The Mother & Baby Substance Exposure Toolkit

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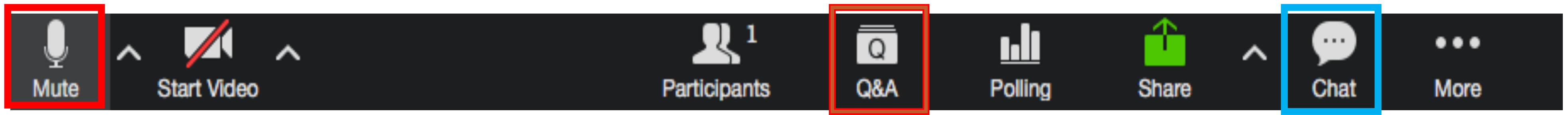
Tech Tips



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Objectives for Today's Webinar

- Understand best practice for universal verbal screening versus toxicology testing
- Identify the types of Medication Assisted Treatment (MAT) and understand why it is the standard of care for Opioid Use Disorder (OUD) in pregnancy
- Describe best practices for nonpharmacologic treatment for newborns with Neonatal Abstinence Syndrome (NAS)
- Understand the importance of preserving the mother/baby dyad for women with OUD and supporting practices
- Identify how hospitals can support the safe discharge of mothers with OUD and their newborns

Presenters

Welcome	Elliott Main, MD and Henry Lee, MD, MS
Addiction 101	Corey Waller, MD, MS
Toolkit Demonstration	Holly Smith, MPH, MSN, CNM
Maternal Best Practices	Carrie Griffin, DO
Newborn Best Practices	Kathryn Ponder, MD
Transitions of Care	Kathryn Ponder, MD & Carrie Griffin, DO
Closing Remarks	Jadene Wong, MD

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Welcome
Henry C. Lee, MD, MS
Elliott Main, MD

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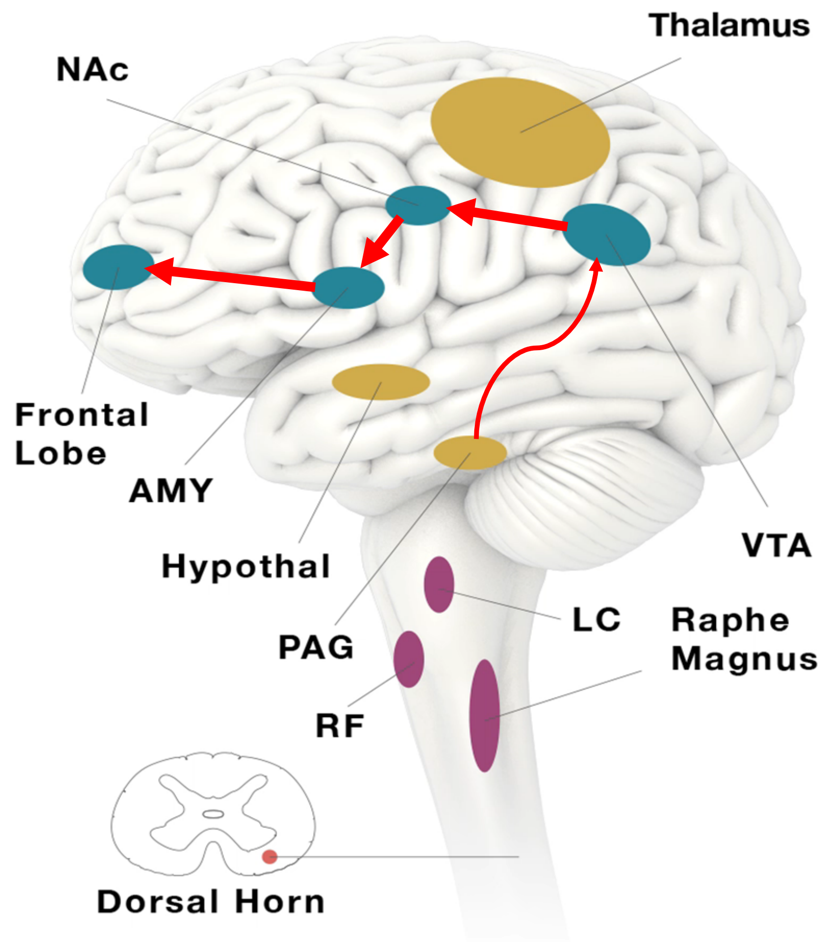
The Mother & Baby Substance Exposure Initiative – Part of the Medication Assisted Treatment (MAT) Expansion Project



