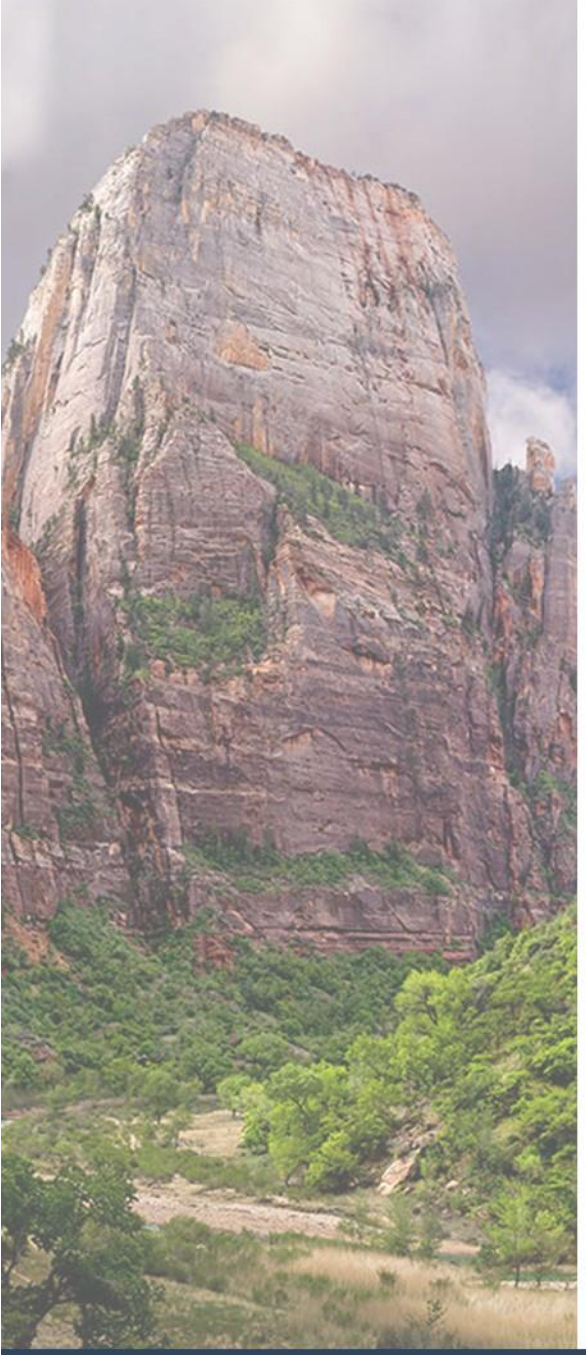

# WELCOME!

## September 3, 2026



# September 2026 Agenda

| | |
|---|---|
| 12:00 p.m. | Welcome & House Keeping |
| 12:05 p.m. | **U of U Health: ASCENT**<br>• Presented by Sarah DeLuca, Erica Torres & Caitlin Quade |
| 12:25 p.m. | U of U Health: ASCENT Q&A |
| 12:30 p.m. | **U of U Health: ELEVATE**<br>• Presented by Assumpta Nantume |
| 12:50 p.m. | U of U Health: ELEVATE Q&A |
| 12:55 p.m. | Closing |


# IMPROVING NO-COST CONTRACEPTIVE ACCESS IN RURAL AREAS

Sarah DeLuca, MPH
Erica Torres, MPH
Caitlin Quade, MPH

HEALTH
UNIVERSITY OF UTAH

ASCENT
Center for Reproductive Health

# ASCENT CENTER FOR REPRODUCTIVE HEALTH


https://medicine.utah.edu/obgyn/ascent

# LEADERSHIP & STAFF

**David Turok, MD, MPH**
*Center Director*

**Lori Gawron, MD, MPH**
*Fellowship Co-Director*

**Jennifer Kaiser, MD, MA**
*Clinical Training & Engagement Core Director*

**Kate Brown, MD**
*Associate Professor*

**Sarah DeLuca, MPH**
*Associate Director*

**Jessica Sanders, PhD, MSPH**
*Research Director*

**Rebecca Simmons, PhD, MPH**
*Implementation Science Director*

**Megan Konigkramer, MD**
*Complex Family Planning Fellow*

**Rachael Clark, MD**
*Complex Family Planning Fellow*

**Susanna Cohen, DNP, CNM**
*Lift Lab Director*

**Sara Hake, CNM, DNP**
*Family Planning Nurse Midwife*

**Jayme Trevino, MD**
*Assistant Professor*

**Caitlin Quade, MPH**
*Technical Director*

**Jami Baayd, MSPH**
*Senior Qualitative Researcher*

**Alexandra Gero, MPH**
*Biostatistician*

**Gentry Carter, MS**
*Biostatistician*

**Madeline Mullholand, MPA**
*Communications Manager*

**Erica Torres, MPH**
*Community Outreach & Training Specialist*

**Brooke Bullington, PhD**
*Post-Doctoral Fellow*

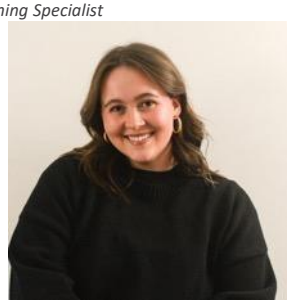
**Bryce Wallis, BS, MSCI**
*Pre-Doctoral Research Assistant*

**Amy Orr**
*Senior Clinical Research Coordinator*

**Corinne Sexsmith, MS**
*Research Manager*

**Stacie Avina**
*Study Coordinator*

**Chelsea Daniels, CMA**
*Practice & Patient Care Coordinator*



**Anna Lysenko**
*Executive Secretary*

**Sydney Gamblin**
*Administrative Assistant*

# WHAT ARE THE OPTIONS?

OVER THE COUNTER


Opill

OVER THE COUNTER


Oral Levonorgestrel 1.5 Mg

PRESECRIPTION


Oral Ulipristal Acetate 30 Mg



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# UTAH PHARMACY ACCESS SURVEY

*MEASURING AVAILABILITY & ACCESSIBILITY*



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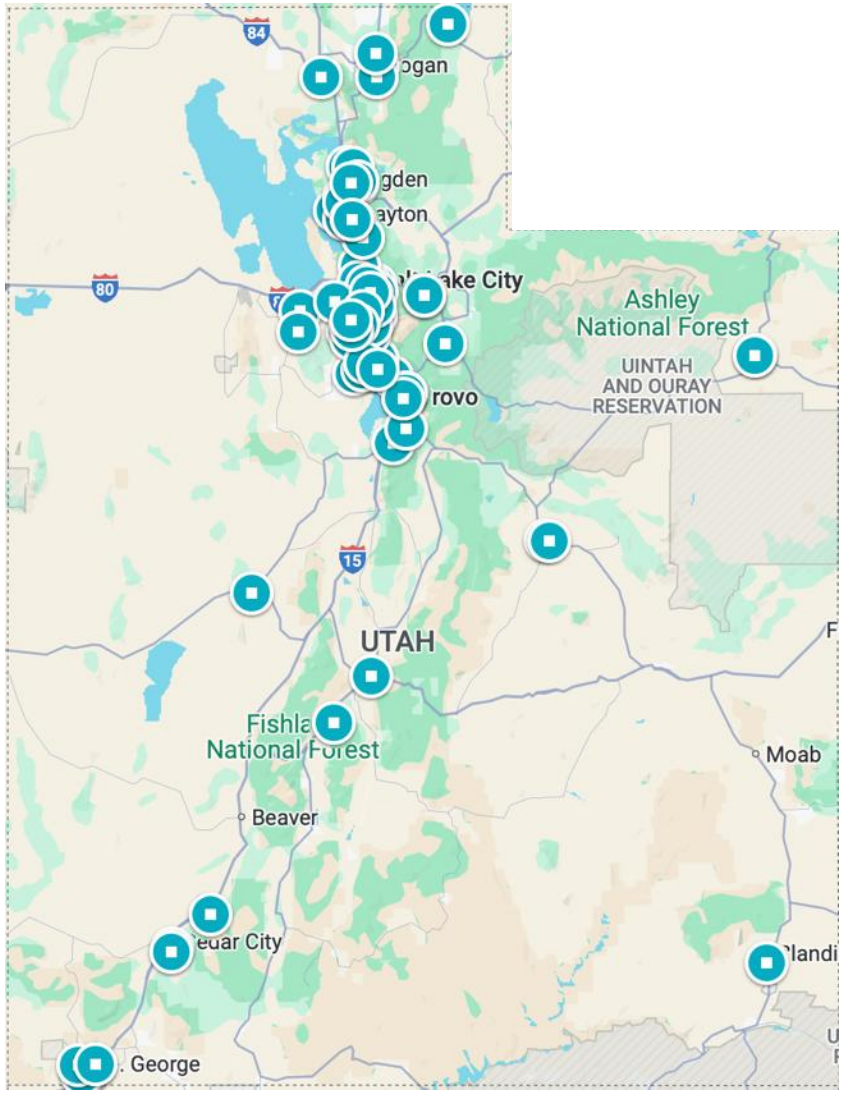
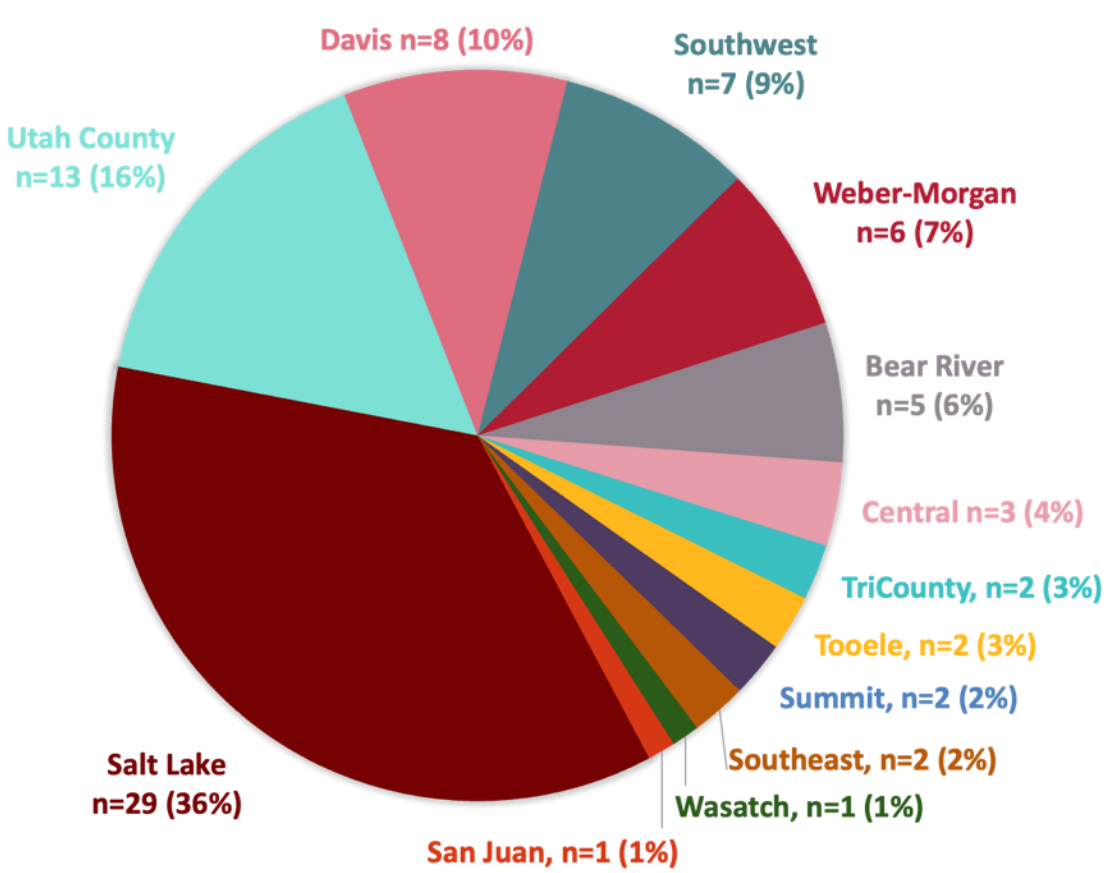
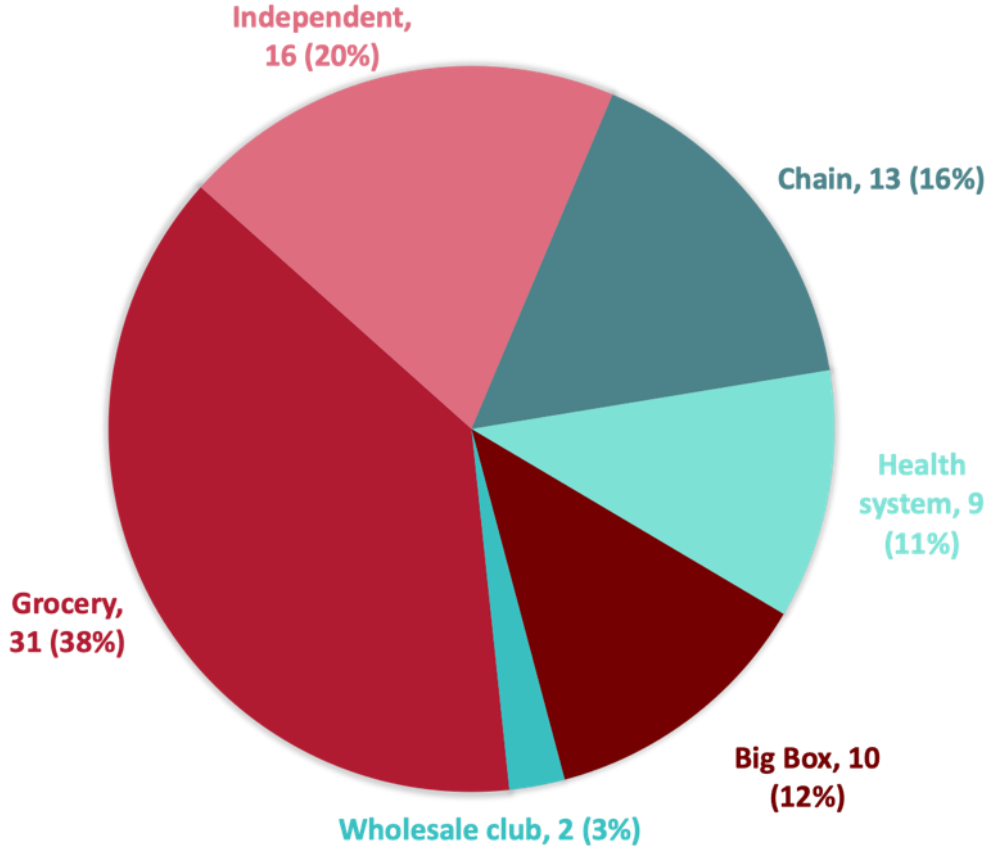
# UTAH PHARMACY ACCESS SURVEY

