Mother & Baby Substance Exposure Toolkit

Outpatient

A part of the California Medication Assisted Treatment Expansion Project

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Use validated verbal screening and assessment tools to evaluate all pregnant women for substance use disorders

Best Practice No. 1

Outpatient, Labor and Delivery, Nursery/NICU, and Screening, Assessment and Level of Care Determination

Overview

Implement universal screening for substance use disorder (SUD) with a standardized, evidence-based screening tool at all locations that provide medical care to pregnant women. A universal screening tool for self-reporting of opioid use and identification of risk for opioid use disorder (OUD) should not be confused with toxicology testing (refer to **Best Practice #3** for more on toxicology testing).

Why we are recommending this best practice

Identification of women with SUD as early as possible in pregnancy is critical in connecting them to treatment. Treatment for SUD, particularly OUD, during pregnancy results in better outcomes for mom and for her newborn.

Drug addiction affects all racial, ethnic, and social groups. Universally screening all women minimizes the potential for implicit bias that can occur when providers use subjective risk factors to determine who should be screened and may also decrease the stigma associated with SUD and screening. Universal screening at the time of entry into prenatal care allows more time to intervene and mitigate the harms associated with SUD in pregnancy and to stabilize the home environment for newborns. If an individual screen is positive for risk of OUD or other SUD, a validated assessment tool (a deeper evaluation intended to solidify a diagnosis and severity of a condition) should be administered to determine the presence and severity of the SUD. It is important to remember that substance use is not synonymous with addiction.

Strategies for Implementation

- Educate staff on how to administer a validated screening tool and the importance of universal screening in order to reduce implicit bias.

- Initial screening for risk takes little time and can be done at many points within care. Validated screening tools include the NIDA quick screen, 4Ps Plus, and the CRAFFT (for women and adolescents 12-26 years old). Refer to a full list of validated screening tools in the Resources section of this Best Practice.

- Screening should be performed at intake of prenatal care to identify needs as early as

possible and at regular intervals thereafter.

- If screening is positive, use a validated verbal assessment tool to establish the diagnosis and severity of an actual SUD. Ideally, this assessment should immediately follow a positive screen. Examples include, but are not limited to, AUDIT-C (alcohol specific), ASSIST (Alcohol, Smoking, and Substance Involvement Screening Test), and DAST-10 (drug use). For descriptions of these and other validated assessment tools, refer to the AIM Opioid Screening Tools in the Resources section of this Best Practice.

- A positive screening should stimulate a brief intervention and referral to appropriate treatment using resources within your setting and community. *Determining severity of disease is critical in referring to the correct level of care* (refer to **Best Practice #2**).

- Screen all women for coerced sex and the possibility of human trafficking. An Adult Human Trafficking Screening Tool has been created by the US Department of Health and Human Services. Please also see a commentary from *The Journal of Ethics* in the References section of this Best Practice.

- Inquire about polysubstance use. If smoking tobacco or drinking alcohol, provide brief intervention and referral to services. Encourage cessation and refer to cessation services to decrease risk for a variety of adverse pregnancy outcomes and to decrease severity of neonatal abstinence syndrome (NAS). If drinking alcohol, counsel the patient that there is no known safe amount of alcohol during pregnancy. Inform patient/family that alcohol is the leading known cause of birth defects.

Kayla

Kayla comes to her local community health clinic and asks to be seen for her ongoing problems with back pain and anxiety. Her history elicited the need for a routine pregnancy test. Kayla starts crying when she finds out she is pregnant and it is unclear at first what this means, but through continued discussion the physician realizes that although Kayla didn't plan on getting pregnant now, she definitely wants to continue the pregnancy and is excited about this new possibility.

The physician asks Kayla if it would be ok to ask some questions about Kayla's personal and family history. She explains that they ask these questions of all women who are pregnant to make sure they get the best possible care during pregnancy. With Kayla's permission, the physician reviews Kayla's medical, social, and family histories; she includes an evidence-based screening tool for substance use disorder that takes only a few minutes to administer. It was only through this interview that the physician identified Kayla as a person with possible SUD and was subsequently able to start her on the best possible care pathway to meet her unique needs.

Resources

1. AIM Opioid Screening Tools.
2. SAMHSA-HRSA Center for Integrated Health Solutions.
3. Council on Patient Safety Women's Health Care Safety Bundle for Obstetric Care for Women with Opioid Use Disorder.
4. Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants. SAMHSA.
5. Adult Human Trafficking Screening Tool and Guide.
6. Accuracy of Three Screening Tools for Prenatal Substance Use.
7. ACOG Postpartum Toolkit (see screening tools in Table 1 of the Substance Use Disorder section of this toolkit).

References

1. ACOG committee opinion No 711: opioid use and opioid use disorder in pregnancy. Obstet Gynecol. 2017; 130: e81-94. doi: 10.1097/AOG.0000000000002235.
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Dr. Carrie Griffin is a family medicine physician who specializes in maternal, child and reproductive health and practices in Humboldt County. She completed her residency at Maine Dartmouth Family Medicine Residency and fellowship at the University of New Mexico. Perinatal substance use is her clinical area of interest and expertise; she currently serves as a mentor for CMQCC's Mother Baby Substance Exposure initiative and the Humboldt RISE project, a community initiative to promote screening and case management services for women with substance use disorders in pregnancy.