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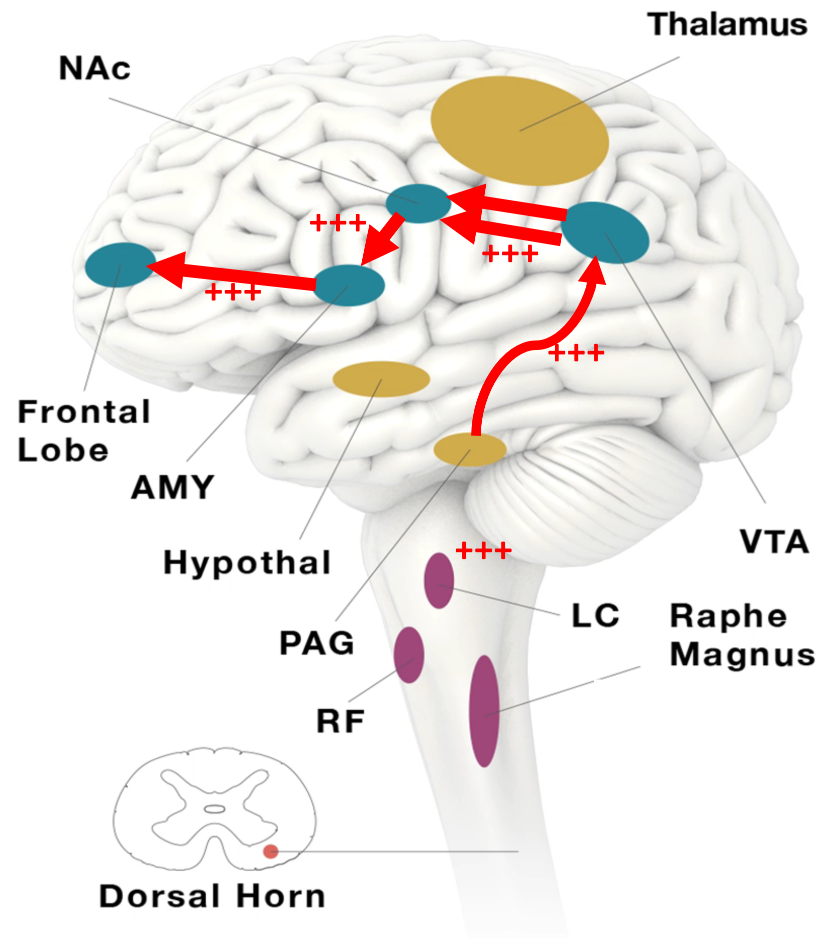

