	NEGATIVE
Barbiturates Screen Urine NEGATIVE	NEGATIVE
Benzodiazepine Urine NEGATIVE	NEGATIVE
Buprenorphine Urine NEGATIVE	NEGATIVE
Cocaine Screen Urine NEGATIVE	**POSITIVE !**
Methamphetamine Screen Urine NEGATIVE	NEGATIVE
Methadone Screen Urine NEGATIVE	NEGATIVE
Opiates Urine NEGATIVE Comment: Hydrocodone can cross react and ca with this test method	**POSITIVE !**
Oxycodone Urine NEGATIVE	NEGATIVE
Phencyclidine Screen Urine NEGATIVE	NEGATIVE
Propoxyphene Urine NEGATIVE	NEGATIVE
Cannabinoids Screen Urine NEGATIVE	**POSITIVE !**
Tricyclic Antidepressants Urine NEGATIVE	NEGATIVE

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Timeline/L&D details:

- Tight abdominal muscles and somewhat smaller uterus
- Foley not placed prior to procedure
- Upper back and shoulder presented upon hysterotomy
- Attempts to elevated fetal breech from maternal pelvis initially unsuccessful due to low station
- Subsequently attempted to flex head out of uterine fundus, again without success
- Returned to elevation of breech and legs delivered, followed by breech, and arms
- Head stuck in clamped down uterus→ gentle traction on jaw/face and incision widened with success

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Timeline/L&D details:

- Anethesia aware of crash section 2126
- Spinal in 2128
- Procedure start 2132
- Uterine incision 2137
- Delivery 2142

- Deep vaginal extension
- No bladder injury
- KUB for crash without counts, negative

- 4 lb 15 oz
- Apgars: 2, 2, 4, 5
- Ballard 36 weeks
- 2 vessel cord
- Placental pathology:
  - Mild focal acute chorio and small infarction

Resuscitation details:

2142 delivery.
No spontaneous respirations→ ventilated by RT

Upon arriving at warmer HR 60s, then 40s→ compression started (OB RN star of resuscitation-your nurses are your greatest resource)

UVC placed by ER physician but unfortunately lost

UVC replaced by FP hospitalist

Intubated by ER doc and confirmed by CRNA subsequently On XR high and pulled back. Epi prepped but HR improving so not given

Given 2 cc NS bolus→ d10 @4 cc/h

Total 14 min CPR– 11 min prior to intubation and 3 min after

2152 infant responsive
2156 pulse 100
Approx 2225 NICU transport arrived (45 min of life)

Outcomes

- Mom
  - Transferred to Meriter the next morning
  - Etonorgesterel arm implant placed prior to discharge
  - R sided rib pain worse with movement or UE weightbearing has continued but improved since delivery. Remained on gabapentin 300 TID for several months.
  - CPS followed for additional monitoring and support
  - No ongoing concerns about parenting or safety related to substance use
- Baby
  - Medflight to Meriter
  - Urine and meconium tox consistent with mother's UDS
  - Normal head u/s
  - Extubated to RA on DOL #2
  - 7 day NICU stay
  - Now 3 years old, healthy, lost to f/u but meeting milestones as of last visit

Key learning points:

- Thank you to a fabulous team
- Communication:
  - Initial call information→anchoring vs. switching gears
  - OR and newborn staff on hand vs. decision for section
  - Discussion regarding urgency
- Need to think about transfer needs early on
  - Notification of transfer NICU team- who, when, additional updates
- Strategies for management of entrapped head
    - Use of nitrous
    - Repositioning

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System issues/Areas for Improvement:

- Safety
  - Placement of foley when transferring to OR
  - Prepping OR and deciding which OR
  - Clarification of Crash
    - Color system with incision-to-decision target time
  - Checklist
    - Avoiding delays in moving to OR after consent signed

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Open Discussion

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Substance Use in Pregnancy and Neonatal Opioid Withdrawal Syndrome

Rachel Hartline and Jillian Landeck

April 22, 2025

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Disclosures

- No Disclosures

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Objectives

1. Demonstrate perinatal and newborn impact of substance use in pregnancy
2. Evaluate potential options for management of substance use in pregnancy
3. Explain neonatal withdrawal symptoms and diagnosis

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Substance Use In Pregnancy

Most common substance: ETOH>nicotine>THC depending on source.