- Random stratified sample of UT retail pharmacies
- Surveyed **81** of 477 eligible pharmacies **(17%)**
    - Quotas for geography & type
- Assessed availability, display, pricing, restrictions
- Data collection: Summer 2024, 2025, 2026
- Not a mystery client survey

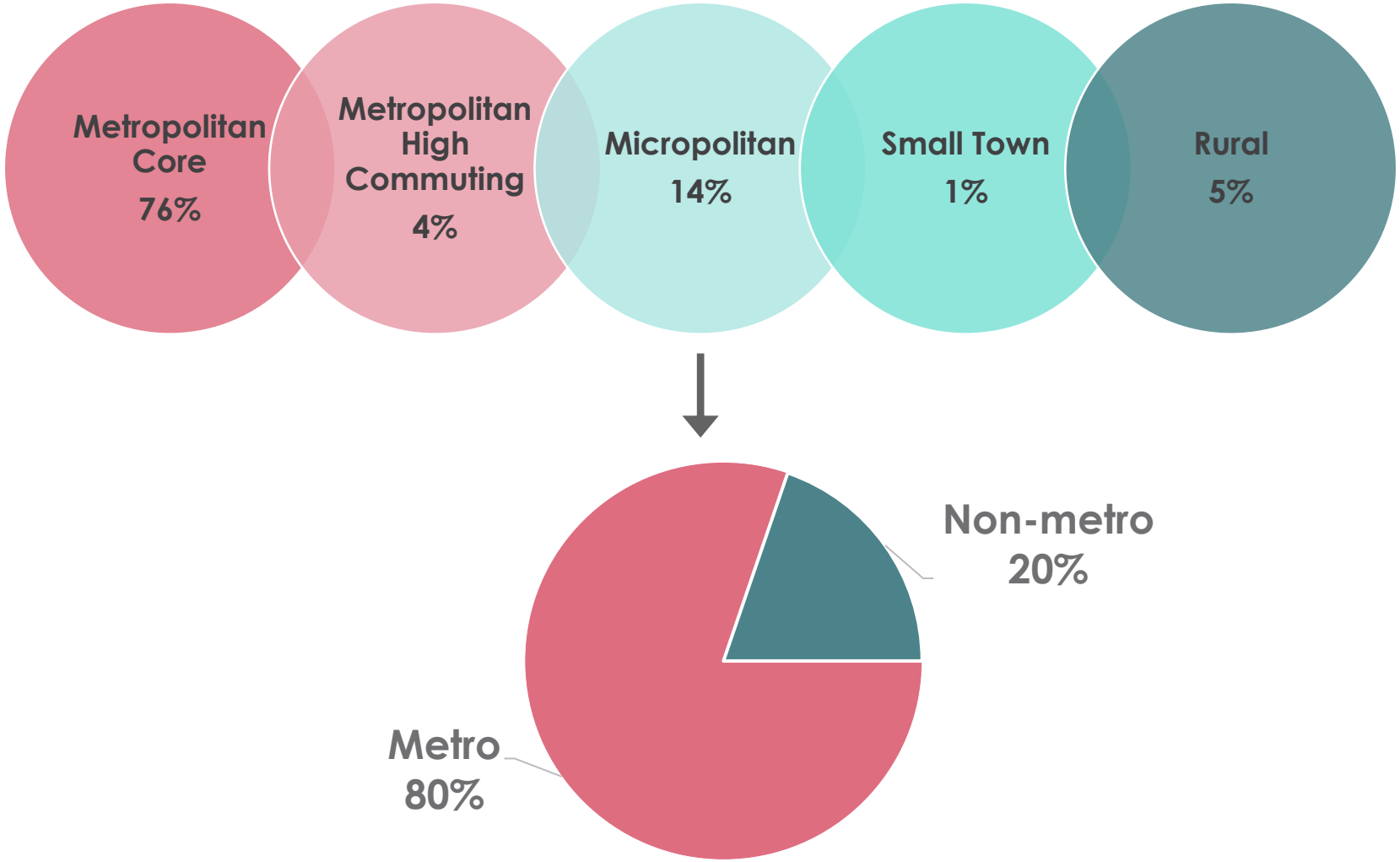


# SURVEY SAMPLE: LOCATION & STORE TYPE



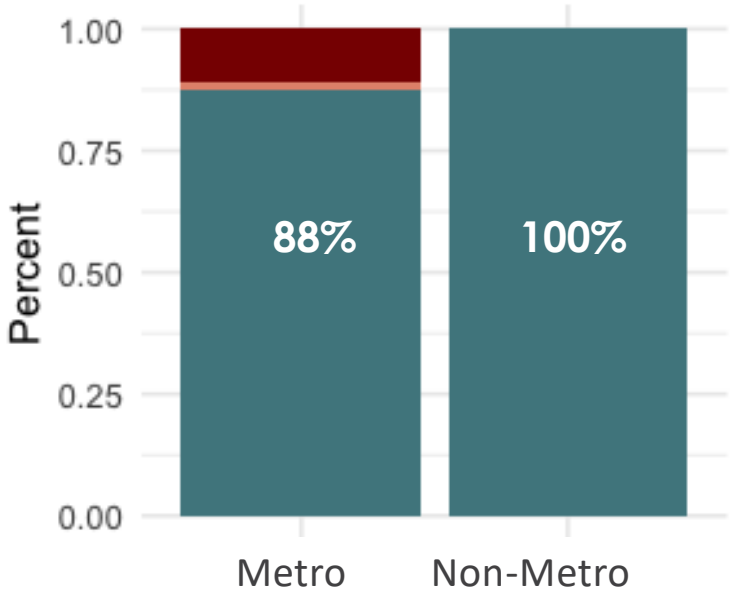
# SURVEY SAMPLE: RURALITY



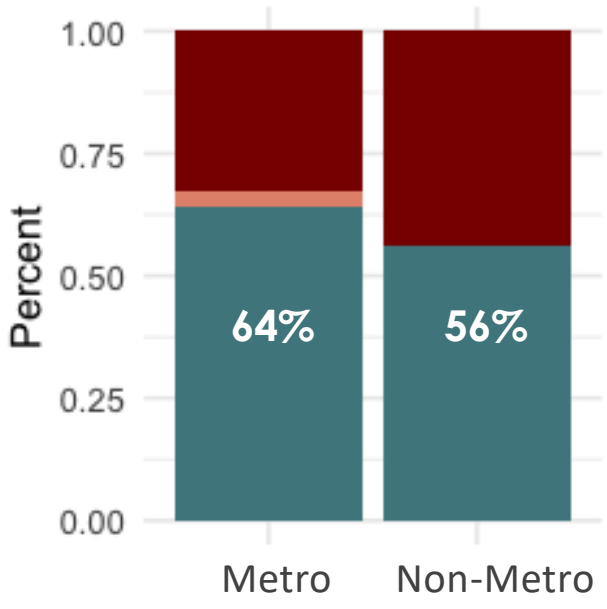
# Availability

# PRODUCT AVAILABILITY AT PHARMACIES

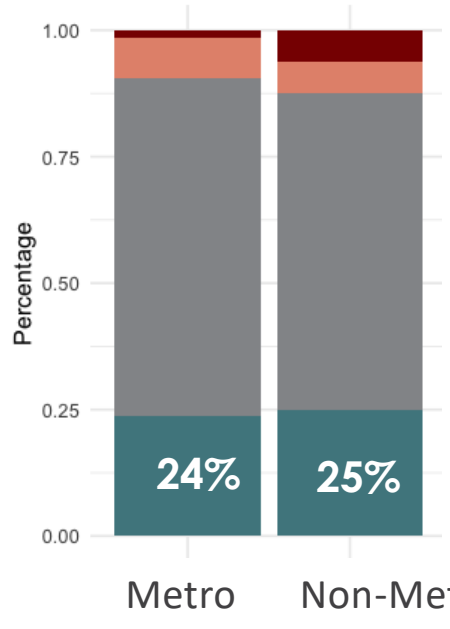
## LNG EC




## Opill




## Ella (UPA EC)



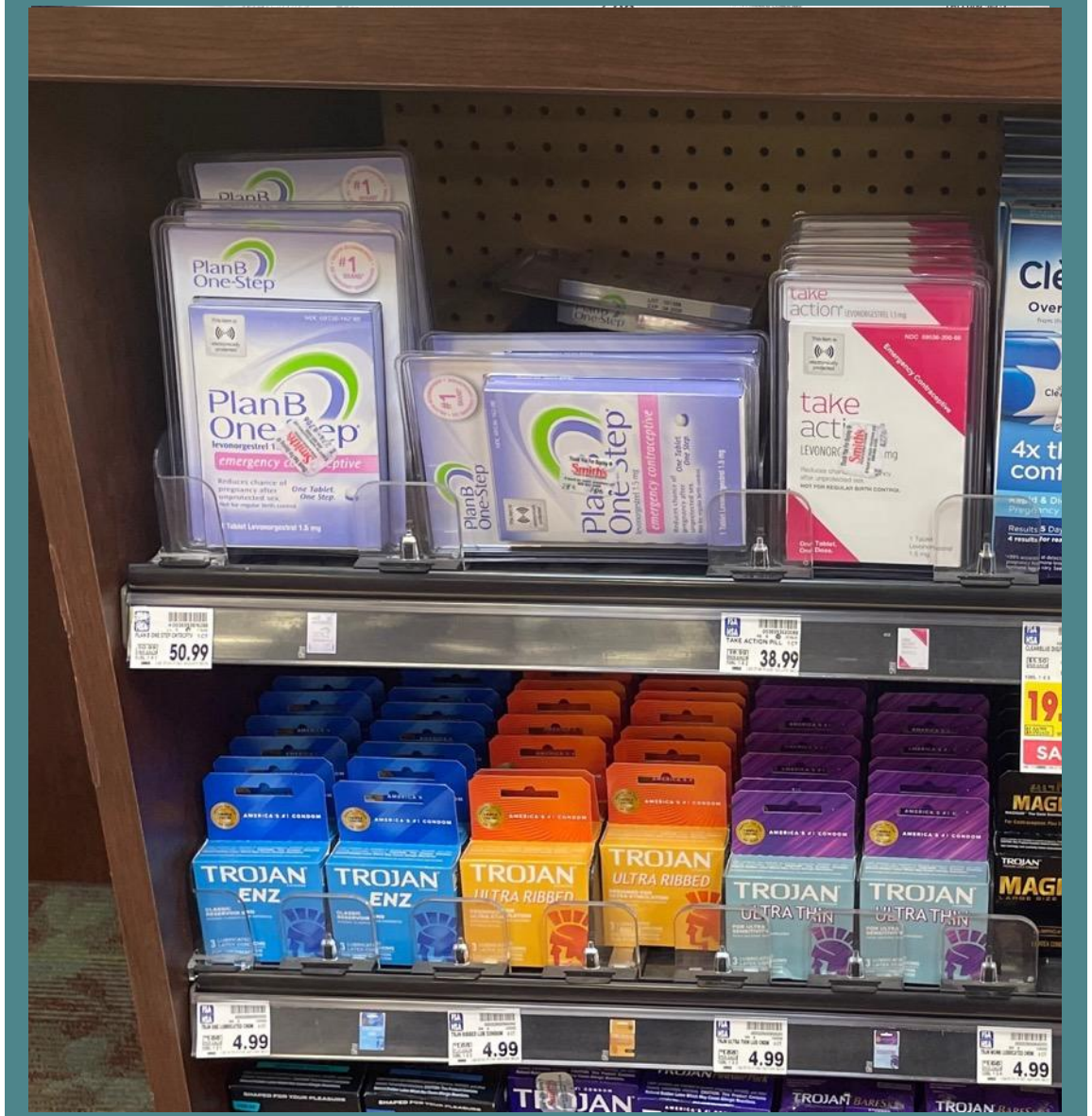

There's no space for it
There is a space for EC, but it's empty
In stock

There's no space for it
There is a space for Opill, but it's empty
In stock

No and will not order
No, it will take 2 or more days to arrive
No, but if ordered, it will generally arrive next day
Yes, it's currently in stock

# Accessibility


1809297
OPILL DAILY
ORAL CONTRACEPTIVE
4X28 DAY SUPPLY 112CT
.536
59.99
Value Pack
Contains 4 x 28 Day Supply
Opill
Norgestrel tablets 0.075mg
Daily Oral Contraceptive
FDA approved
Full prescription strength
Now available over the counter
Opill
Daily Birth Control Pill
553486
NATURE'S BOUNTY
HAIR, SKIN & NAILS


PlanB One-Step
take action
50.99
38.99
TROJAN ENZ
TROJAN ULTRA RIBBED
TROJAN ULTRA THIN
4.99


Aftera
PlanB One-Step
Opill
Norgestrel tablets 0.075mg
Daily Oral Contraceptive
LIBIDO
Personal Lubricant Liquid
silicone
Intense
tingling

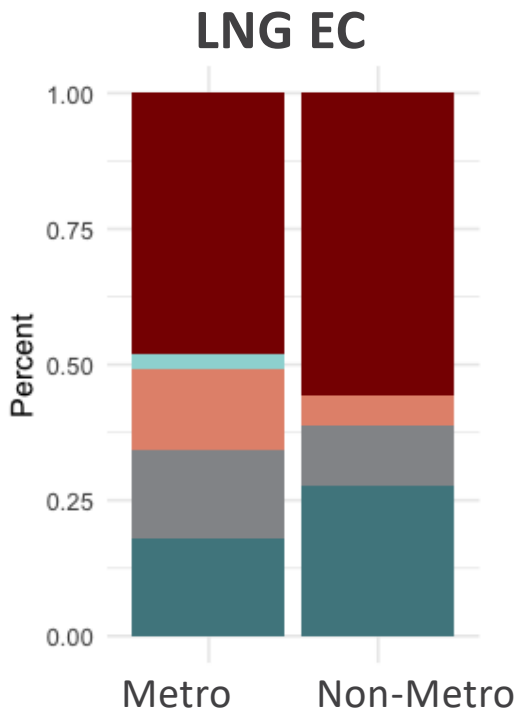

PlanB One-Step