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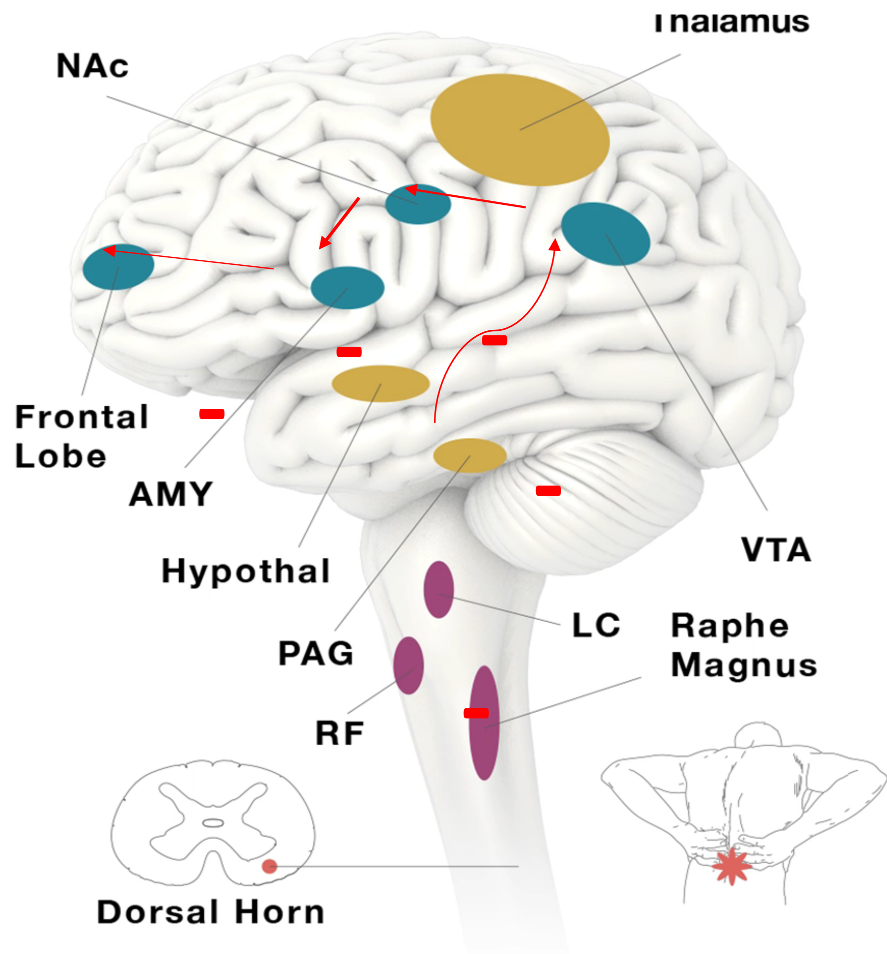

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DSM-5 Diagnostic Criteria: OUD

A minimum of 2-3 criteria is required for a mild substance use disorder diagnosis, while 4-5 is moderate, and 6 or more is severe.

- ❑ Taking the opioid in larger amounts and for longer than intended
- ❑ Wanting to cut down or quit but not being able to do it
- ❑ Spending a lot of time obtaining the opioid
- ❑ Craving or a strong desire to use opioids

- ❑ Recurrent use of opioids in physically hazardous situations
- ❑ Consistent use of opioids despite acknowledgment of persistent or recurrent physical or psychological difficulties from using opioids

- ❑ Repeatedly unable to carry out major obligations at work, school, or home due to opioid use
- ❑ Continued use despite persistent or recurring social or interpersonal problems caused or made worse by opioid use
- ❑ Stopping or reducing important social, occupational, or recreational activities due to opioid use

*Withdrawal manifesting as either characteristic syndrome or the substance is used to avoid withdrawal (Does not apply when used appropriately under medical supervision)
*This criterion is not considered to be met for those individuals taking opioids solely under appropriate medical supervision. Source: APA 2013

Fundamentals of Addiction Treatment

Identify the presence and severity of the addiction

Provide medication for the stabilization of the disease

For OUD, buprenorphine or methadone

Provide psychosocial support for the disease

Deliver these at the appropriate level of care for the appropriate amount of time

Toolkit Demonstration

Holly Smith, MPH, MSN, CNM

Maternal Best Practices

Carrie Griffin, DO

Objectives

- Understand best practice for universal verbal screening versus toxicology testing
- Identify the types of Medication Assisted Treatment (MAT) and understand why it is the standard of care for Opioid Use Disorder (OUD) in pregnancy

BP #1: **Use Validated Screening and Assessment Tools to Screen All Pregnant Women**

Why:

- Early identification allows more time to assess, recommend and implement a treatment plan for patients as well as stabilize home environment
- Universal screening of all pregnant patients controls for implicit and explicit bias regarding who is screened
- Decreases stigma about SUD if all women are routinely screened

BP #1: **Use Validated Screening and Assessment Tools to Screen All Pregnant Women**

How:

- Choose a validated verbal screening tool which can be easily administered at many different points in prenatal care and ideally at beginning of prenatal care
- Positive screens can be followed up by validated assessment tools to identify presence of a substance use disorder and its severity

BP#2: **Once substance use is identified, perform a brief intervention and referral to appropriate treatment (SBIRT)**

Why:

- Screening, Brief Intervention and Referral to Treatment (SBIRT) is a validated process to adequately address SUDs

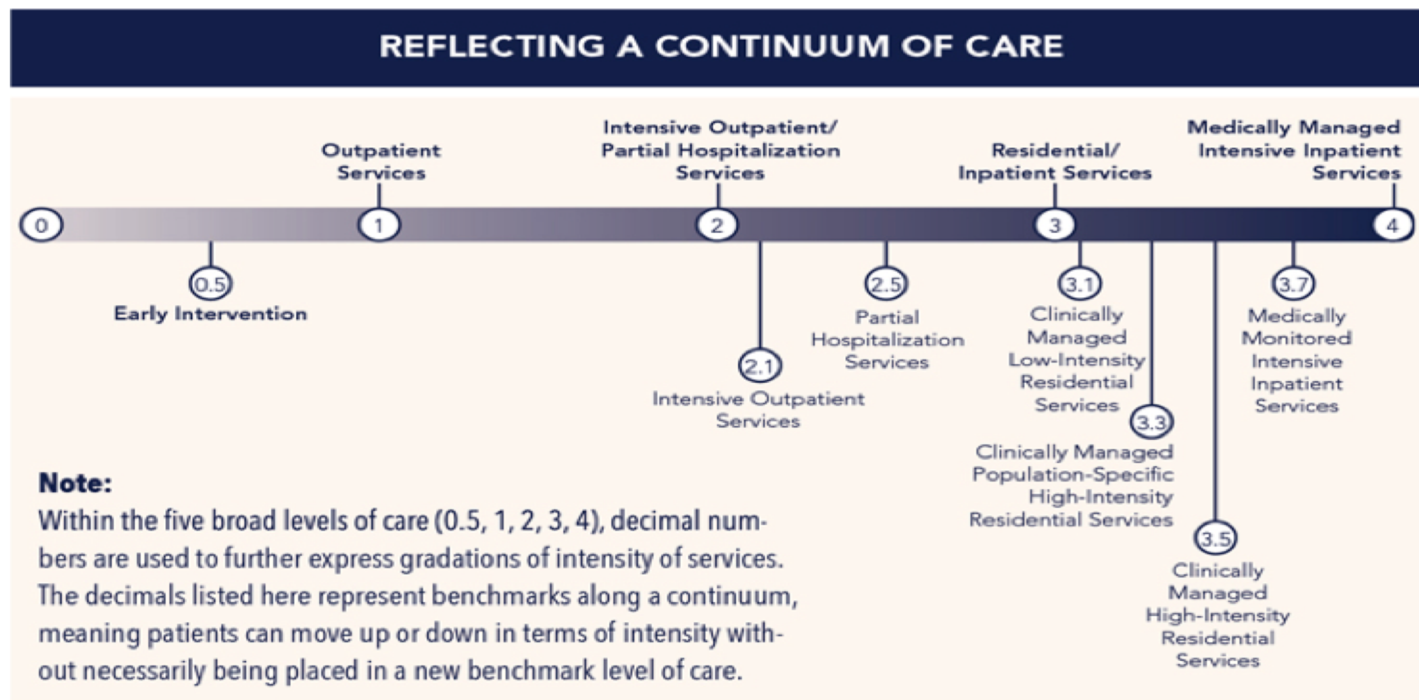
How:

- Train staff about what a Brief Intervention is and universal capacity for anyone to initiate a Brief Intervention
- Warm hand offs to behavioral health, social workers, or other identified staff can be considered as part of a practice's workflow around positive screens and assessments

BP#2: **Once substance use is identified, perform a brief intervention and referral to appropriate treatment (SBIRT)**

- **Low Risk Patients:** Brief advice about their identified substance
- **Moderate Risk Patients:** Brief intervention
- **High Risk Patients:** Should have a level of care recommendation made by completing an ASAM Co-Triage or Continuum screening to identify the most appropriate setting for their specific SUD treatment needs

BP#2: **Once substance use is identified, perform a brief intervention and referral to appropriate treatment (SBIRT)**



BP#3: **Maternal urine toxicology and the role of implicit/explicit bias in decision making**

*** A positive urine toxicology result does not equal a substance use disorder any more than a negative result rules it out.***

BP#3: **Maternal urine toxicology and the role of implicit/explicit bias in decision making**

Limitations:

- Many substances may not be detected (false negatives), including synthetic opioids and designer drugs
- Risk of false positives
- Any positive toxicology result requires confirmatory testing
- Testing does not provide information on severity or duration of use
- Testing can only assess for current or recent use
- Even if results are negative, sporadic use is not ruled out

BP#3: **Maternal urine toxicology and the role of implicit/explicit bias in decision making**

How:

- Talk to patients about urine drug screening prior to obtaining it
- Patients have the right to refuse testing and should not be coerced into being tested
- Create policies that account for implicit bias so that women of color or lower socioeconomic status are not disproportionately screened
- Send unexpectedly positive or negative results for confirmatory testing
- For patients in labor, be aware of receipt of Fentanyl, Ephedrine, vasopressin which could cause false positive results

BP#10: **Implement Medication Assisted Treatment in the Prenatal Setting**

Why:

- Pregnancy often a motivating factor and period to address SUD treatment
- MAT decreases risk of relapse and increases engagement in prenatal care and addiction treatment
- Adherence to MAT during pregnancy has been shown to decrease pregnancy complications as well

How:

- Identify where patients can obtain MAT in your community
- Encourage prenatal providers to become X-licensed buprenorphine prescribers
- Even if no local practitioners or experts available make use of phone consultation services

BP#13: **Ensure methadone and buprenorphine doses are not tapered in the immediate postpartum period**

Why:

- Women in the postpartum period are at high risk of relapse and overdose

How:

- Encourage close follow up with obstetric provider and MAT provider after hospital discharge
- Heighten discharge planning to include warm handoffs to appropriate community providers
- If integrated prenatal and MAT services are not employed, ensure education for nursing, obstetric, pediatric hospital staff to reinforce the need to continue with MAT and stable dosing during this period

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The Mother & Baby Substance Exposure Initiative – Part of the Medication Assisted Treatment (MAT) Expansion Project

Objectives

- Describe best practices for non-pharmacologic treatment for newborns with NAS
- Understand the importance of preserving the mother/baby dyad for women with OUD and supporting practices

BP#16: **Implement a non-pharmacologic NAS bundle of care for medical staff and parents to follow**

Why:

- Minimize medication
- Reduce the length of stay
- Keep staff and parents aligned on the care being provided the newborn

How:

- Collaborate with nursing and health care teams to develop a written guideline with a bundle of care that is specific for your unit

Examples of Non-Pharmacologic Care

Environment

- Minimizing noise, overstimulation, too many visitors
- Clustering nursing care

Feeding

- On-demand
- Lactation support when no contraindications
- Consider higher calories if poor growth

Skin Care

- Diaper dermatitis
- Skin excoriation due to tremors

Caregiver Contact

- Skin-to-skin or swaddling
- Volunteers if parents unavailable
- Parental presence or rooming-in

BP#17: **Develop guidelines for inpatient monitoring of newborns managed with a non-pharmacologic bundle of care**

*** For in utero **opioid** exposure managed solely with a non-pharmacologic bundle of care, we recommend a **minimum of 72 hours** of inpatient monitoring. ***