Once substance use is identified, perform a brief intervention and referral to appropriate treatment (SBIRT)

Best Practice No. 2

Outpatient, Labor and Delivery, Nursery/NICU, and Screening, Assessment and Level of Care Determination

Overview

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a comprehensive, evidence-based approach to the identification and delivery of services for a variety of conditions including substance use disorder (SUD). Once substance use is identified, perform a brief intervention and refer to the treatment most appropriate for a patient's needs. A brief intervention is a patient-centered, structured conversation that utilizes the principles of Motivational Interviewing (refer to **Best Practice #8**), in order to motivate the person to progress through the stages of readiness toward concrete changes that address their SUD. Brief interventions have been shown to improve outcomes for patients with substance use, and formal treatment is required for those with a diagnosable SUD.

Why we are recommending this best practice

SBIRT is a validated process for addressing SUD. Each facility should identify resources in their community to assist women who screen positive and include a warm hand-off to a care navigator to help connect them with appropriate resources.

Strategies for Implementation

- Identify and train the appropriate staff in the use of screening and brief intervention techniques. This can include sample scripting for staff around screening itself and how to respond to positive screens – this is important for any type of screening completed. Refer to **Best Practice 7** for more information on Trauma-Informed Care and how to avoid re-traumatization.

- Have a list of resources or informational packets available for each American Society of Addiction Medicine (ASAM) level of care to support women at all levels of risk.

- Establish a clear system and workflow for positive, validated screening and/or assessment tools.

- Please see the Resources section of this Best Practice for information on risk ("AIM Opioid Screening Tools").

  - Low risk patients can receive brief advice related to their identified substance.
  - Moderate risk patients should have a brief intervention
  - As described in Best Practice # 1, after a positive screen for SUD, use a validated assessment tool to determine the presence and severity of the SUD followed by the identification of and referral to the appropriate level of care that matches the severity of the patient's needs. The state of California mandates that all counties with Drug Medi-Cal Organized Delivery System (DMC-ODS) contracts use the ASAM criteria to determine the appropriate level of care for an individual with SUD. The ASAM Co-triage or the ASAM Continuum clinical decision supports are ideal assessment tools to meet that requirement.

- Other than the Co-triage, which is designed as a ten-minute provisional evaluation tool, each assessment typically takes an hour to complete. Identifying clinic personnel who can be trained to effectively administer the chosen screen, assessment, and level of care evaluation prior to SBIRT implementation will streamline workflow.

- Identify local options for each level of care, including the full spectrum of office-based treatment (level 1), methadone clinic management (level 1 OTP), intensive outpatient centers (levels 2.1 and 2.5), residential treatment centers (levels 3.1, 3.3, 3.5, and 3.7) and medically managed inpatient treatment (level 4). Please see the Resources section of this Best Practice for the SAMHSA treatment locator tool. For more on levels of care, please refer to the ASAM CONTINUUM in the Resources section of this Best Practice.

- Referral sites may be any of the above depending on the level of care determined to be most appropriate.

Kayla

Kayla's screen is positive for risk of substance use disorder, and she has shared that she is using opioid pain medications for her back pain, marijuana for her anxiety, and smoking cigarettes. While you are talking, she takes a pack of cigarettes out of her purse and throws it in the trash. She tells you that she knows smoking isn't good for her baby, and she is going to quit right now. She explains that she knows she should stop everything, but she needs the pain medication and marijuana to manage her back pain and anxiety, especially since pregnancy will probably make her back pain worse.

The physician applauds Kayla's desire to make healthy choices for herself and her baby. She explains that all medications women take during pregnancy may have some effects on the baby and that there are treatments available for women who have become dependent on opioids; these treatments not only help mom feel better but are safer for developing babies. She explains that abruptly stopping opioids suddenly can be dangerous for her baby. She asks if Kayla would like to meet with Hannah (a social worker), who can help her set up an appointment to talk about treatment, as well as assist with any other needs Kayla may have during her pregnancy.

Resources

1. SAMSHA'S guide to SBIRT.
2. ASI (Addiction Severity Index) Sample.
3. ASAM Continuum - Guide to Levels of Care for Substance Use Treatment.
4. NNEPQIN Toolkit for Perinatal Care of Women with Substance Use Disorders. Chapter 3 on SBIRT.
5. SBIRT Oregon's online curriculum guide to teaching and using SBIRT.
6. AIM Opioid Screening Tools.
7. Behavioral Health Treatment Services Locator.

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Maternal urine toxicology and the role of explicit/implicit bias in decision-making

Best Practice No. 3

Outpatient, Labor and Delivery, and Screening, Assessment and Level of Care Determination

Overview

Understanding toxicology testing and its limitations is important for providing optimal care to women who use substances during pregnancy. Universal screening via a validated verbal screening tool (see **Best Practice #1**) should not be confused with urine or blood toxicology, which historically has been applied inconsistently and has often resulted in a system of race and class-based testing. Thus, toxicology testing should be carefully applied with the intention of improving clinical decision-making, such as informing the pain management approach during the intrapartum period and improving efforts to link the mother with appropriate services and treatment.