- THC most common “illicit” substance
- If harder substances, usually accompanied by these three as well
  - Our patient not atypical since she had cocaine and questionable opiates.
- Older patients more likely to consume ETOH during pregnancy.

- ACOG recommends using a validated screening tool universally at first prenatal visit
- If positive brief intervention (motivational interview) and referral to treatment
- Make sure to screen for and treat comorbid mental illness

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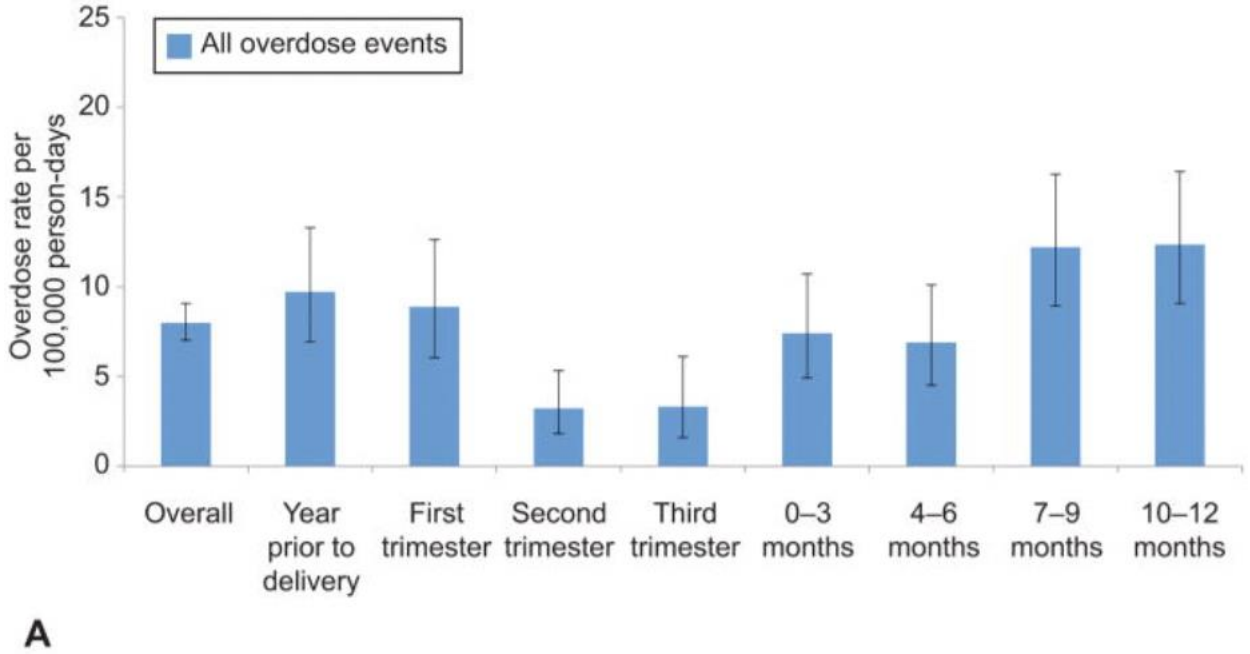
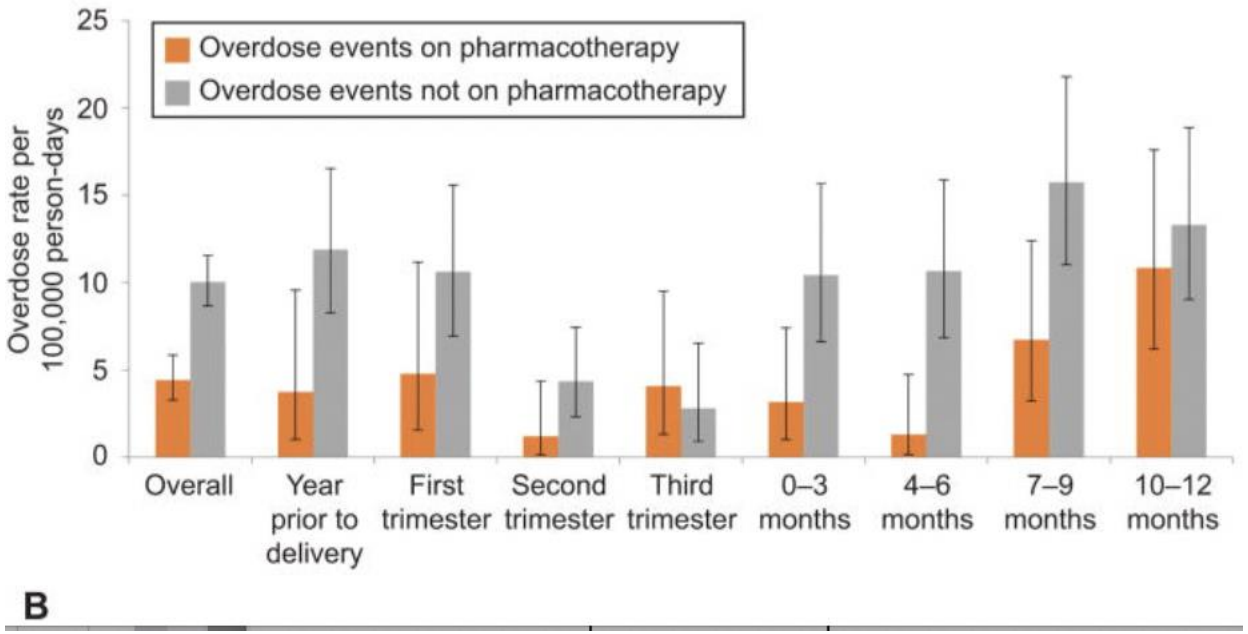
Overdose accounts for 1/3 of pregnancy-associated deaths in WI