levonorgestrel 1.5 mg
emergency contraceptive
1 Tablet Levonorgestrel 1.5 mg
Save $10 on Plan B
take action
ASTROGLIDE
GEL
Pre-Seed
FERTILITY LUBRICANT
for use by couples when trying to conceive
Sperm Check
Fertility
Home Test for Men
Mix & match
Buy 2 get 3rd Free
Good Clean Love
Estroven
Clearblue
4x the confirmation

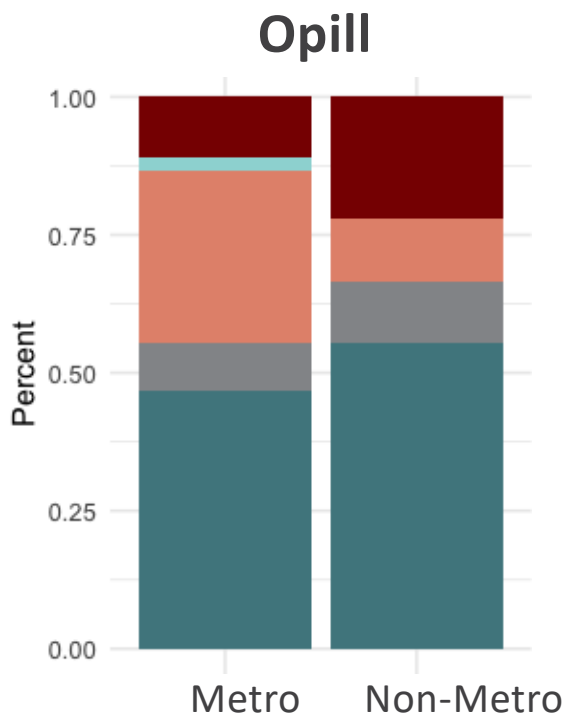

PRESS FOR ASSISTANCE
Everyday Low Price
$9.98
Poise
PADS
20 PADS/SERVIETTES
48 PADS/SERVIETTES
56 PADS/SERVIETTES
Clearblue
Opill
Julie
Plan B One-Step
KY
ASTROGLIDE
MAGNUM
TROJAN
Raw

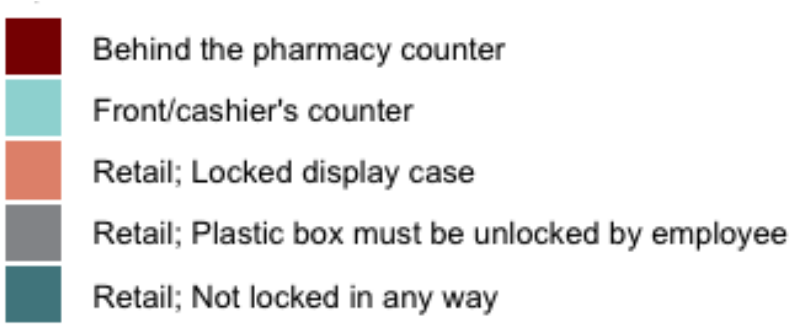

7.99
15.79
19.89
PlanB One-Step
46.99
42.99
34.99
take action

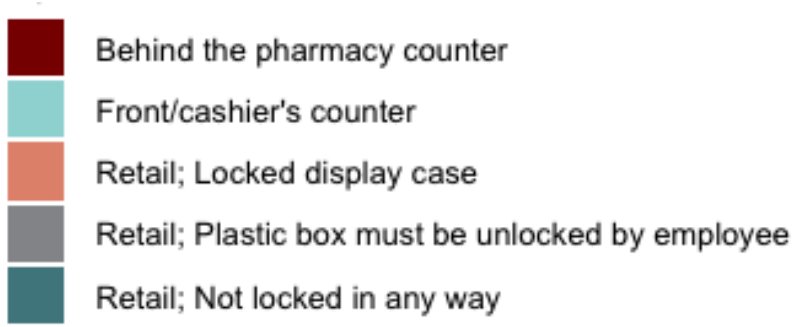

Opill
Daily Birth Control Pill
Now available over the counter
Also available at Walgreens.com or at Pharmacy
New
Now available over the counter
Opill
Daily Birth Control Pill
Scan and ship to your home
New
Now available over the counter
Opill
Daily Birth Control Pill
Scan and ship to your home
New
PLEASE ASK FOR THIS ITEM
AT THE PHARMACY
19 99
49 99
Specially designed to support women through all of life's stages, from menstruation and menopause to everyday wellness.
Earn 5% Walgreens Cash rewards
NOW AVAILABLE OVER THE COUNTER
Daily birth control pill
your way
No prescription | No appointment | No hassle
FDA approved
Full prescription strength
LEARN MORE
Clearblue
value pack
Over 99% Accurate
from the day you expect your period*
Pregnancy Test
Walgreens
Compare to Clearblue® Digital*
DIGITAL
Pregnancy
Clearblue
Over 99% Accurate
from the day you expect your period*