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

Why we are recommending this best practice

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

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

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

Even objective medical criteria for determining who should have toxicology testing may be

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

Strategies for Implementation

- Ensure policies that delineate criteria for toxicology testing do not directly or indirectly target low income women and women of color.
- Behaviors *(*e.g signs of acute intoxication) are more important as prompts for toxicology screening than selective indicators of risk.
- Each institution should be aware of the sensitivity and specificity of the tests used at their facility.
- Everyone should be familiar with the current laws and regulations for their county and state. Each institution should have the following:
    - A clear policy, consistent with state and federal law, regarding what constitutes grounds for reporting to child protective services (CPS)
    - Education for all staff members who work with pregnant women about this policy
    - Routine reviews to ensure that the policy is being applied consistently and appropriately

- Every patient must be able to give informed consent. Informed consent requires a clear explanation of why testing is necessary, the benefits of testing, and risks of testing including the potential legal, criminal, or child welfare consequences. If the provider or nurse is unable or unwilling to thoroughly explain the typical course of events after a positive drug test at their facility, a reasonably prudent patient would not have sufficient information to make an informed decision. Additional talking points are included in the Resources section of this Best Practice.

- Every patient has a right to withhold consent and coercive language should not be used.

- Multiple biological substances can be used for toxicology testing, including urine, saliva, blood, hair, and meconium. Urine is often used to test pregnant women as the filtering action of the kidneys allows detection of smaller quantities for a longer period than blood.

- Toxicology tests generally fall into two types: screening tests and confirmatory tests.

- It is essential to confirm unexpected results from toxicology screening tests. If the result of the screening test matches an expected result, it is usually not necessary to

obtain confirmatory testing. Examples of unexpected results might include:
    - A patient tests positive for a substance that she denies taking
    - A patient tests negative for a substance that is prescribed, and she indicates she is taking regularly

- Toxicology testing does not provide information on how recently someone used a substance or the quantity they used. Toxicology screening tests are qualitative and only indicate the presence/absence of a substance. Confirmatory testing often does report a quantitative level, but this should not be used to infer how much a woman is using a substance. Many factors are involved, and any value over the cutoff level should be a qualitative positive unless evaluated by a medical review officer.

- Urine drug toxicology on admission to the hospital need to be monitored for timing of the sample related to administration of intrapartum pain medications. Fentanyl can lead to false positive opioid results. Ephedrine and vasopressin can lead to false positive amphetamine.

- For an excellent review of drug screening immunoassays for clinicians to become proficient in understanding and interpretation of results, please see Nelson ZJ et al. They also provide a full description of false positives and false negatives.

	Screening Tests	Confirmatory Tests
Methodology	Usually enzyme-linked immunosorbent assay (ELISA) like pregnancy strep tests.	Gas chromatography–mass spectrometry (GC/MS); Liquid chromatography–mass spectrometry (LC/MS); others
Accuracy	Can produce false positives and negatives.	Very sensitive to the drug being tested for but may have difficulty with synthetic versions.
Cost	Relatively inexpensive	More expensive then ELISA
Speed	Can be done at point of care thus providing relevant information at time of visit.	Needs to be sent off resulting in delays in making clinical decisions.

Toxicology Screening vs. Confirmatory Testing

Resources

1. Maternity Drug Policies by State.
2. Toxicology FAQs.

References

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Scott Haga is Senior Consultant wiht Health Management Associates and is a passionate patient advocate with a focus on motivational training, evidence-based treatment, collaboration and tackling the national opioid crisis head-on. He is an experienced medical provider who co-founded and co-led an interdisciplinary complex care intervention for high frequency emergency department utilizers. He has been recognized as a subject matter expert on addiction, medication assisted treatment for substance use disorders, and building well-functioning interdisciplinary treatment teams.

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Create a prenatal checklist for care of women with opioid use disorder

Best Practice No. 4

Outpatient and Screening, Assessment and Level of Care Determination

Overview

Create a flow chart and/or checklist of care steps for antenatal care of women with opioid use disorder (OUD). Refer to the example below and an additional example in the Resources section of this Best Practice.

Why we are recommending this best practice

A checklist will help providers remember the many steps involved in the antenatal care of women and families with OUD. While these services and activities would normally be addressed over the course of prenatal care, they may need to be compressed depending on when the woman presents for care. Referenced are examples from the Illinois Perinatal Quality Care Collaborative and the Northern New England Perinatal Quality Improvement Network.

Strategies for Implementation

Collaborate with health care team members to adapt a written checklist that is specific for your site of care.

OUD Clinical Care Checklist (Adapted for CA)

Checklist Element	Date	Comments
Antepartum Care		
Counsel on MAT for OUD and arrange appropriate referrals		
Counsel and link to behavioral health counseling /recovery support services		
Social work consult or navigator who will link patient to care and follow up		
Obtain recommended lab testing- • HIV / Hep B / Hep C (if positive viral load & genotype) • Serum Creatinine/ Hepatic Function Panel		
Institutional drug screening policies and plan for testing reviewed		
Urine toxicology testing for confirmation per policy (consent required)		
Discuss Narcan as a lifesaving strategy and prescribe for patient / family		
Neonatology/Pediatric consult provided, discuss NAS, engaging mom in non-pharmacologic care of opioid exposed newborn, and plan of safe care.		
Child Protective Services policies reviewed, discuss mom/baby safe discharge plan		
Screen for alcohol/tobacco/non-prescribed drugs and provide cessation counseling		
Screen for co-morbidities (ie: mental health & domestic violence)		
Consent for obstetric team to communicate with MAT treatment providers		
Consider anesthesia consult to discuss pain control, L&D and postpartum		
Third Trimester		
Repeat recommended labs (HIV/HbsAg/GC/CT/RPR)		
Ultrasound (Fluid/Growth)		
Urine toxicology with confirmation (consent required), and review policy		
Review safe discharge care plan and DCFS process		
Patient Education: OUD/NAS, participating in non-pharmacologic care of the opioid exposed newborn, including breastfeeding, and rooming in.		
Comprehensive contraceptive counseling provided and documented		
During Delivery Admission		
Social work consult, peds/neonatology consult, anesthesia consult		
Verify appointments for support services (MAT/Behav Health/ Recovery Services)		
Confirm Hep C, HIV, Hep B screening completed		
Discuss Narcan as a lifesaving strategy and prescribe for patient / family		
Provide patient education & support for non-pharmacologic care of newborn		
Review plan of safe care including discharge plans for mom/infant		
Schedule early postpartum follow-up visit (within 2 weeks pp)		
Provide contraception or confirm contraception plan		