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Screening Tools

- Your biggest ally is creating a non-judgmental environment that makes mother feel safe sharing her struggles with you
- Shifting from “Why would someone who uses drugs get pregnant?” to “Substance use is common. How can we support someone who uses drugs when they get pregnant?”
- Words Matter
- Helpful to use a validated screening tool that standardizes verbiage and addresses concerns around use of information

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Perinatal Providers

EAST BATON ROUGE PARISH

4Ps Plus Screen for Perinatal Substanc

☐ INITIAL SCREEN ☐ REPEAT SCREEN

Physician: _____

Patient Name: _____

Date Of Birth: _____

Address: _____

Patient's Phone #: _____

Parents	Did either of y drugs or alcoh
Partner	Does your par
	Is your partne
	Have you ever
	Does your par
Past	Have you ever
	Have you ever
	Have you lost
Pregnancy	In the month b many cigarette
	In the month b much wine/be

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Follow-up Questions to 4

1. Sometimes a woman feel better or to relax?
   a. Talk things over wit
   b. Smoke cigarettes?
   c. Smoke marijuana o
   d. Have a drink of bee
   e. Take some type of
2. And last month, about ho
   ☐ Did not drink
3a. During the month before
   ☐ Did not use any drug
3b. During the month before heroin or meth?
   ☐ Did not use any drug
4a. And last month, about h
   ☐ Did not use any drug
4b. And last month, about h
   ☐ Did not use any drug
5. And last month, about h
   ☐ Did not smoke

Intervention and Referrals M

Referral

☐ Brief Intervention
☐ Domestic Violence
☐ Tobacco Cessation
☐ Substance Abuse Treatment
☐ Mental Health
☐ Other, Specify: _____

☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No

Date: _____ Signature: _____

Circle: MD RN MSW LPN NP MA RD BCS

Screening Site: _____

Introduction (Please read to patien

Hi, I'm _____, nice to mee
help me give you better medica
and other drugs. Some of the su
medications). But I will only rec
prescribed. I'll also ask you abou

Instructions: For each substance, r
monthly in the past year, put a ma

NIDA *Quick Screen* Question:

In the past year, how often ha

Alcohol

- **For men, 5 or more dr**
- **For women, 4 or more**

Tobacco Products

Prescription Drugs for Non-Me

Illegal Drugs

- If the patient says **"NO"** for
  complete.

The CRAFFT Screening Questions - Appendix A

Please answer all questions honestly; your answers will be kept confidential.

Part A

During the PAST 12 MONTHS, did you:	No	Yes
1. Drink any alcohol (more than a few sips)?	☐	☐
2. Smoke any marijuana or hashish?	☐	☐
3. Use anything else to get high?	☐	☐

"Anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff".

If you answered NO to ALL (A1, A2, A3) answer **only B1** below, then STOP.