# IN-STORE LOCATION & DISPLAY

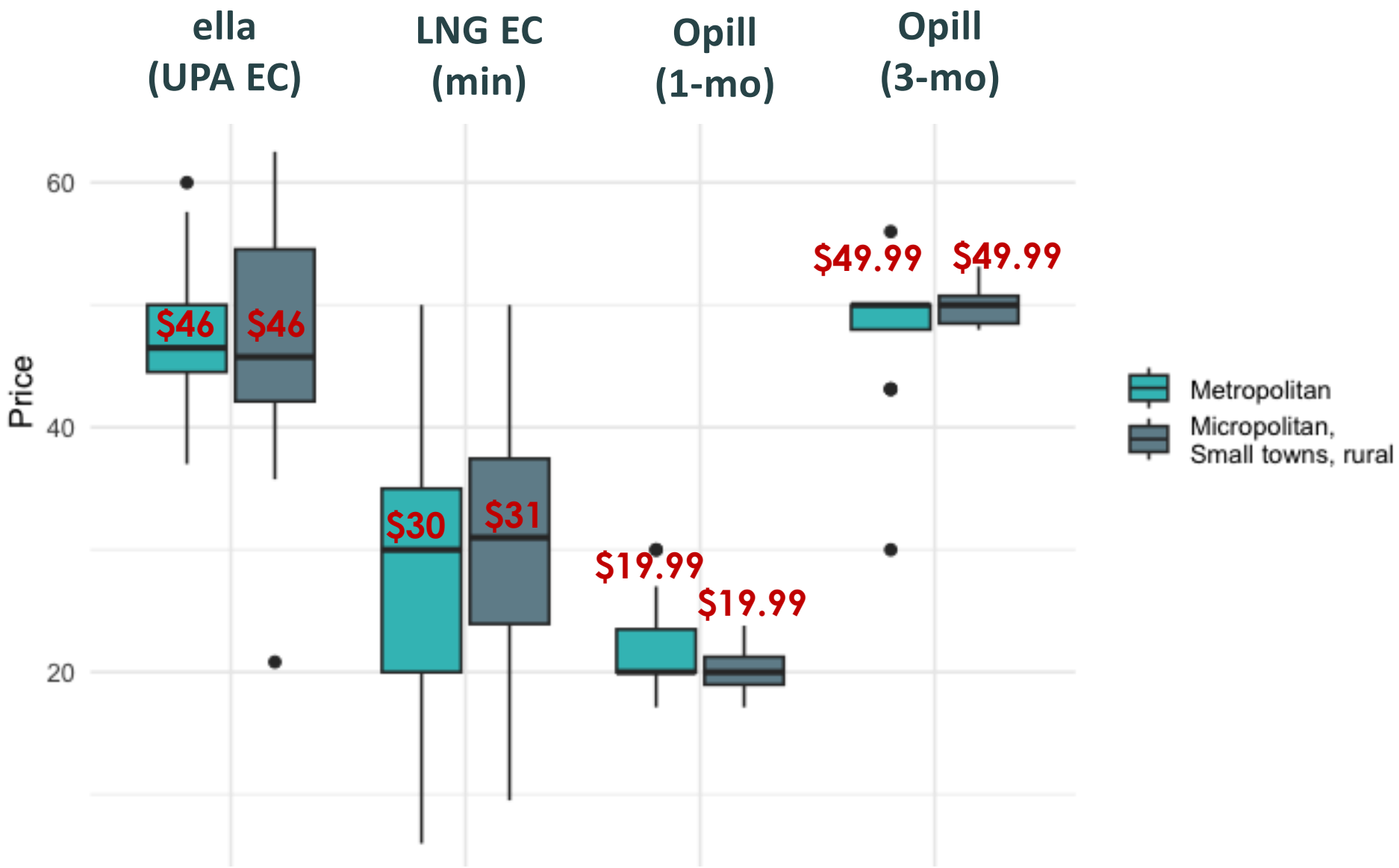


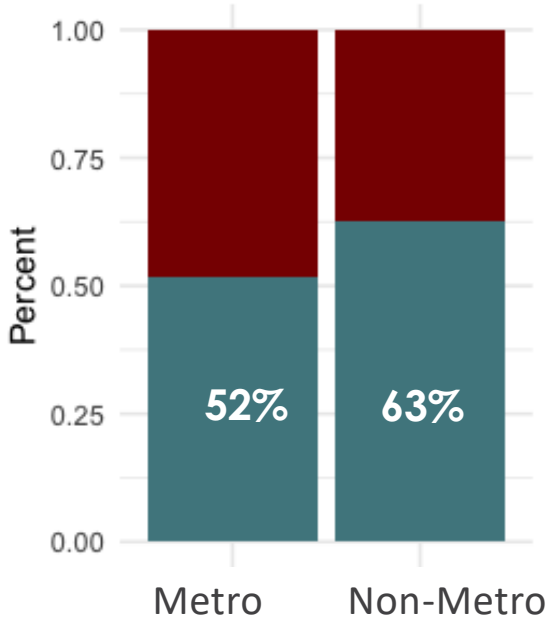



# PRICING


ella
(UPA EC)
LNG EC
(min)
Opill
(1-mo)
Opill
(3-mo)
Price
60
40
20
$46
$46
$30
$31
$19.99
$19.99
$49.99
$49.99
Metropolitan
Micropolitan,
Small towns, rural

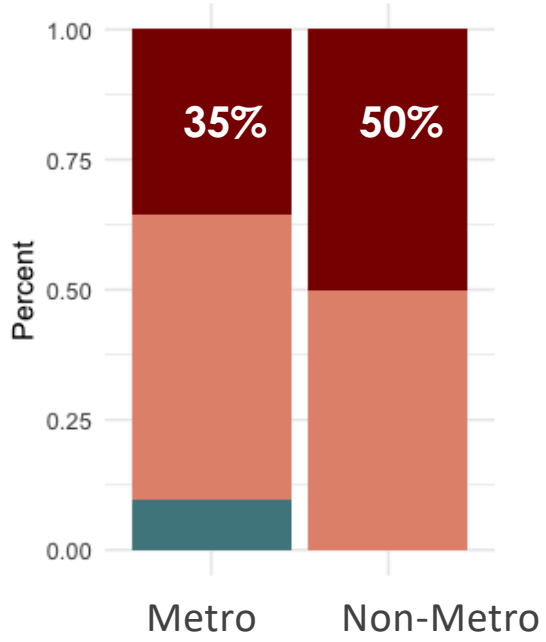
# PHARMACIST CONTRACEPTIVE PRESCRIBING




Does this pharmacy offer pharmacist-prescribed contraception?

No

Yes




If yes, how frequently does this pharmacy prescribe contraception?

Even less frequently or "never"

A few times per year

At least once per month

# EMERGING THEMES

- Wide availability of EC, even in rural areas
- Requiring pharmacy staff interaction may compromise privacy, particularly in small or rural communities
- Cost presents a major barrier to access
- Pharmacy prescribing offers a theoretical access channel, but utilization is low

# FREE EMERGENCY CONTRACEPTION

**Program Details:**

- For anyone 18+
- In-person OTC access at any University of Utah pharmacy
- Accessible through University of Utah MyChart
- Established care NOT required to utilize the program
- Simple request form
- Request 1 dose of either/both Oral Levonorgestrel 1.5 mg (Plan B) or Ulipristal Acetate 30 mg (Ella)
- Select urgency level
    - Urgent/Very Urgent – pickup in pharmacy
    - Not Urgent – mail order available
- 17 pharmacy locations
- 5 counties have physical location
- Mail order can cover any address in Utah



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# HOW TO ACCESS

Free EC Webpage

Free EC Webpage

MyChart Account Creation

MyChart Account Creation



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# FREE EMERGENCY CONTRACEPTION

## University of Utah Systems

- Requires engagement in the University of Utah system
- Available only to folks 18+ due to state policy restriction – NO age restriction for OTC products provided retail/outside of the University of Utah
- All requests reviewed by Family Planning providers/nursing staff
- Prescription sent to selected pharmacy

## Impact

- Over 4,500 requests in 3.5 years
- ~4,000 Levonorgestrel Pills, ~5,600 Ulipristal Acetate Pills
- Of Utah's 29 counties – only 5 are urban. Remainder are frontier or rural
- ~30% of requests are ship to home

# COLLEGE & COMMUNITY DISTRIBUTION MODEL

*MEETING PEOPLE WHERE THEY ARE*



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# COLLEGE CAMPUS DISTRIBUTION

**USE EXISTING CAMPUS TOUCHPOINTS TO MAKE NO-COST OTC SUPPLIES EASIER TO FIND**

- **University of Utah Campus Partners**
  - Basic Needs Collective
  - SASSH Center
  - Center for Student Wellness; Pleasure Pack Program
  - Student Union Vending Machine
  - Residential Halls Vending Machine

- **Additional College Campus Partners**
  - Westminster University
  - Utah Tech University
  - Utah State University
  - Utah Valley University
  - Salt Lake Community College; Distribution at 2 campus locations


**Campus reach to date:**

**7,791 EC doses**

2,286 campus partners + 5,505 vending machines

**337 Opill doses**

109 campus partners + 228 vending machines



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# COMMUNITY-BASED DISTRIBUTION

## COMMUNITY SETTINGS CAN MAKE NO-COST SUPPLIES REACHABLE IN PLACES WHERE CLINIC OR CLINIC OR RETAIL ACCESS IS LIMITED

- **Collaborated with 14 Community-Based Organizations:**
  - Alliance Community Services
  - Promise South Salt Lake
  - YWCA
  - Syringe Exchange Program

- **Open Access/Staff Supported**
- **Events**
- **Kits**

**Community reach to date:**

- 4,472 EC doses
- 703 Opill doses



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# HOW ASCENT CAN SUPPORT YOUR COMMUNITY

**1. Request**
Use the OTC Form to tell us what you need

**2. Discuss**
Choose distribution approach that fits

**3. Distribute**
Share supplies with education and access options

**4. Adjust**
Restock based on uptake and feedback


Section 1 of 6

## ASCENT OTC Contraception & Educational Materials Request Form

Are you interested in making over-the-counter contraceptives and patient education materials available to the communities you serve? You've come to the right place! The ASCENT Center for Reproductive Health and its Family Planning Elevated program partner with manufacturer donation programs to make the resources below available free of cost to community and clinic partners in Utah and the greater Mountain West region. Please use this form to request family planning resources for your clinic or outreach site.

Note that over-the-counter contraceptives (emergency contraception, Opill, and condoms) available through ASCENT must be distributed in the US, must be provided to patients at no cost (cannot be resold), and are limited to recipients ages 18+. If your organization requires a large volume of OTC contraceptives or OTC contraceptives without age restrictions, please contact Erica Torres (erica.torres@hsc.utah.edu) for information on requesting donations directly from the manufacturers.