ILPQC OUD Clinical Care Checklist (adapted for CA)

Deep Dive

Checklists come in many forms: some for use in emergencies, some for use prior to surgery, and some simply as reminders for the supermarket. A prenatal checklist serves both as an ongoing set of reminders and as documentation of important tasks completed. A checklist, such as the one above, is central to the care of a complex patient with many external consultations over a long period of time, and a pregnant woman with substance use disorder is one of the most challenging to care for. A provider must navigate special laws and unfamiliar regulations, co-manage with other key providers, order different panels of blood tests, approach building communication and developing trust differently, and provide education on topics not usually covered in prenatal care. Examples of the latter include special plans for labor pain management, preparation for neonatal substance withdrawal, and most important of all, developing a Plan of Safe Care (POSC) for both the baby and mother.

The Prenatal Checklist provides the central direction for the team's actions in antenatal care. It belongs front and center in the prenatal record and should be reviewed at

every visit by providers, staff, and the patient. This toolkit provides several examples. Through small tests of change, modifications can be made to the example checklists until it meets the needs of patients at the care site. Follow up at the postpartum visit should include questions about what the patient thinks could be improved—no checklist is ever a final product!

Resources

1. ILPQC MNO-OB OUD Protocol.
2. ILPQC OUD Clinical Care Checklist.
3. NNEPQIN Opioid Use Disorder Clinical Pathway.

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Implement Trauma-Informed Care to optimize patient engagement

Best Practice No. 7

Outpatient, Labor and Delivery, Nursery/NICU, and Treatment

Overview

Implement Trauma-Informed Care to optimize patient engagement in prenatal care.

Why we are recommending this best practice

Many pregnant women with opioid use disorder (OUD) have experienced significant traumatic events, adversity, and toxic stress in their lives, including sexual abuse and other Adverse Childhood Experiences (ACEs). Trauma refers to intense and overwhelming experiences that involve serious loss, threat, or harm to a person's physical and/or emotional well-being. These experiences may occur at any time in a person's life; they may involve a single traumatic event or may be repeated over many years. These traumatic experiences often overwhelm a person's coping capacity. In many cases, prescription and/or illicit opioid use begins as a coping mechanism to manage the symptoms of post-traumatic stress disorder (PTSD).

Trauma-Informed Care is a strengths-based service delivery approach "that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment" (Hopper E, et al, 2009). Trauma-Informed Care acknowledges a patient's life experiences as key to improving engagement and outcomes while lowering unnecessary utilization. It changes the paradigm from one that asks, "What's wrong with you?" to one that asks, "What has happened to you?" Just as with "universal precautions" for infection control, Trauma-Informed Care necessarily assumes that every patient, and indeed every provider or staff person, has a history of traumatic stress.

In order to be successful, Trauma-Informed Care must be adopted at both the organizational and clinical levels and cannot be implemented as a singular, disconnected intervention that occurs between providers and a few patients who are seemingly appropriate for this kind of care based on their diagnosis and social history. Successful implementation requires a commitment from the agency, service line, or department for significant culture change at the organizational and clinical levels. Trauma-Informed Care is not a "one and done" training for staff and management. Rather, it is a comprehensive journey to implement systematic changes in how care is delivered for every person who enters care. It involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to retraumatize individuals, and it upholds the importance of consumer participation in the development, delivery, and evaluation of services. Furthermore, a trauma-informed organizational structure addresses the impact of trauma across the lifespan and the critical role of health care service delivery systems to interrupt the cycle of trauma by employing trauma-aware services, policies, and mindsets.

SAMHSA recognizes six principles that are fundamental to a Trauma-Informed Approach:

- Safety. Do we help promote a sense of safety for every person?
- Trustworthiness and Transparency. Do we conduct all patient care with complete transparency and with the goal of building and maintaining trust?
- Peer Support. Do we provide any peer support services or mutual help services that build upon the trauma-informed framework of safety, trust, and collaboration in care?
- Collaboration and Mutuality. Do we share power in decision making in a meaningful way and maximize the ability of patients to engage in care decisions?
- Empowerment, Voice, and Choice. How are we providing the resources necessary to both staff and patients in order to ensure skill building, goal-setting, and non-coercive treatment for every patient
- Recognition of cultural, historical, and gender issues. Are we actively working to move beyond cultural stereotypes based on gender-identity, race, sexual orientation, socio-economic status, and more? Do we recognize historical trauma and impact on race-based disparities?

Strategies for Implementation

- The Trauma-Informed Care Implementation Resource Center, developed by the Center for Health Care Strategies with support from the Robert Wood Johnson Foundation, offers a one-stop information hub for health care providers interested in implementing Trauma-Informed Care. It houses the following:
    - foundational content regarding the impact of trauma on health
    - testimonials from providers who have adopted trauma-informed principles
    - in-the-field examples illustrating how to integrate Trauma-Informed Care into health care settings
    - practical strategies and tools for implementing trauma-informed approaches
    - information for state and federal policymakers interested in supporting Trauma-Informed Care

- Review SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach (refer the Resources section of this Best Practice), which offers first steps to organizational assessment and development around the Trauma-Informed Care model of care. Identify how this model of care can be integrated into your current care model.