If you answered YES to ANY (A1, to A3) answer **B1 to B6** below.

Part B

	No	Yes
1. Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
2. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?	☐	☐
3. Do you ever use alcohol or drugs while you are by yourself, or ALONE?	☐	☐
4. Do you ever FORGET things you did while using alcohol or drugs?	☐	☐
5. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?	☐	☐
6. Have you ever gotten into TROUBLE while you were using alcohol or drugs?	☐	☐

Risks of Use

- NOT teratogenic
- Growth restriction
- preE
- Abruption
- Preterm birth
- PPROM
- PPH
- Neonatal withdrawal
- Postnatal growth issues
- SIDS
- Neurobehavioral problems

- Opioids→ primarily related to peaks and troughs and periodic withdrawal
- Cocaine→ HTN and increased cardiovascular toxicity
- THC→ strongest evidence for growth concerns and neurobehavioral issues
- Alcohol→ FAS
- Tobacco→ vasculopathy of placenta
- Difficult to separate from other social factors

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Principles for Treatment

- Weigh risks vs. benefits and consider maternal factors and health
- Connect with behavioral support (but don’t withhold MOUD if pt refuses)
- Open and honest communication with patient and shared decision-making

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Pharmacotherapy Options

- <u>Opioid agonist (buprenorphine or methadone) MOUD is standard of care</u>
  - Most dangerous physiologically and for relapse is opioid withdrawal
  - More engagement with care
  - Maybe slightly better outcomes with bup than methadone

- Gabapentin
  - May increase risk of growth restriction and preterm birth

<u>Stimulant use disorder pharmacotherapy</u>

- Treatment of co-occurring ADHD can reduce illicit stimulant use
- Topiramate contraindicated due to teratogenesis and cleft palate risk
- Bupropion
  - May increase miscarriage rate
  - May decrease birth weight
  - Greater risk at >300 mg/day
  - Risks similar or greater with untreated mental health and substance use
  - Consider stopping if preE develops due to lowering seizure threshold
- Mirtazapine
  - Caution regarding usual side effects (weight gain, sedation)

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Testing Methods

Urine
Meconium- gold standard
Umbilical cord sampling – increase in use

- need to obtain consent
- Get confirmatory testing with GC/MS on immunoassay results

Contraception

Reproductive coercion is real
Critical to ensure patients have a choice about their reproductive plans

Unintended pregnancy
- 50% in general population
- 86% in patients receiving treatment for OUD

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Neonatal Abstinence Syndrome (NAS)/Neonatal Opioid Withdrawal Syndrome (NOWS)

Typically opioids however SSRIs, nicotine, ETOH, benzos capable of producing sx

Presentation:

- sleep/wake cycle disturbance
- Easily overstimulated ie by feeding, talking, eye contact
- Hypertonicity, tremor, jitters
- Tachypnea, diarrhea, gas, vomiting, lack of suck/swallow coordination
- Autonomic dysfunction ie yawning, sweating, sneezing

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Differential diagnosis

- Seizure
  - severe NAS vs hypoglycemia vs anoxic brain injury, electrolyte abnormality ie Ca++
- Irritability/agitation
  - NAS vs sepsis
- Jitters/tremor
  - NAS vs hyperthyroidism

History/Workup:

- hx GDM or maternal thyroid disorder, prolonged deceleration(s) or shoulder dystocia
- CBC, electrolyte panel, glucose, vitals