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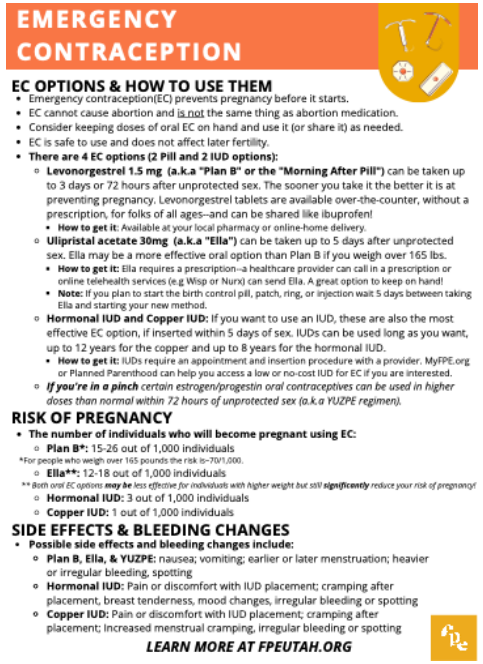
# TOOLS CREATED TO SUPPORT DISTRIBUTION

## WHAT'S AVAILABLE THROUGH THE OTC ORDER FORM?



**EMERGENCY CONTRACEPTION**

**EC OPTIONS & HOW TO USE THEM**

- Emergency contraception(EC) prevents pregnancy before it starts.
- EC cannot cause abortion and is not the same thing as abortion medication.
- Consider keeping doses of oral EC on hand and use it (or share it) as needed.
- EC is safe to use and does not affect later fertility.
- **There are 4 EC options (2 Pill and 2 IUD options):**
  - **Levonorgestrel 1.5 mg (a.k.a "Plan B" or the "Morning After Pill")** can be taken up to 3 days or 72 hours after unprotected sex. The sooner you take it the better it is at preventing pregnancy. Levonorgestrel tablets are available over-the-counter, without a prescription, for folks of all ages--and can be shared like ibuprofen!
    - **How to get it:** Available at your local pharmacy or online-home delivery.
  - **Ulipristal acetate 30mg (a.k.a "Ella")** can be taken up to 5 days after unprotected sex. Ella may be a more effective oral option than Plan B if you weigh over 165 lbs.
    - **How to get it:** Ella requires a prescription--a healthcare provider can call in a prescription or online telehealth services (e.g Wisp or Nurx) can send Ella. A great option to keep on hand!
    - **Note:** If you plan to start the birth control pill, patch, ring, or injection wait 5 days between taking Ella and starting your new method.
  - **Hormonal IUD and Copper IUD:** If you want to use an IUD, these are also the most effective EC option, if inserted within 5 days of sex. IUDs can be used long as you want, up to 12 years for the copper and up to 8 years for the hormonal IUD.
    - **How to get it:** IUDs require an appointment and insertion procedure with a provider. MyFPE.org or Planned Parenthood can help you access a low or no-cost IUD for EC if you are interested.
  - ***If you're in a pinch** certain estrogen/progestin oral contraceptives can be used in higher doses than normal within 72 hours of unprotected sex (a.k.a YUZPE regimen).*

**RISK OF PREGNANCY**

- **The number of individuals who will become pregnant using EC:**
  - **Plan B*:** 15-26 out of 1,000 individuals

*For people who weigh over 165 pounds the risk is~70/1,000.

  - **Ella**:** 12-18 out of 1,000 individuals.

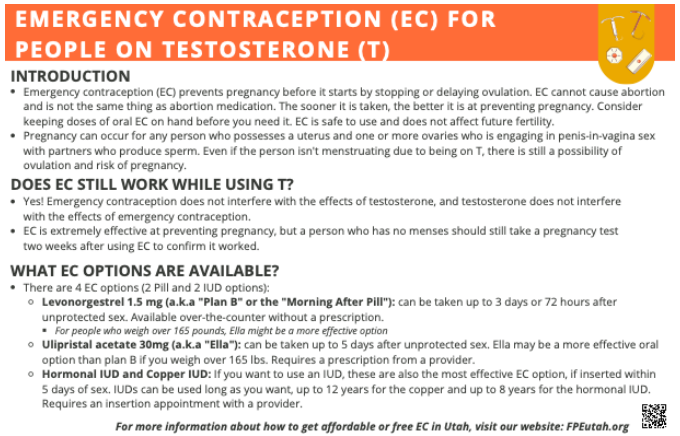
** *Both oral EC options **may be** less effective for individuals with higher weight but still **significantly** reduce your risk of pregnancy!*

  - **Hormonal IUD:** 3 out of 1,000 individuals
  - **Copper IUD:** 1 out of 1,000 individuals

**SIDE EFFECTS & BLEEDING CHANGES**

- **Possible side effects and bleeding changes include:**
  - **Plan B, Ella, & YUZPE:** nausea; vomiting; earlier or later menstruation; heavier or irregular bleeding, spotting
  - **Hormonal IUD:** Pain or discomfort with IUD placement; cramping after placement, breast tenderness, mood changes, irregular bleeding or spotting
  - **Copper IUD:** Pain or discomfort with IUD placement; cramping after placement; increased menstrual cramping, irregular bleeding or spotting

***LEARN MORE AT FPEUTAH.ORG***



**EMERGENCY CONTRACEPTION (EC) FOR PEOPLE ON TESTOSTERONE (T)**

**INTRODUCTION**

- Emergency contraception (EC) prevents pregnancy before it starts by stopping or delaying ovulation. EC cannot cause abortion and is not the same thing as abortion medication. The sooner it is taken, the better it is at preventing pregnancy. Consider keeping doses of oral EC on hand before you need it. EC is safe to use and does not affect future fertility.
- Pregnancy can occur for any person who possesses a uterus and one or more ovaries who is engaging in penis-in-vagina sex with partners who produce sperm. Even if the person isn't menstruating due to being on T, there is still a possibility of ovulation and risk of pregnancy.

**DOES EC STILL WORK WHILE USING T?**

- Yes! Emergency contraception does not interfere with the effects of testosterone, and testosterone does not interfere with the effects of emergency contraception.
- EC is extremely effective at preventing pregnancy, but a person who has no menses should still take a pregnancy test two weeks after using EC to confirm it worked.

**WHAT EC OPTIONS ARE AVAILABLE?**

- There are 4 EC options (2 Pill and 2 IUD options):
  - **Levonorgestrel 1.5 mg (a.k.a "Plan B" or the "Morning After Pill"):** can be taken up to 3 days or 72 hours after unprotected sex. Available over-the-counter without a prescription.
    - *For people who weigh over 165 pounds, Ella might be a more effective option*
  - **Ulipristal acetate 30mg (a.k.a "Ella"):** can be taken up to 5 days after unprotected sex. Ella may be a more effective oral option than plan B if you weigh over 165 lbs. Requires a prescription from a provider.
  - **Hormonal IUD and Copper IUD:** If you want to use an IUD, these are also the most effective EC option, if inserted within 5 days of sex. IUDs can be used long as you want, up to 12 years for the copper and up to 8 years for the hormonal IUD. Requires an insertion appointment with a provider.

***For more information about how to get affordable or free EC in Utah, visit our website: FPEutah.org***



**Scan for:**

- OTC oral contraceptives
- Bilingual Educational materials
- Access information
- Free training requests from ASCENT staff/providers

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# OTHER WAYS ASCENT CAN SUPPORT YOU

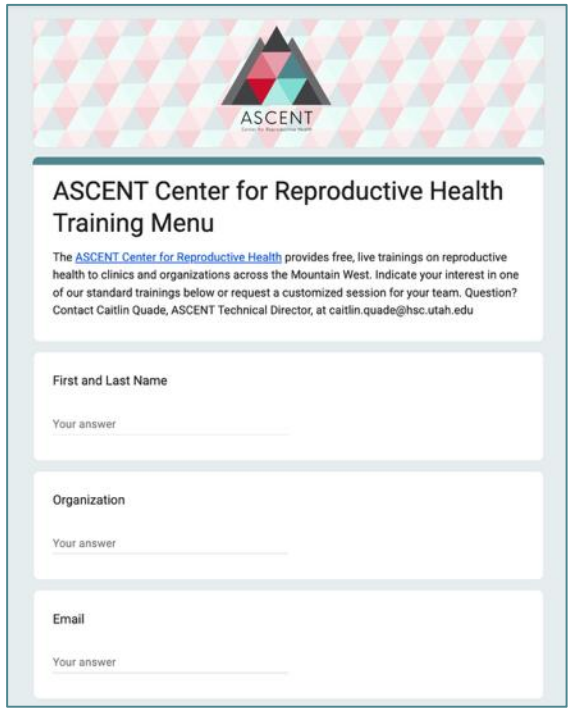
## TRAINING

Annual Conference
Sept. 14th -15th, 2026, Salt Lake City, UT


Register at:

FPETC2026.eventbrite.com

Customized Trainings




Request at:

https://forms.gle/3XRn14b3WUTTgX8A7



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# OTHER WAYS ASCENT CAN SUPPORT YOU

## PATIENT ASSISTANCE PROGRAM

COMING SOON!

Sign up for ASCENT's Newsletter here:



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# THANK **YOU**

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**Caitlin Quade, MPH**
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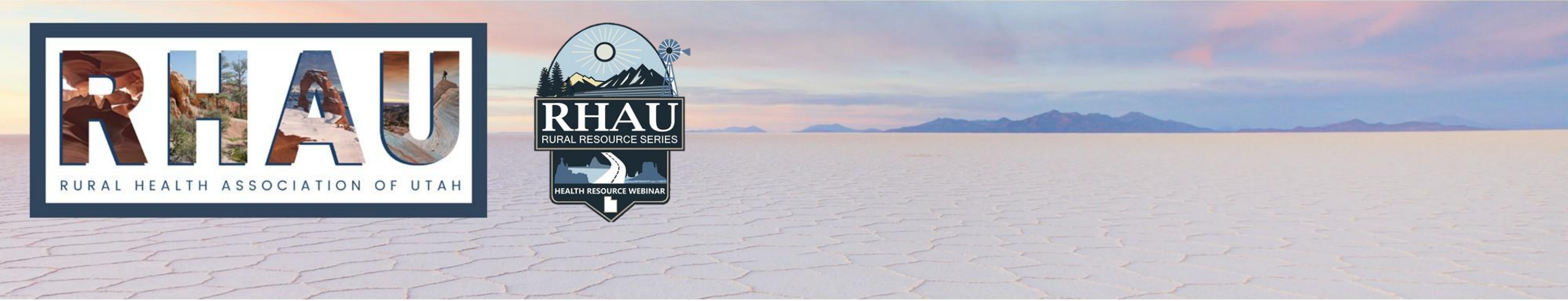



# U of U Health: ASCENT

## Q&A

# Improving Intrapartum Care for Patients with Substance Use Disorder Across Utah

ELEVATE Maternal Health Center of Excellence
(U54 HD113169)


| | |
|---|---|
| Center PI: | Torri Metz, MD |
| Project MPIs: | Susanna R. Cohen, DNP, CNM |
| | Melissa Watt, PhD |
| Project Manager: | Assumpta Nantume, MSc |


Rural Health Association of Utah

Webinar Series

Sep 2026

ELEVATE

INSPIRE

# The Challenge

- Patients with substance use disorder (SUD) face stigma and substandard care during childbirth.

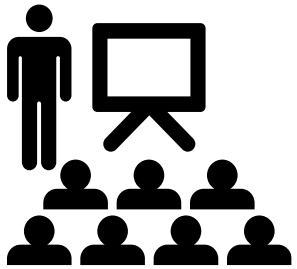
- These disparities contribute to poor maternal and newborn outcomes, especially postpartum.

- Rural hospitals often lack the expertise and resources to support these patients.

ELEVATE

INSPIRE

# The Solution



- **INSPIRE** (Interprofessional Simulation Program for Clinical Resilience and Empathy) is a simulation-based training curriculum co-developed with patients, providers, and community partners.

- Focuses on key components of care:  intrapartum pain management, neonatal withdrawal syndrome, legal/policy literacy, respectful maternity care, communication, and clinical empathy.