- Create a comprehensive organizational structure, whereby the entire workforce operates under a Trauma-Informed Care model. The San Francisco Department of Public Health Workforce Training Model and The Sanctuary Model examples can be found in the Resources section of this Best Practice.

- Start to adopt new organizational and clinical practices that address the impact of trauma on patients and staff, including but not limited to:
    - Lead and communicate about being trauma-informed
    - Engage patients in organizational planning and shared decision making about treatments

- Train both clinical and non-clinical staff in trauma-specific approaches and build a trauma-informed workforce
- Create a safe physical and emotional environment
- Prevent secondary traumatic stress in staff
- Hold each other accountable
- Screen all patients for trauma
- Engage referral sources and partner organizations that are also trauma-informed

Resources

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Margaret Lynn Yonekura, M.D., F.A.C.O.G. is a board certified obstetrician-gynecologist with subspecialty certification in Maternal-Fetal Medicine. She is a recognized expert in the fields of infectious diseases in Ob-Gyn and perinatal substance abuse. Throughout her career Dr Yonekura has established comprehensive care programs to address her patients' complex needs. She is currently a member of the Women's Health Policy Council of L.A. County's Office of Women's Health, L.A. County Perinatal & Early Childhood Home Visiting Consortium, Reproductive Health and the Environment Advisory Committee, and L.A. County Diabetes Prevention Program Community Advisory Committee.

Understand and implement the principles of Motivational Interviewing

Best Practice No. 8

Outpatient, Labor and Delivery, Nursery/NICU, and Treatment

Overview

Motivational Interviewing (MI) is a patient-centered counseling approach rooted in key theoretical principles—including decisional balance, self-perception theory, and the transtheoretical model of change—that uses directed techniques to enhance patients' intrinsic motivations for and reduce their ambivalence toward behavior change. Introduced in the early 1980s as a counseling strategy for encouraging behavior change among people with alcohol dependence, the principles, methods, and specific techniques employed in MI have been researched and analyzed for a variety of health conditions for which behavior change is a critical part of health-promoting interventions. MI has now been firmly established as an effective, evidence-based practice in the treatment of substance use disorders (SUDs) and other health conditions including diabetes, obesity, and smoking cessation.

MI uses principles of collaboration between the provider and client (rather than confrontation), the intent of which is to develop rapport and trust, along with evocation of the client's own thoughts and ideas (rather than imposing the provider's opinions), and autonomy and self-efficacy (rather than authority). MI recognizes that true motivation for behavioral change rests within the client. While the provider may have different opinions about the timing or approach to a particular condition, an understanding of the client's experience and beliefs and ultimately eliciting the client's own motivations for changing unhealthful behaviors is more likely to result in lasting change.

The optimal implementation of this best practice would be for hospital and office-based providers to organize MI trainings and regular practice opportunities for all of their staff, especially clinical staff involved in gathering patient information who might have the opportunity to motivate behavior change. In the absence of resources for MI training, this best practice includes several techniques that can be employed without significant training. Additionally, the curriculum included in the Resources section of this Best Practice incorporates links to several web-based videos demonstrating some of these techniques that may be helpful adjuncts to staff interested in further MI exposure and practice.

Why we are recommending this best practice

- Motivation is a key to behavior change. It is multidimensional, dynamic, and fluctuating; influenced by social interactions; and can be modified and influenced by the provider's style. The provider's task is to elicit and enhance motivation.

- MI is effective as an adjunct to enhancing entry into and engagement and retention in interventions that support various kinds of behavior change, including but not limited to substance abuse treatment. It has also been used to encourage rapid return to

treatment following relapse.

- MI is increasingly used as a stand-alone brief intervention during routine encounters with patients.

- MI is an approach that has been empirically shown to be more effective than giving advice, which tends to occur frequently in health care delivery.

- “Readiness to change bad habits is generally a developmental process, and the precepts of MI, including patience, listening, empathy, and change talk, can be useful tools.” (Prochaska J, et al, 1995).

Strategies for Implementation

Ideally, providers can use MI curricula to become more proficient in these techniques, and all levels of staff can participate in these curricula and employ these techniques. One such curriculum is included in the Resources section for this Best Practice. In the absence of formal training, several specific MI strategies and techniques are described below.

Incorporate the foundational principles of MI into communication with pregnant and parenting women with opioid use disorder (OUD). These foundational principles of MI should be employed continuously over time and include:

- Express empathy through reflective listening
- Develop discrepancy between patient’s goals or values and their current behavior
- Avoid argument and direct confrontation
- Adjust to patient resistance rather than opposing it directly
- Support self-efficacy and optimism

Employ the following general style of MI in all patient communication:

- **Asking Permission** – Permission is a deeply respectful foundation of mutual dialogue
- **Engaging** – Engagement is the establishment of trust and a mutually respectful relationship
- **Focusing** – Focus is the ongoing process of seeking and maintaining a direction for the exploration conversation
- **Evoking** – Evoking refers to eliciting the patient’s own motivation for change.
- **Planning** – Planning is the process of deciding on a specific plan for change that the patient agrees is important and is willing to undertake.
- **Linear and Iterative Processes** – Change talk within MI is both a linear and iterative process.