BP#18: **Consider parental rooming-in with the newborn when a plan of safe care can be implemented**

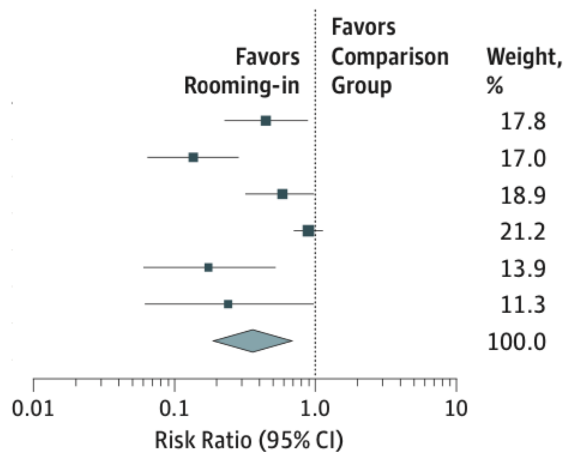
Why:

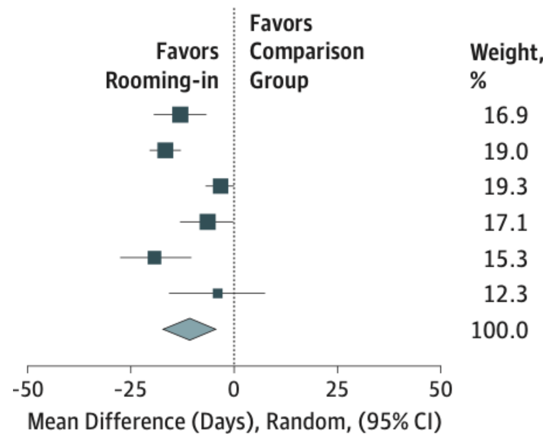
- Reduce pharmacotherapy use
- Reduce length of stay

How:

- Respectful and non-judgmental manner
- Safe sleep habits

Meta-analysis: **Rooming-in decreases pharmacotherapy use and length of stay**





- Not associated with readmission or in-hospital adverse events
- Authors recommend rooming-in as a preferred inpatient care model for NAS over the NICU

MacMillan et al *JAMA Pediatr 2018*

BP#28: **Continue to establish a therapeutic relationship with parents and empower parents to be involved in the care of their newborn**

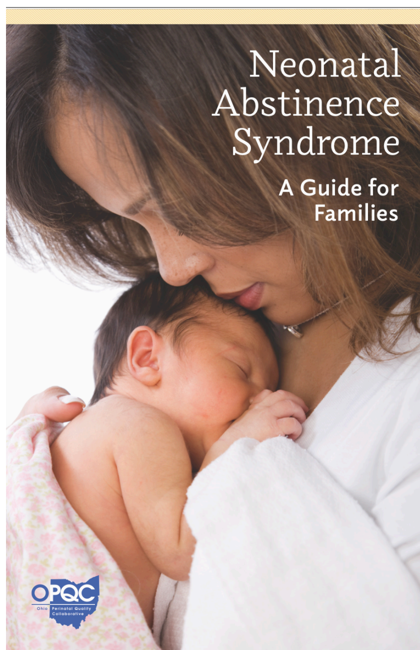
Why:

- Increase parental confidence in managing symptoms
- Establish healthy attachment to newborn
- Allow parents to better succeed in the transition to home

How:

- Prenatal/postnatal counseling
- Non-judgmental attitude
- Consistency
- Confidentiality
- Promote positive maternal/paternal attachment
- Caregiver diary/other written material