Timeline for symptom onset

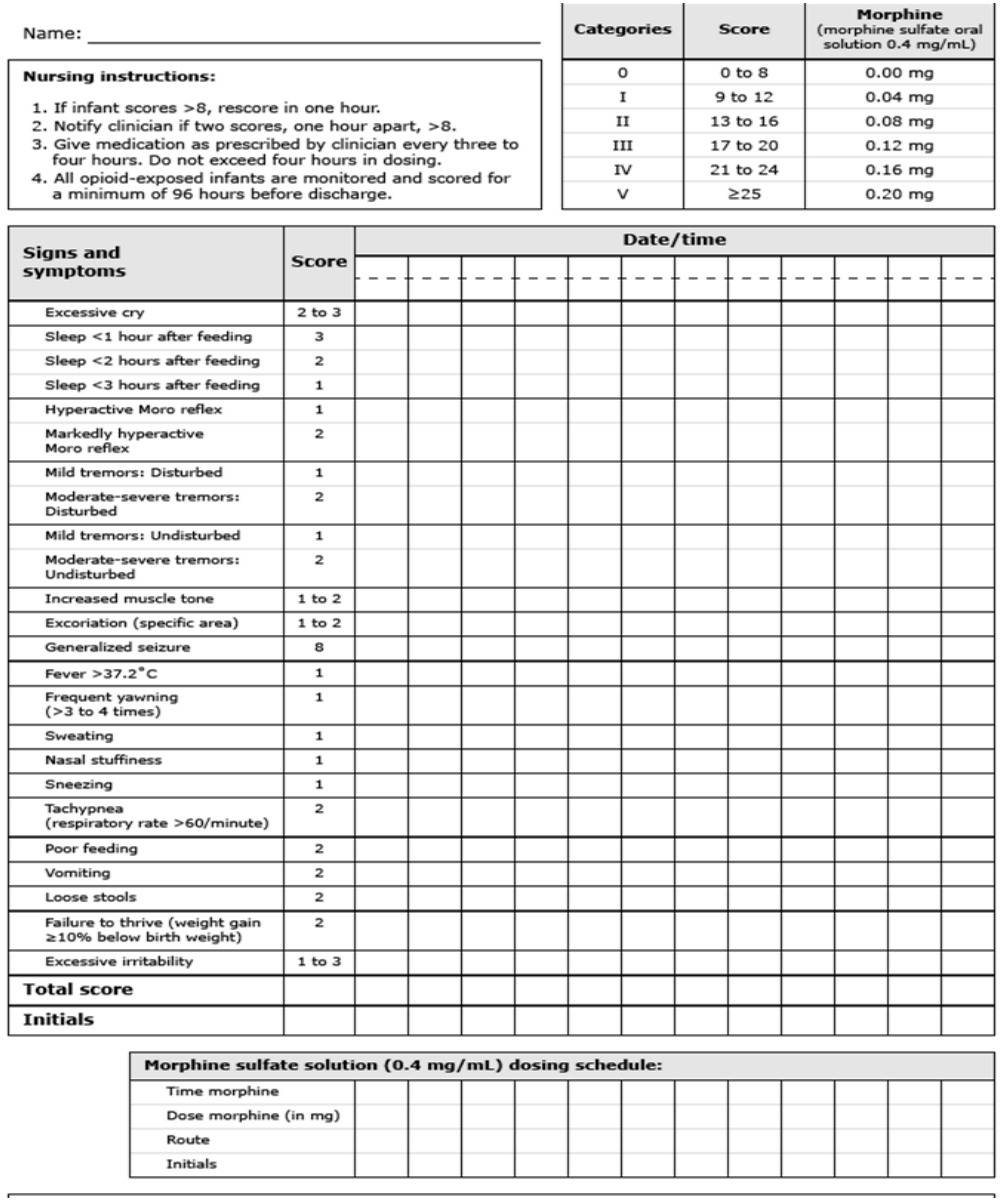
Dependent on substance:

Longer half life substance -->more time until manifestation of sx :

- Methadone, buprenorphine 24-72h, last up to 5 days
- SSRIs vary- 24-48h
- Short acting opiates, benzos typically within 24h, last up to 3 days
- Fentanyl can be more variable (12h-72h) and more severe depending on frequency of exposure

Finnegan scoring system

- Requires unswaddling
- Some symptoms may not be exclusive to NOWS (e.g. hyperactive moro reflex, frequent yawning, nasal stuffiness, sneezing, etc.)
- Concern re: overestimation of needs for pharmacologic treatment
- For infants >37 wks



Name: _____

Nursing instructions:

1. If infant scores >8, rescore in one hour.
2. Notify clinician if two scores, one hour apart, >8.
3. Give medication as prescribed by clinician every three to four hours. Do not exceed four hours in dosing.
4. All opioid-exposed infants are monitored and scored for a minimum of 96 hours before discharge.