The following are specific motivational skills and strategies that can be practiced and incorporated into all patient engagements, especially those that involve behavior change and compliance with treatment plans. Each of these strategies is described in more detail in the MI Curriculum included in the Resources section of this Best Practice.

Employ the **OARS+** model as one set of specific MI skills.

- **O**pen ended questions elicit crucial information that may not be gathered from close ended questions.
    - *Instead of asking "Have you used any drugs during your pregnancy?", one might say "I treat a number of women who have used prescription medications and other drugs during their pregnancy. Please share with me which kinds of prescription meds or other drugs, if any, you have used during or before this pregnancy."*
    - *Instead of asking "Have you ever been in treatment?", one could request "Tell me about your recovery journey."*

- **A**ffirmations are statements of appreciation
    - *"I'm impressed that you followed up with the MAT referral"*
    - *"You've stayed off drugs for 2 months. That's great!"*

- **R**eflections establish understanding of what the patient is thinking and feeling by saying it back to the patient as statements, not questions.
    - *Patient: "I've been this way for so long."*
    - *Provider reflection: "So this seems normal to you" or "So this seems like a hard cycle to break."*

- **S**ummaries are highlights of the patient's ambivalence that are slightly longer than brief reflections and serve to ensure understanding and transition from one topic to another.
    - *For a patient wanting to stop using drugs during pregnancy: "You have several reasons for quitting drugs: You want to get your life back, you want to give your baby the best chance at a healthy life, and you want to be able to manage life's issues without relying on drugs as a crutch. On the other hand, you're worried about what kind of recovery path would work for you; you're worried that you won't have the motivation and strength to stick with a recovery path. Would that sum it up?"*

Rolling with resistance requires the listener/provider to pause and shift conversations when signs of an argument or confrontation begin to appear. Resistance behavior occurs when points of view differ, generally when the provider is moving the patient ahead too quickly, or the provider fails to understand something of importance to the patient. When resistance appears, the listener/provider should change strategies and utilize OARS techniques.

Developing discrepancy involves the listener/provider guiding the conversation so the patient can articulate their personal beliefs and future goals (listen especially for statements about life, family, health, financial status, living situation, and other personal considerations). Developing discrepancy between the patient's behaviors and their broader life goals is essential because patients are more often motivated to change when they arrive at that conclusion themselves rather than hearing it from someone else.

Change Talk is defined as statements made by the patient that indicate motivation for,

consideration of, or commitment to change behavior. There are clear correlations between patients' change talk and outcomes. Once the listener/provider and patient have established a trusting relationship and have open communication about the patient's substance use, the listener/provider can guide the patient to expressions of change talk using some of the techniques listed below. Each of these strategies is described in more detail in the Motivational Interviewing Curriculum included in the Resources section of this Best Practice, along with additional strategies for eliciting change talk.

- **Preparing change talk** employs the **DARN** model as one set of specific MI skills
  - **D**esire to change (*Ask "Why do you want to make this change?")*
  - **A**bility to change (*Ask "How might you be able to do it?")*
  - **R**easons to change (*Request "Share one good reason for making this change.")*
  - **N**eed to change (*Ask "On a scale of 0-10, with 10 being the highest, how important is it for you to make this change?")*

- **Implementing change talk** employs the **CAT** model as one set of specific MI skills.
  - **C**ommitment (*Ask "What do you intend to do?")*
  - **A**ctivation (*Ask "What are you ready (or willing) to do"?)*
  - **T**aking steps (*Ask "What steps have you already taken?")*

Coding and Reimbursement – MI focused on increasing the patient's understanding of the impact of their substance use and motivating behavior change can be coded for reimbursement whenever a positive screen (through interview, formal screening tool, or toxicology) is identified and documented in the medical records. Evaluation and Management (E/M) service codes for both assessment and intervention are listed below (and can be coded with modifier 25 when they are performed during the same clinical visit as other E/M services):

- 99408 – Alcohol and/or substance abuse (other than tobacco) structured assessment and brief intervention services 15-30 minutes (the comparable Medicare code is G0396)
- 99409 – Alcohol and/or substance abuse (other than tobacco) structured assessment and brief intervention services greater than 30 minutes (the comparable Medicare code is G0397)

Deep Dive

Decisional Balance is a Motivational Interviewing tool that encourages change talk by eliciting the client's own ideas and motivations for change. The grid below is an easy way of remembering the questions asked in Decisional Balance, which are most effective when asked in sequence.

1. **What are some of the good things about using *fill in the substance*?**
This will not elicit much change talk, but will get the client talking in a non-defensive way.

2. **What are some of the bad things about using *fill in the substance*?**
This question begins to elicit a client's ambivalence about their behavior and will start the change talk.

3. **What are some of the downsides of getting into a treatment/recovery program?**
Clients will often start talking about their fears.

4. **What are some of the good things about getting into a treatment/recovery program?**
This question will likely elicit the most change talk, as the client discusses their own ideas and motivations for change. When this comes from the client instead of the provider, it comes without resistance and may include some motivations that the provider would not have considered.

	Good	Not so Good
Not Changing	1. What are the advantages of the status quo?	2. What are the disadvantages of the status quo?
Changing	3. What are the advantages of changing	4. What are the downsides of changing?

Decisional Balance Grid

Resources

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Dr. Helen DuPlessis is a Principal at Health Managment Associates.