ELEVATE

INSPIRE

# The INSPIRE Intervention

## A provider intervention to improve evidence-based and respectful maternity care for individuals with SUD

Interactive online modules

4-hour in-person team simulation

Interactive online modules

# The INSPIRE Intervention

- Real Patient Stories
- Confidence
- Learning Modes
- Coaches
- Case-Based Learning and Clinical Questions
- Interactive Assessments
- INSPIRE Notes
- AI assisted Resource Library

# Progressive Case-Based Learning

Case 1

- Age: 26
- G3P1011
- induction of labor at 39 weeks
- h/o O.U.D.
- uncomplicated pregnancy with normal fetal growth.

**Katie**

- 26-year-old G3P1011 at 39w0d
- 10 antenatal care visits
- All Labs wnl, Rh positive, Rubella Immune, GBS negative
- Substance use history
  - fentanyl, last use 2 years ago, Buprenorphine 24 mg q day
  - Nicotine user (cigarettes, 1 pack per day)
  - methamphetamine last use 30 days
- Medications: Prenatal vitamins and buprenorphine 24 mg
- H/o asthma, albuterol PRN
- Anxiety with GAD-7 of 15
- Urine toxicology upon admission positive only for buprenorphine

Case 2

- Age: 32
- G1P1
- Urgent cesarean section 4 hours ago at 41 weeks and 2 days
- 26 hours of labor
- Non-reassuring Fetal heart tones and Triple I

**Maria**

**Brief Medical History for Maria:**

- 6 antenatal care visits
- All Labs Wnl, including HIV, Hepatitis B and C, and Syphilis negative, Rh positive, Rubella Immune, and GBS negative
- History of opioid use in the first trimester; currently on methadone 50mg BID
- All urine analysis screens have been as expected since starting methadone
- H/o asthma, albuterol PRN
- Anxiety with GAD-7 of 10

**Procedures:** Primary Low Transverse Cesarean Section – Urgent

**Indications:** NRFHT and Triple I, at 8 cm
s/p Amp and Gent
Current dose of methadone continued
She was anxious during the surgery and was given Ketamine
She also received Ketorolac 30 mg IV 4 hours ago, Acetaminophen 650 mg po 3 hours ago, and Pregabalin 75mg po 1 hour ago.
She still has her epidural in and the plan is to remove it at 24 hours post-op

**Brief Medical History for the baby:**

- Apgar scores: 7 and 9
- Weight at birth: 6.8 pounds / 3084 grams
- Transition nursey for 1 hour, now back

Case 3

- Age: 21
- G2P1001
- R.O.B at 33 weeks
- BP: 132/82
- Pulse: 68
- Temp: 36.5
- Fetal Heart Tone 150s
- Fundal Height 33 cms
- Started prenatal care at 13 weeks

**Alison**

**Brief Medical History for Maria:**

- 21 yo, G2P1001 33 weeks
- VS: BP 132/82, P 68, T 36.5
- FHT 150s
- FH 33 cms
- 4 antenatal care visits, SUPeRAD Clinic
- All Labs wnl, Rh positive, Rubella Immune, GBS negative
- Ultrasound at 32 weeks: normal growth, EFW 45%, AFI 15 cm, placenta posterior, os free.
- Fetal echo normal
- Substance use history
  - ETOH – last use 18 weeks
  - Cannibis – last use 18 weeks
- Anxiety with GAD-7 of 12
- Medications: Naltrexone 50 mg, Prenatal vitamins, Sertraline 100 mg

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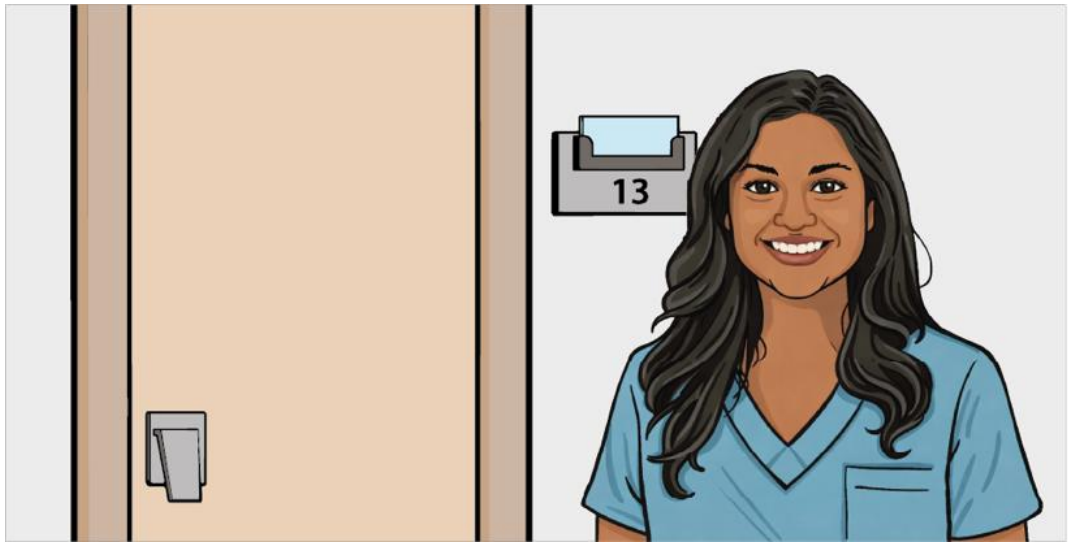
# Familiar Coaches



# Three Learning Modalities

Watch

Listen

Read

# *The PRONTO Model:*

## *High-fidelity, Team-based Simulation Training*

| Duration: | Start Time: | Activity |
|---|---|---|
| 0:10:00 | 8:00 | Welcome & Introductions |
| 0:05:00 | 8:10 | Introduction to INSPIRE project, where we are at in training journey |
| 0:10:00 | 8:15 | Leave Your Worries/Group Norms/Parking Lot/Agenda |
| 0:15:00 | 8:25 | Introduction to Simulation & simulation assignments for today. Review Teamwork core competencies |
| | | SIMULATION 1: SimPack 1 (labor scenario) |
| 0:07:00 | 8:40 | Pre-brief |
| 0:20:00 | 8:47 | Simulation |
| 0:30:00 | 9:07 | Debrief: |
| 0:03:00 | 9:37 | Transition time |
| | | SIMULATION 2: SimPack 2 (postpartum scenario) |
| 0:07:00 | 9:40 | Pre-brief |
| 0:20:00 | 9:47 | Simulation |
| 0:30:00 | 10:07 | Debrief: |
| 0:03:00 | 10:37 | Transition time |
| | | SIMULATION 3: SimPack 3 (postpartum scenario) |
| 0:07:00 | 10:40 | Pre-brief |
| 0:20:00 | 10:47 | Simulation |
| 0:30:00 | 11:07 | Debrief: |
| 0:03:00 | 11:37 | Transition time |
| 0:10:00 | 11:40 | Questions |
| 0:10:00 | 11:50 | Next steps in Inspire journey (post-modules) |
| | 12:00 | |
| | | |
| 4:00:00 | | |

PRONTO™
INTERNATIONAL

# PRONTO *INSPIRE*

## SimPack™ 1 - Community Hospitals

### VAGINAL BIRTH OF A VIGOROUS INFANT TO A PATIENT WITH A HISTORY OF POLYSUBSTANCE USE IN REMISSION ON BUPRENORPHINE WITH A 2ND DEGREE PERINEAL LACERATION




## UNCOMPLICATED VAGINAL BIRTH OF A VIGOROUS INFANT TO A PATIENT WITH POLYSUBSTANCE USE IN REMISSION ON BUPRENORPHINE

### SESSION OVERVIEW

1. Review simulation, objectives, and materials (15 minutes).
2. Set-up the simulation area (30 minutes).
3. Recruit and prepare the patient actor and the support person (20 minutes).
4. Assign and orient the providers (5 minutes).
5. Perform the Pre-Brief and patient case overview (10 minutes).
6. Conduct the Simulation (10-15 minutes).
7. Facilitate the Debrief (20-30 minutes).

### TARGET LEARNERS AND FACILITY INFORMATION:

**FACILITY CHARACTERISTICS:**

- Community hospital
- >200 <500 births per year
- Level II - Special Care Nursery (some larger community hospitals may have Level III - NICU)
- Cross-trained maternal/newborn/postpartum nurses
- Maternity care provider (may be on-call or on-site, may be Family Medicine practicing obstetrics, Ob/Gyn or CNM)
- Pediatrician (may be on-call or on-site)
- May have access to the tele-NICU (on-call)
- A Family Practice or Emergency Medicine physician based in the Emergency Department
- Anesthesia and additional Family Practice (practicing obstetrics) physicians on-call (within 20 minutes)

**ACTIVE SIMULATION ROLES:**

Minimum number of participants required: 3 + patient actor and support person

- 1 Nurse (Postpartum/Newborn)
- 1 Maternity provider (Family Medicine who practices Obstetrics, CNM, or Ob/Gyn)
- 1 Pediatrician

**ON-CALL/BACK-UP SIMULATION ROLES:**

- 1 Pediatric provider (Pediatrician or Family Practice)
- 1 Tele-NICU provider (via tele screen, if applicable)
- 1 Labor and Delivery Charge Nurse
- 1 House Supervisor Nurse
- 1 Anesthesia provider (MD or CRNA)

**SIMULATION OBSERVER ROLES:**

- Social Workers
- All Emergency Department providers

### LEARNING OBJECTIVES

**Cognitive:**

1. Recognize that Substance Use Disorder (SUD) is a medical condition.
2. Discuss pain management for labor patients with SUDs.
3. Understand pathophysiology and pain perception in patients with SUD.
4. Understand any potential effects of prenatal substance use exposure (alcohol, tobacco, opioids, stimulants, cannabis) on the infant.
5. Identify the importance of immediate skin-to-skin for neonatal transition.
6. Understand safety and importance of breastfeeding for SUD-exposed dyads.
7. Recall resources for SUD treatment (how to connect patients, dosing for MOUD, medications for opioid use disorder).
8. Discuss the benefits of providing respectful and routine maternity care, using supportive and empathetic communication, and respecting patient's preferences.
9. Understand principles of trauma informed care.
10. Understand importance of destigmatizing language.
11. Reflect on personal biases and the impact on quality of care.

**Technical:**

1. Discuss pharmacologic and non-pharmacologic pain control options within a person-centered framework.
2. Provide potential increased pain medication, if needed.
3. Address reduced pain thresholds for patients with SUDs, if necessary.
4. Initiate immediate skin-to-skin and breastfeeding.
5. Provide respectful and routine maternity care, using supportive and empathetic communication, and respecting patient's preferences.
6. Demonstrate use of destigmatizing language.
7. Apply trauma informed principles/care.

**Behavioral:**

1. Demonstrate communication with the team, specifically around maternal pain management pain and neonatal care plan:
   - SBAR
   - Check-Back
   - Call-Out
   - Thinking-Out-Loud
   - Two-Challenge Rule
2. Demonstrate empathetic and respectful communication with the patient and support person.
3. Perform kind and respectful person-centered care.