Categories	Score	Morphine (morphine sulfate oral solution 0.4 mg/mL)
0	0 to 8	0.00 mg
I	9 to 12	0.04 mg
II	13 to 16	0.08 mg
III	17 to 20	0.12 mg
IV	21 to 24	0.16 mg
V	≥25	0.20 mg

Signs and symptoms	Score	Date/time
Excessive cry	2 to 3	
Sleep <1 hour after feeding	3	
Sleep <2 hours after feeding	2	
Sleep <3 hours after feeding	1	
Hyperactive Moro reflex	1	
Markedly hyperactive Moro reflex	2	
Mild tremors: Disturbed	1	
Moderate-severe tremors: Disturbed	2	
Mild tremors: Undisturbed	1	
Moderate-severe tremors: Undisturbed	2	
Increased muscle tone	1 to 2	
Excoriation (specific area)	1 to 2	
Generalized seizure	8	
Fever >37.2°C	1	
Frequent yawning (>3 to 4 times)	1	
Sweating	1	
Nasal stuffiness	1	
Sneezing	1	
Tachypnea (respiratory rate >60/minute)	2	
Poor feeding	2	
Vomiting	2	
Loose stools	2	
Failure to thrive (weight gain ≥10% below birth weight)	2	
Excessive irritability	1 to 3	
Total score		
Initials		

Morphine sulfate solution (0.4 mg/mL) dosing schedule:	
Time morphine	
Dose morphine (in mg)	
Route	
Initials	

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Eat Sleep Console

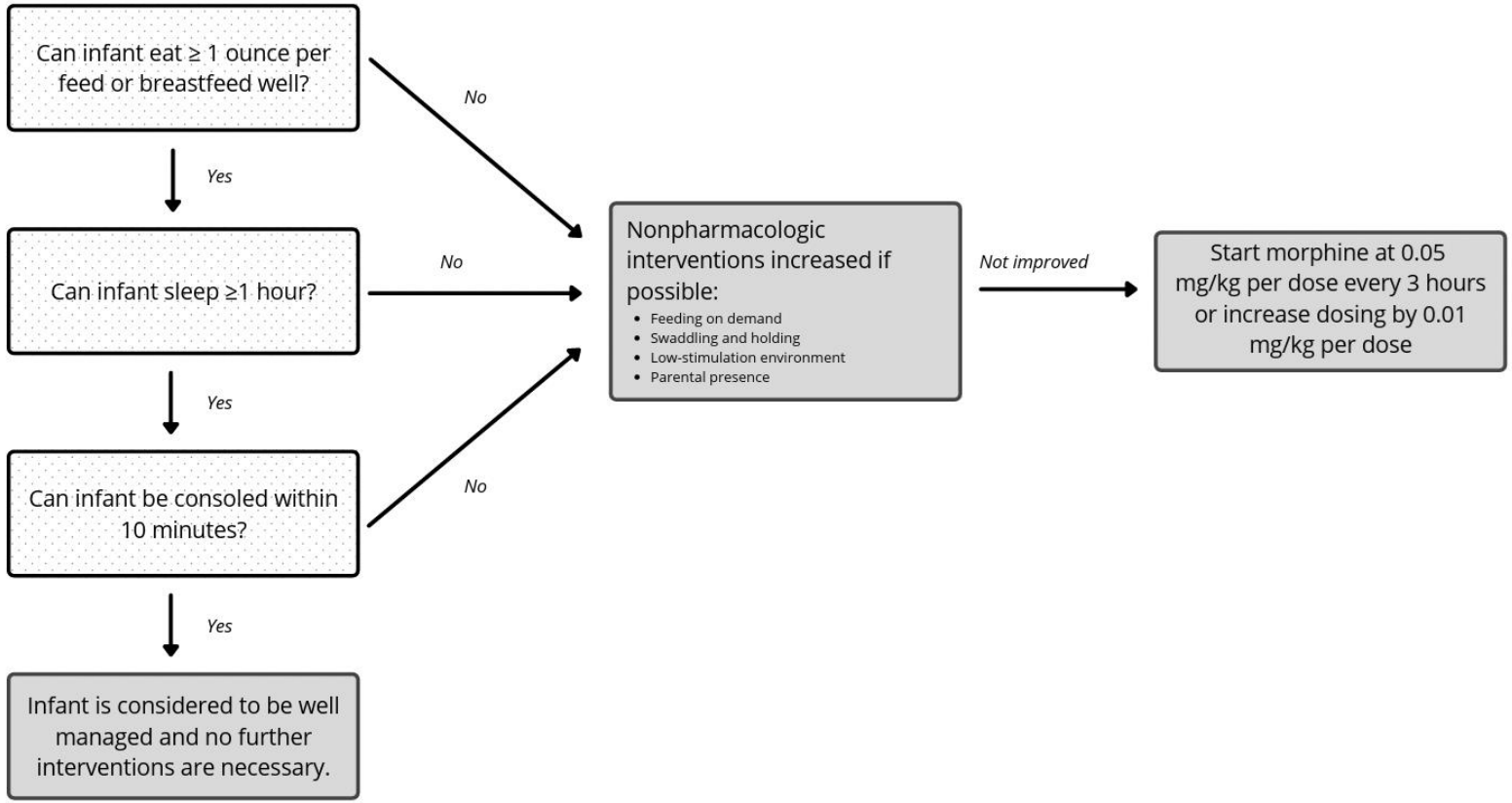
Less complex scoring
with functional milestones and focus on parental involvement