She has a rich history of involvement in healthcare administration for a variety of organizations, expertise in program and policy development, practice transformation, public health, maternal, and child health policy, community systems development, performance improvement, and managed care. Prior to joining HMA, Dr. DuPlessis served as the chief medical officer with St. John’s Well Child and Family Center. Other notable professional experiences include her work as senior advisor to the UCLA Center for Healthier Children, Families and Communities where she provided leadership, research, program development support, counsel and representation to local, state and national efforts, and community level systems transformation. She also trained and mentored students in various disciplines and educational levels.

Encourage breastfeeding for women with opioid use disorder

Best Practice No. 9

Outpatient, Labor and Delivery, Nursery/NICU, and Treatment

Overview

Women should feel empowered to make an informed decision about newborn feeding. Women should be given information about the benefits of breastfeeding, as well as information that addresses concerns specific to opioid use disorder (OUD) and breastfeeding.

Why we are recommending this best practice

The first few hours and days of a newborn's life constitute a critical window for establishing lactation. Breastfeeding confers many advantages on both mother and infant. The United States Surgeon General, World Health Organization (WHO), and American Academy of Pediatrics (AAP) recommend exclusive breastfeeding for the first six months unless contraindicated.

California State Bill (SB) 402, signed into law in 2013, states "This bill would require all general acute care hospitals and special hospitals that have a perinatal unit to adopt, by January 1, 2025, the 'Ten Steps to Successful Breastfeeding,' as adopted by Baby-Friendly USA, per the Baby-Friendly Hospital Initiative, or an alternate process adopted by a health care service plan that includes evidenced-based policies and practices and targeted outcomes, or the Model Hospital Policy Recommendations as defined."

Although a stable mother being treated for OUD with pharmacotherapy is encouraged to breastfeed her infant, there are some situations where breastfeeding is not recommended, including if the mother is HIV-positive, has active tuberculosis, has active herpes simplex lesions, is Hepatitis B or C-positive and has cracked or bleeding nipple(s), or has returned to illicit or inappropriate drug use.

HIV: In resource rich areas such as the United States, the CDC recommends AGAINST breastfeeding in mothers with HIV regardless of the viral load or treatment history.

Hepatitis B, Hepatitis C, Herpes Simplex: The CDC recommends breastfeeding for women with Hepatitis B infection when infants have been appropriately immunized with Hepatitis B Immunoglobulin and vaccine; and for women with Hepatitis C infection, as long as nipples are not cracked or bleeding. If the mother with Herpes Simplex Virus has lesions on the breast, or who has Hepatitis B or C and has cracked or bleeding nipples, the CDC recommends to temporarily stop nursing and to express and discard the breastmilk. When the nipple(s) are well-healed and no longer bleeding, the mother may return to breastfeeding. If only one side is affected, the mother may continue to breastfeed on the unaffected side.

Active (untreated) tuberculosis: The AAP recommends against breastfeeding in the setting

of active, infectious tuberculosis. In this situation, expressed milk can still be given to the newborn. Breastfeeding can resume after a minimum of 2 weeks of treatment for tuberculosis, and when the mother is documented to no longer be infectious.

Illicit or Inappropriate Drug Use*:* According to the AAP "maternal substance abuse is not a categorical contraindication to breastfeeding" and therefore well-nourished narcotic dependent mothers being treated for OUD with pharmacotherapy are encouraged to breastfeed in the absence of illicit drug use. Breastfeeding is contraindicated if "relapse" occurs, or a return to any illicit drug use or frequent legal substance misuse, especially if relapse has occurred in the 30-day period prior to delivery. Infrequent substance use, especially if outside of the 30-day window before delivery, may not necessarily be a contraindication to breastfeeding, but each woman must be carefully and individually evaluated for type of substance used, length of time since last use, and other risk factors. Refer to ABM Clinical Protocol #21 in the References section of this Best Practice for more detailed guidelines.

Strategies for Implementation

- **Develop breastfeeding protocol for women with OUD.** Create a multidisciplinary team ideally including obstetricians, midwives, family physicians, pediatricians, nurses, lactation specialists, pain/addiction specialists, pharmacists, and social workers to create a facility-specific protocol addressing the following topic areas:
    - Information for women with OUD and clinicians caring for them: Create user-friendly resources on the benefits of breastfeeding for women with OUD and their newborns and include important contraindications.
    - Develop a protocol for identification of women with OUD and mobilization of required resources to support breastfeeding, emphasizing best practices such as early skin-to-skin care.
    - Develop a plan for outpatient breastfeeding and newborn nutritional support. Develop a workflow to ensure pregnant patients with OUD are discharged with a plan to support breastfeeding and the overall nutrition for their newborns; this plan should include appropriate short interval pediatric follow-up, access to advice on lactation continuation, and access to local or online breastfeeding support resources.

- **Train the workforce on breastfeeding for women with OUD.** Educate physicians, nurses, and other care team members on the benefits of breastfeeding for women with OUD and institute multimodal strategies for implementation of developed protocols.
    - Educate clinical staff on the strength of evidence and criteria for safety of breastfeeding for women with OUD. Determine appropriate avenues through which to educate hospital staff (e.g., emails, physical bulletin boards, staff meetings) and mitigate discrimination and bias toward patients with OUD.
    - Train providers on OUD treatment protocols. Create standards for providers caring for pregnant patients to provide information relevant to breastfeeding decisions and ask questions about the mother's concerns and barriers surrounding breastfeeding.

- **Implement quality improvement strategies to improve breastfeeding in women**

with OUD: Create process metrics that allow for regular evaluation of facility-based breastfeeding support protocols.