## OVERVIEW AND SETUP FOR FACILITATOR TEAM

**This page is for the facilitators ONLY and should NOT be read to the participants.**

| CLINICAL CONTENT: | FACILITY SETTING: | MINIMUM NUMBER OF PARTICIPANTS: | ANTICIPATED DURATION OF SIMULATION: |
|---|---|---|---|
| Uncomplicated vaginal birth<br>Substance use disorder (SUD) | Community hospital, Level II (or III) NICU | 3-4 (depending on setting) | 10-15 minutes |

### GENERAL OVERVIEW

**This scenario takes place in a community hospital with a Level II (or III) NICU - whatever level is available at this facility.**

Katie is a 26-year-old G3P1011, in labor at 38 weeks and 6 days. She had an induction of labor last night and has been in labor for 11 hours. She has had an uncomplicated pregnancy with normal fetal growth. Katie has a history of an Opioid Use Disorder (OUD) and has been on buprenorphine for two years, current dose is 24 mg. She has active nicotine use (smoker), and reports active methamphetamine use in this pregnancy; last use was 30 days ago. Katie has a 2-year-old son, Alexander, who was removed from her care by DCSF at birth due to her active fentanyl use. Her son currently lives with Katie's mom. Her first labor and delivery were uncomplicated.

Kati arrived for an induction of labor last night and has been in labor for 11 hours; her mom is here with her. Katie has a high level of anxiety, mistrust, and fear that this baby might be taken from her as well. She was adament that she not receive any pain medications in labor because she was concerned the fentanyl in the epidural would cause her to test positive and return to use. The nurse noticed that she was not coping well, and after counsel and a long discussion about pain medication options and what is in an epidural, Katie decided she would have the epidural. She did ask to go have a cigarette before her epidural was placed, she was offered a nicotine patch instead and accepted it.

Katie's epidural is in place, but she feels like it has "worn off". She is on continuous fetal monitoring. The scenario begins with Katie feeling lots of rectal pressure. Once the provider is in the room, Katie will deliver her baby, and the baby will be born vigorous. Katie will be unable to control her pushing due to pain, and will continue to push even if told to wait. She will experience a second degree perineal tear, which will need to be repaired. The provider should place the baby skin-to-skin on Katie's chest to initiate immediate skin-to-skin.

The placenta will deliver normally, and she will have normal uterine postpartum bleeding and a firm uterus. During the perineal examination, the providers will discover that she has a deep second degree perineal laceration that is not actively bleeding. They should address and treat her pain associated with the laceration. During the discussion Katie will express high levels of anxiety around the use of fenantyl. The scenario will end once the team has initiated routine newborn and maternal care, and discussed all available pain medication options, and made a plan for the laceration.

**Give participants the opportunity to prepare for the delivery before instructing patient to push.**

### Brief Medical History:

- 10 antenatal care visits
- All Labs wnl, Rh positive, Rubella Immune, GBS negative
- Substance use history (methamphetamine and fentanyl)
- Medications: Prenatal vitamins and buprenorphine 24 mg
- Nicotine use (cigarettes, 1 pack per day)
- H/o asthma, albuterol PRN
- Anxiety with GAD-10 of 15
- Urine toxicology at time of admission positive only for buprenorphine

### OVERVIEW OF PATIENT SETUP

- Select a patient actor who is willing to simulate a birth and who is NOT currently pregnant.
- Give the patient waterproof pants, and one of the two shirts to put on.
- When changed, place the IV arm bands on both of the patient's arms. Secure an IV collection bag to the patient's back with tape. Thread the tubing through one of the IV arm bands, sticking through the band.
- **Tape simulated epidural tubing to the back of the patient's first shirt and connect it to the epidural box.**
- Then, give the patient the second shirt to put on to cover the IV collection bag and epidural tubing.
- Secure the diapers around their waist (over the waterproof pants), with tape.
- Help her into PartoPants™ **pre-loaded** with blood.
- Once wearing the PartoPants™, attach the injection pad(s) to the outside of the PartoPants™.
- **Place a pulse ox and blood pressure monitor on the patient's finger and arm.**
- **Put an absorbent pad saturated with water to simulate amniotic fluid, under her bottom on the bed.**
- Insert the baby and placenta into the PartoPants™, being careful to not entangle them in the blood tubing.
- Review the patient history and simulation hand signals with the patient actor AND support person **(see INSTRUCTIONS FOR THE PATIENT ACTOR page).**





## INSTRUCTIONS FOR THE PATIENT ACTOR

**After dressing the patient, review the specifics of the case, and then give the patient this page to read on their own. After the patient has read it, "quiz" them to confirm that they understand the simulation. Then, practice the simulation hand signals.**

### PATIENT HISTORY

***Name and age:*** *Katie, 26*
***Gestations:*** *G3P1011*
***Gestational age:*** *38 weeks 6 days*
***Attitude:*** *Anxious, pain levels are increasing, tired*
***Support person:*** *Your mom*

***Summary:*** *You have been in recovery from OUD and on buprenorphine 24 mg for two years. You have active nicotine use (smoker, ~1 pack a day), and report methomphetamine use in this pregnancy; your last use was 30 days ago. You have a 2-year-old son, Alexander, who was removed from your care by DCSF at birth due to fentanyl use at the time. Alexander lives with your mom, who you are also living with. Your first labor and delivery were uncomplicated.*

*You arrived for an induction of labor last night and have been in labor for 11 hours. You are having anxiety and mistrust that this baby might be taken from you as well. You have been adamant that you do not want an epidural or other medication during your labor because you are concerned that the fentanyl in the epidural might cause you to test positive or have a return to use. The nurse has noticed that you are not coping well, and after counsel and a long discussion about pain medication options and the epidural, you decided you would get the epidural. You asked to go have a cigarette before the epidural was placed, the nurse said no, but offered you a nicotine patch instead, which you accepted. Your water broke an hour ago.*

*The scenario begins with you telling the nurse that you are feeling an urge to push and having lots of intense rectal pressure. Your epidural is in, but you feel like it is wearing off, and you are starting to feel overwhelmed by the increased pain. Please continue to complain of pain and that you feel like your epidural is not working, especially if they do not respond to your complaints of pain. Once the provider is in the room; watch for the facilitator's signal to begin to push. The pediatric team may be called to your room to stand by; if so, ask who they are. During pushing, you will feel that you cannot stop pushing, even if they say to stop, keep saying you can't stop. During pushing you will experience a second degree perineal laceration. The baby will be born vigorous. The provider should immediately place the baby skin-to-skin on your chest. If they do not announce the sex or time of birth, ask what they baby is and/or what time they were born, depending on the information provided to you. If they do not immediately give you your baby, please ask for your baby to be skin-to-skin. You will have normal postpartum bleeding, and a normal placental delivery; watch for the facilitator's hand signals for when to push out the placenta and briefly turn the blood on, and off. During the perineal examination, the providers will discover that you have a second degree laceration and you will need a repair, and the provider will need to administer fentanyl to complete the repair. Express extreme anxiety and fear during this conversation. If they weigh your baby and do not announce the weight, ask how much your baby weighs. If asked, you are naming your baby girl Ella.*

*When the provider is completing your perineal examination, you should complain of intense pain, and ask if you can have more pain medication. The scenario will end once the care team has initiated routine newborn and maternal care, and discussed all available pain medication options.*

***For the support person - Mom:*** *Please act as a typical mom would do while her daughter is in labor. Be supportive, but slightly anxious for your daughter. Reassure her throughout, and feel free to ask the team questions.*

*The more you express your pains, worries, and emotions, the more it will help participants believe this is real. You control the reality of the simulation. Please avoid stepping out of your role, laughing, or giving medical suggestions.*

### SIMULATION HAND SIGNALS

**Before the simulation, review and practice the simulation and hand signals with the patient (birth the baby, turning blood on or off, etc.).**


***Turn on blood***
*(Open the tube lock to turn on the blood)*


***Turn off blood***
*(Close tube lock to turn off the blood)*


***Firm uterus***
*(Place fist under blood pouch to simulate a contracted uterus)*


***Contraction***


***Hold the baby or placenta back or stop whatever you are doing***


***Birth***
*(baby or placenta)*

**Practice delivering the baby and turning the blood on and off with the patient, then reposition the baby and make sure it is not tangled in tubing. Recheck that the blood is flowing.**

**Patient will begin in bed with the baby about to be born (cephalic presentation). Pour water on the pad to simulate amniotic fluid. Cover the patient with a sheet.**

**Confirm the pulse ox, blood pressure cuff, and epidural tubing are in place.**

***If you ever feel uncomfortable, say PINEAPPLE! or if you are having a medical emergency say, OMAHA! and the simulation will stop.***





## PRE-BRIEF FOR EVERYONE: SIMULATION PARTICIPANTS AND OBSERVERS

**Introduce simulation participants to the group and assign observers to watch for concepts or skills. Have a copy of the Teamwork & Communication and Respectful Maternity Care Checklists printed for the assigned observers to reference. Allow the simulation participants time to look around the area to check the materials.**

### PRE-BRIEF

**Read the following instructions aloud:**

*Welcome! Thank you for participating. Before beginning, I will identify the providers in this simulation and their roles* **(identify providers).**

*If you need to call for any on-call providers or providers from other departments for additional help, you will have to do so via your usual method* **(point to the on-call providers assigned to these roles, and who is currently in-house or off-site).**

*For those participating in the simulation, please look around the simulation area to see if all of the supplies normally available in a* ***labor and delivery room*** *are present. Please let me know if anything is missing that is typically available in your facility* **(allow time to look around at supplies).**

*Now that you have reviewed your supplies, let's review the Ground Rules of Simulation:*

- *We believe that everyone participating is intelligent, capable, cares about doing their best, and wants to improve.*
- *Remember, performance in simulation does not impact your job or salary.*
- *Try to make this as real and believable as possible.*
- *Have an open mind.*
- *Please avoid side conversations during the simulation.*
- *Maintain confidentiality.*
- *Allow mistakes to be made in order to learn from them.*
- *Be open with and respectful of other participants.*
- *Work as a team without worrying about personal ego.*

*For those observing, you will stay here and watch the action being live streamed. I am going to divide you into groups* **(divide them into groups based on where they are standing)** *and assign each group a concept or skill to observe. During the simulation, watch for your assigned concept or skill. You will be asked to discuss it in the debrief.*

***Group 1:*** *Trauma-informed Patient Centered Care*
***Group 2:*** *Teamwork and Communication*
***Group 3:*** *Clinical Competencies*
***Group 4:*** *Respectful Maternity Care Checklist*

**Skip the instructions in the gray box below if the participants already participated in simulation today.**

*As a reminder to participants:*

- *The patient wears injection pads on both legs. To administer medications, draw them up and inject them into the injection pads ONLY. They also wear IV bands on both arms, which are connected to IV collection bags, so you are able to start the pumps* **(show the locations of injection pads and IV arm bands).** *To start an IV, connect the tubing to the collection tubing under the arm bands.*
- *If vital signs are required, please take them via the usual method, and the findings will be shown on the facilitator's whiteboard or sheet taped in on the monitors.*
- *Remember, do NOT cut the umbilical cord of the baby, instead, undo the closure on the baby's back.*
- *The PartoPants™ have a rectum and urethra to administer rectal medications or insert a catheter. There is a symphysis pubis, and a blood bag inside the pants which simulates a uterus and allows the points to bleed* **(show them the locations on a pair of PartoPants™).** *If the uterus is contracted, there will be a firm fist under the bag; if not, the uterus is not contracted.*
- *If the baby is born breathing, you will hear the PRONTOCry* **(play the cry card).** *If you do not hear it, the baby needs resuscitation, and the baby will be switched for the resuscitation baby* **(show them the resuscitation doll under the towel).**