Parental Education and Empowerment



Newborn Care Diary

Baby's name: ____________ Medical Record Number: ____________ Date: ____________

Time of feed (start to finish)	Breast feeding (total # minutes)	Bottle feeding (total # mL)	Time baby fell asleep	Time baby woke up	Did baby feed well? (if no, describe)	Did baby sleep for an hour or more? (If no, describe)	Did baby console in 10 min? (if no, describe)	Check box for diaper wet	Check box for diaper dirty (please describe)	Care provided and extra comments	Update given to care team
8:10-8:25	L-10 R-15		8:35	11:50	Yes, but I had a hard time getting him to latch since he was crying. Took 10 min to get him on	Yes	Yes, but he was very fussy and I had to offer the breast	√	√√ Loose	Skin to skin provided right when he woke up.	√ 1/1/19 @ 1205

BP#19: **Prioritize measurement of functional impairment as the basis for pharmacologic treatment, initiation, escalation**

Why:

- Subacute symptoms of NAS can continue for weeks or months
- May reduce length of stay and pharmacotherapy exposure
- Studies of this method indicate no increase in readmission rates; however, there are no long-term studies yet to evaluate benefit vs harm of this method

Examples of published methods emphasizing functional impairment

Finnegan Symptom Prioritization

- Most recent reports include poor feeding, poor sleep, and continuous crying as prioritized functional measures.
- Other components of the Finnegan score that are sometimes included are emesis, diarrhea, tachypnea, or fever

“Eat, Sleep, Console” (ESC)

- Eating < 1oz per feed or poor breastfeeding
- Sleep less < 1 hour after feeding
- Inability to be consoled within 10 minutes

Holmes et al Pediatrics 2016; Grossman et al Pediatrics 2017; Grossman et al Pediatrics 2018; Wachman et al J Perinatol 2018

Kathryn Ponder, MD
Carrie Griffin, DO

Objective

- Identify how hospitals can support the safe discharge of mothers with OUD and their newborns

BP#33: **Communicate directly with the outpatient PCP…to review the hospital course & discuss follow-up**

Why:

- Withdrawal signs may last weeks to months
- Feeding and weight gain
- Drug exposure in utero is a marker of environmental risk. Caretaker involvement, family resources, and community resources are protective factors that can improve long-term outcomes for children

How:

- PCP within 24-72 hours of discharge + home health visit if available
- Consider a NAS discharge checklist

Protective factors can mitigate behavior problems after prenatal drug exposure

Family

- Secure attachment
- Home environment
- Caretaker involvement
- Caregiver supervision
- SES
- Family support
- Family resources

Child Resilience

Community

- Neighborhood environment
- Number of friends
- Extracurricular activities

Bada et al Pediatrics 2013

BP #25: **Identify community care resources for the mother and newborn**

Why:

- SUD treatment occurs across multiple potential settings – prenatal care clinics, MAT programs, residential treatment centers, and other behavioral health and social services resources
- Appropriate treatment of these families involves linking services across all of these settings making it imperative to know what resources are unique to your community

BP #25: **Identify community care resources for the mother and newborn**

How:

- Create a file of outpatient resources (federal, state, local) to have in hospital
- Identify a clear process for who assesses women for and then refers to appropriate programs
- Encourage referral to appropriate services prenatally as well

BP#27: **Implement OUD discharge checklists unique to all hospital-based points of entry**

Why:

- The postpartum period can be chaotic for mother and baby and a discharge planning checklist can help mitigate this transition from hospital to home
- These are not just boxes to check even if it is a checklist; the goal is to increase communication between all community organizations, clinics and other public resources to ensure a safe and supportive start to mothering

Closing Remarks

Jadene Wong, MD

Future Directions

- Promote universal verbal screening and MAT for pregnant women with OUD in a setting free of stigma and bias
- Advocate for hospitals to use functional scoring and non-pharmacologic care for newborns with NAS
- Develop a Plan of Safe Care that preserves the mother/baby dyad

Resources:

- CA Bridge: https://www.bridgetotreatment.org/resources
- CA DHCS: https://www.dhcs.ca.gov/provgovpart/Pages/sud-directories.aspx
- HMA's Addiction Free CA: https://addictionfreeca.org

THANK YOU!

Nastoolkit.org

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