Assess q3-4h
If >4 doses morphine/24h-->NICU

Monitor 3d with short acting opioids
5d with methadone and bup

<u>ECS-NOW trial</u>

- Decreased LOS (mean - 8.2 vs 14.9d)
- Reduced pharmacologic tx (19.% vs 52%)
- No increase in adverse outcomes (16.1% vs 15.8%)



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CPS and Criminal Legal considerations

- WI ACT 292 “unborn child has certain basic needs … to be free from physical harm due to the habitual lack of self control of the expectant mothers”
    - Could apply to lots of things (marathon running, eating too much sugar if GDM)
    - Allows the state to take physical custody of pregnant person and assigns lawyer to fetus but not the pregnant person, can force the person into addiction treatment, psychiatric hospitalization or even jail.
    - Enforced differentially across WI, 1200 women investigated yearly.
    - Permissive, no required reporting for positive toxicology or history of use

- ACOG: “Seeking OB-GYN care should not expose a woman to criminal or civil penalties, such as involuntary commitment, loss of custody of her children or loss of housing”
- CPS referral: should not be routine, consider for active substance use with safety related concerns
- Focus on engagement above all else, referral to resources

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Resources

WI Association for Perinatal Care SUD Initiative https://wiperinatal.org
California Perinatal Quality Care Collaborative: https://nastoolkit.org/
California Bridge Buprenorphine Quick Start in Pregnancy:
https://bridgetotreatment.org/resource/buprenorphine-quick-start-in-pregnancy/

SAHMSA Clinical Guidance (Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants (samhsa.gov))
Academy of Perinatal Harm Reduction: www.perinatalharmreduction.org

National Harm Reduction Coalition Resource Center: www.harmreduction.org
UW Addiction Consultation Hotline:

Madison Area Providers Call:
608-263-3260

Statewide Providers Call:
1-800-472-0111

The Consult Line is available weekdays from 8 a.m. to 5 p.m.

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A great resource!
Join us for GROW-WI on June 24 to hear more!

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WISAM WEBINAR

WHERE EMPATHY AND EVIDENCE MEET:

Empowering Providers to Recognize and Manage Perinatal Substance Use

MAY 1, 2025 | 12:15 PM

Panelists: Elizabeth Hovis, MD, Charles Schauberger, MD, and Sreevalli Atluru, MD

Moderators: Ritu Bhatnagar, MD, MPH and Ezra Lyon, MD

WISAM

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References

- Wisconsin Maternal Mortality Review Team Recommendations: 2020 Pregnancy-Associated Deaths, 2024
- Heil et al. Unintended pregnancy in Opioid abusing women. J Subst Abuse Treatment. 2011.
- Schiff et al. Fatal and Nonfatal Overdose Among Pregnant and Postpartum Women in Massachusetts. Obstet Gynecol. 2018
- Hovis. Substance Use Disorders in the Perinatal Patient. https://the-periscope-project.org/education-modules/ accessed 2024.

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THANK YOU! Questions?

Attendance

- For attendance purposes please text the code PEHROZ to 608-260-7097.
- Please text for attendance, **even if you are *not* claiming** continuing education credit.

Continuing Ed Credit

To receive continuing education credit:

1. Log your attendance (as above)
   - Create an ICEP account if you don't already have one.

2. Fill out the session evaluation form to receive credit – **REQUIRED for credit**.
   - A link to the evaluation will be sent after you text the code.

**Continuing Education Units with the Midwifery Education Accreditation Council are coming!

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