- *Please remember to treat this patient and baby like you would in real life: if there is blood, manage the bleeding, communicate like you would with a real patient, and so forth.*
- *We acknowledge that the simulation materials we use have limitations. We have done everything in our power to provide a valuable learning experience for you. We ask that you meet us halfway and act as if you were in the clinical environment.*
- *Remember that only the facilitator and the patient can stop the simulation. If the patient says PINEAPPLE, the simulation will stop. If the patient says OMAHA, they are having an actual medical emergency and the simulation will stop.*
- *Any questions?*

***I am now going to ask the on-call or back-up provider(s) to join the observers. You will be called if needed by your colleagues, or a facilitator. If called upon, please enter the scene as if you have no information about the case.***

**Pre-brief continues on the next page**





## SIMULATION PROGRESSION

| TIME | VITAL SIGNS AND CLINICAL FINDINGS | PATIENT SIMULATION HAND SIGNALS | APPROPRIATE & EXPECTED CARE TEAM ACTIONS | REACTIONS TO INAPPROPRIATE ACTIONS FOR PATIENT OR COMPANION |
|---|---|---|---|---|
| 3-4 minutes | **Amniotic fluid:** Present<br>**BP:** 125/76<br>**Temperature:** 37.0<br>**Pulse:** 80<br>**Respiration Rate:** 22<br>**Oxygen:** 98%<br>**Cervix:** C/C+1<br>**Fetal Heart Rate:** 140, moderate variability, positive accels, early decels | Contractions, but do NOT push baby | Takes or reviews vital signs: BP, P, R, T, O2<br>Helps the patient cope with the pain and pressure<br>Checks to see if baby crowning or head visible<br>May offer nitrous oxide, and/or call anesthesia for additional pain medication options | If pain is not addressed or patient counseled on options, the patient should continue to complain of pain and say,<br>***"I don't think my epidural is working anymore."*** |
| 5-7 minutes | **Baby:** Crowning<br>**Fetal Heart Rate:** 140, moderate variability, positive accels, occasional variable decels | Contractions, but do NOT push baby | Washes hands and gloves<br>Calls the OB provider<br>Prepares for birth and resuscitation<br>Clearly communicates with the patient with empathetic and specific guidance | |
| 8-11 minutes | **Tone and Color:** Good / Pink (SHOW PHOTO)<br>**Neonatal HR:** 120<br>**APGAR:** 8 & 9 | Birth of the baby<br>Press Cry card | Completes hand maneuvers for vaginal birth and notes time of birth<br>Performs drying/stimulating on maternal abdomen<br>Places the baby skin-to-skin on the patient's chest<br>Performs delayed cord clamping<br>Administers oxytocin for AMTSL per hospital protocol | If baby not placed on maternal abdomen for drying/stimulating, or baby not placed on patient's chest quickly, patient should ask:<br>***"Can I have my baby?"*** |
| 12-15 minutes | **MATERNAL FINDING:**<br>**BP:** 120/72<br>**P:** 80<br>**O2:** 98% RA<br>**Temp** 37.0 C<br>**Perineum:** 2nd degree laceration<br>**Placenta:** Complete<br>**Uterus:** Firm<br>**NEONATE FINDINGS:**<br>**Lungs:** Clear<br>**Respirations:** 50<br>**HR:** 120<br>**Temperature:** 36.8 | Birth of placenta<br>Turn blood on briefly and then off<br>Firm uterus | Delivers and inspects placenta<br>Uterine assessment<br>Discusses pain options with patient with compassion<br>Offers and provides additional pain options to patient (epidural bolus, other pain medication, non-pharmacological options) for repair<br>Begins neonatal assessment and takes neonatal vital signs, on the patient<br>Discusses plan for perineal repair | If pain is not addressed or patient counseled on options, the patient should continue to complain of pain and say,<br>***"I don't think my epidural is working anymore."***<br>If they have not communicated with the patient about the baby, the patient should ask:<br>***"What time was my baby born? How much does the baby weigh?"*** |
| 16-17 minutes | **Uterus:** Firm<br>**BP:** 117/70<br>**P:** 70<br>**T:** 37.0<br>**O2:** 99% RA | Press Cry card | Communicates with patient about how they both are doing | |

## DEBRIEFING QUESTIONS (20-30 MINUTES)

| DEBRIEF QUESTIONS (READ ALOUD TO GROUP) | FACILITATOR NOTES AND APPROPRIATE ANSWERS |
|---|---|
| **DESCRIPTION PHASE** | |
| ***For those who participated in the simulation, how did that feel?*** | Allow participants to reflect and answer. They may need to vent frustrations they might be feeling, allow for this. |
| ***Can someone give a BRIEF overview of what happened in the simulation?*** | Birth of a vigorous infant to a patient with polysubstance use in remission on Buprenorphine. |
| **ANALYSIS PHASE** | |
| ***Let's start by talking about what went well in this scenario.*** | Discuss. |
| ***In the pre-brief, we learned that Katie initially expressed concern about the epidural due to the fentanyl. Is this an experience you have encountered in your clinical practice? What kind of patient-centered counseling strategies do you use to address this patient concern?*** | Discuss. |
| ***How was the patient's request for additional pain medication handled right before pushing?*** | • Discuss additional pain medication or coping strategies provided to patient.<br>• Review counseling provided.<br>• Highlight any care, compassion, and dignity demonstrated. |
| ***We know that patients with SUDs can experience increased pain levels; what kind of pain options have you all found most useful in supporting this population during labor and birth?*** | • Review non-pharmacological options utilized in this facility.<br>• Discuss this facility's ability to administer nitrous oxide to patients with epidurals. |
| ***In a patient with SUD experiencing uncontrolled pain, what should the role of opioids be in pain management?*** | • The full spectrum of pain management options should be offered to the patient.<br>• Review if a SUD diagnosis change the order of what pain medication is offered.<br>• Do NOT withhold opioids if required - remember to assess the patient's priority in avoiding opioids. |
| ***What additional options for non-pharmacological and pharmacological pain relief are available to labor patients?*** | • Nitrous oxide.<br>• Hydrotherapy (pre-epidural, fine for ruptured patients and patients with GBS).<br>• Non-pharmacological options: Massage, heating pack on the back, change of positions, breathing. Anything else? |
| ***Outside of labor, and in the immediate postpartum period, there are additional options for pharmacological pain relief. What options are utilized in your facility to augment an epidural for a perineal repair?*** | • Lidocaine.<br>• Nitrous oxide.<br>• Ketorolac.<br>• Others? |

**Debrief continues on the next page**

# Rural Simulation Pilot (July 2025)

# Research Question 1

## Patient-level outcomes

Patients w/ SUD giving birth (n=100)

Interactive online modules

4-hour in-person team simulation

Interactive online modules

Patients w/ SUD giving birth (n=100)

6m pre-intervention

12-month intervention period to train providers

6m post-intervention

***Does INSPIRE improve the experience of maternity care for people with SUD?***

OUTCOME: Patient-centered maternity care, 35 items (Afulani et al)

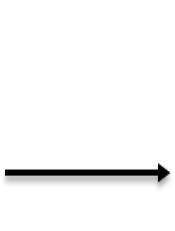
# Research Question 2

## Provider-level outcomes

200 providers enrolled in a single arm study

Baseline

Interactive online modules



4-hour in-person team simulation

Midline

Interactive online modules

Post

***Does INSPIRE make providers better equipped to support patients with SUD?***

PRIMARY OUTCOME: Bias using Medical Condition Regard Scale for SUD, 11 items

SECONDARY OUTCOMES: Knowledge, Self efficacy

# Research Question 3

## Implementation outcomes

Interactive online modules → 4-hour in-person team simulation → Interactive online modules

Provider self-report:

- Acceptability of INSPIRE (AIM)
- Appropriateness of INSPIRE (IAM)
- Feasibility of INSPIRE (FIM)
- Usability of the online modules (SUS)
- Open-ended questions to positive/negative aspects, and advice for modifications

Observed fidelity:

- Did participants complete all components?
- How much time did they spend on online modules?
- What "path" did they choose on online modules?
- Were simulations conducted as planned (checklist)?

# Expansion Across Utah


**Years 6-7**:
Take experience at the University of Utah and scale up across the state to reach other L&D locations.

- Adaptations for rural settings
- Compatibility w/ different LMS platforms
- Training of trainers (regional)
- Relevant implementation outcomes

# Expansion Beyond Utah


**Years 6-7**:
Take experience in Utah and pilot our solution in Colorado and Wyoming.

**Implementation Partner:**

# Contact

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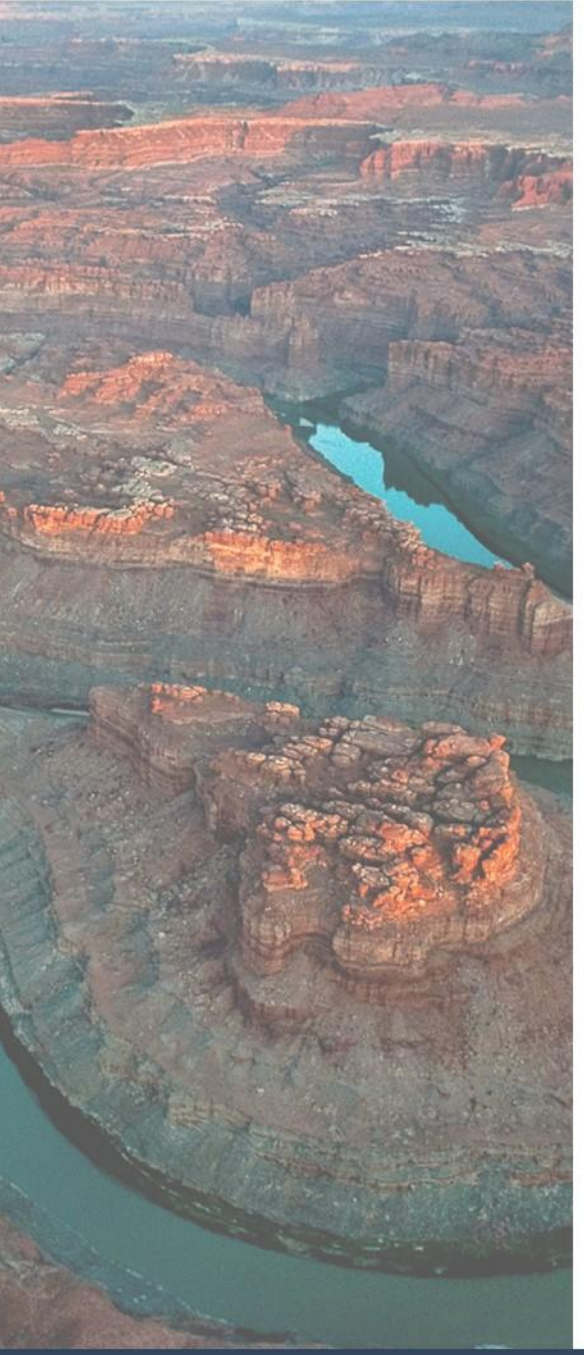
# U of U Health: ELEVATE

## Q&A


# Regular Registration is now open!!!

Learn more at https://www.rhau.org/conference



# CLOSING

- Next Session is October 1, 2026 at 12:00 p.m.
  - Topics:
    - Gibson Insurance (Returning)
    - TBD
- The recordings from today will be available at: https://www.rhau.org/rhau-webinar-series
- The application to request to present can also be found on the RHAU website, we encourage you to apply to present!
- THANK YOU FOR ATTENDING!!!

**October 2026 RSVP**