- Define target metrics for breastfeeding in OUD. Develop facility-specific metrics for tracking implementation and effectiveness of the breastfeeding program for women with OUD, including measurement of initiation and continuation of breastfeeding.
- Delineate role(s) for OUD treatment assessment and improvement. Designate either an individual or a team to take accountability for ongoing facility-level assessment and improvement of metrics for breastfeeding in women with OUD.

Baby M

As soon as Baby M is born, the maternity nurse asks if she can place him on Kayla skin-to-skin. Although Kayla had been unsure about breastfeeding, with encouragement from the nurse with whom she has begun to establish a trusting relationship, she decides to place Baby M on the breast. This makes Kayla feel happy and helps her bond with Baby M. She feels that she can soothe his cries by breastfeeding.

Breastfeeding is beneficial for the health of both the mother and newborn. It reduces the risk of infection, immune mediated disorders, and obesity in the newborn; and it reduces the risk of postpartum hemorrhage, hypertension, diabetes, and breast and ovarian cancer in the mother. In newborns at risk for NAS, breastfeeding reduces the need for pharmacologic treatment. The process of breastfeeding stimulates the release of oxytocin. Oxytocin induces the dopaminergic pathway of the reward system, which mediates a mother's behavioral response to her newborn's cues, promoting bonding and attachment between mother and newborn. Supporting breastfeeding in a woman with OUD empowers her to provide the best care for her newborn. The reward and stress response pathways may be altered in women with OUD, making it especially important that providers promote breastfeeding in this vulnerable population to optimize emotional and behavioral outcomes for both mother and newborn.

While promoting breastfeeding and skin-to-skin care, it is important to emphasize safe sleep methods. If a mother is fatigued or too sleepy to safely hold her newborn, she should lay the newborn on its back on a firm sleeping surface to decrease the risk of sudden infant death syndrome.

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Jacqueline Rad

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Mimi Leza is the Perinatal Services Coordinator for Ventura County Public Health and currently the co-chair of the Perinatal Substance Use Taskforce of Ventura County. Her background is in Pediatric nursing with extensive experience in caring for NICU babies with NAS and children with prenatal substance use exposure. As a Public Health Nurse, she specialized in providing case management for pregnant and parenting women with SUD and recruiting and training perinatal providers in the SBIRT process.

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Dr. Pamela Flood is Professor of Anesthesiology, Perioperative, and Pain Medicine at Stanford University. Her research interests include prevention and reduction of pain and opioid use in women after delivery. She divides her clinical time between labor and delivery and her outpatient pain management clinic. She clinical work is directed toward compassionate weaning of high dose opioids and management of pelvic pain syndromes.

Initiate medication assisted treatment in the prenatal setting

Best Practice No. 10

Outpatient and Treatment

Overview

Implement an outpatient protocol for evidence-based evaluation, treatment, and continuity of care for pregnant patients with opioid use disorder (OUD). Arranging for the provision of medication assisted treatment (MAT) on site is an optimal way to deliver the standard of care for pregnant women with OUD.

Why we are recommending this best practice

The pregnant woman with OUD who presents for prenatal care has a unique opportunity to initiate treatment for OUD. While the care team may initially find such a patient challenging, they have a chance to introduce life-changing therapy. Along with the screening and brief intervention portions of SBIRT, obstetric providers can offer MAT treatment. Few obstetric providers have received training in OUD management and understandably feel reluctant to begin this practice. Obstetric providers often feel more comfortable referring patients with OUD to a stand-alone outpatient opioid treatment clinic or other office-based outpatient treatment (OBOT) program for induction and management of OUD with MAT. However, the desired future state in opioid treatment is for patients with OUD to be able to begin treatment wherever they receive medical or prenatal care. Providers who can initiate treatment for OUD will have a significant impact on the unmet treatment gap in their county.

Strategies for Implementation

- Engage the whole team. Successful integration of a new service will require front office, back office, and providers all educated about the successful outcomes in pregnant women with OUD who are on MAT.

- Providers must receive a Drug Addiction Treatment Act of 2000 (DATA 2000) X waiver to be able to prescribe MAT. Federal legislation (SUPPORT Act, 2018) and previous legislation includes CNMs, NPs, and CRNAs in addition to physicians as eligible to complete this training. Online training programs are readily available. Physicians require 8 hours of training, and non-physician providers require 24 hours of training.
- Build policies/procedures for MAT to allow for a uniform care delivery system.

- Use a toolkit. Numerous toolkits exist that provide clinics with the education and resources needed to offer MAT. One such is example is the Providers Clinical Support System (PCSS). https://pcssnow.org/resources/clinical-tools/

- Identify who to call for help. Know how to refer patients who fail buprenorphine to methadone treatment programs when necessary. Consider using a consultation service such as the FREE Clinician Consultation Center at UCSF which has a Substance Use Warmline at 855-300-9595 and is available Monday through Friday during daytime business hours, and a specific Consultation line for licensed practitioners in California that is available 24/7. This line is staffed by physicians, pharmacists, and nurses with special expertise in pharmacotherapy options.

- Explore emerging therapies. Aside from traditional in-office induction, consider other modalities that best suit your patients. These include home and hospital induction, micro-dosing transition, and Buprenorphine Quick Start.

Resources

1. SAMHSA Waiver Application and Training.
2. Providers Clinical Support System (PCSS). Clinical Tools.
3. Guidelines for Physicians Working in California Opioid Treatment Programs. Chapter 4.
4. ED Bridge. Buprenorphine Quick Start in Pregnancy Algorithm.
5. California Health Care Foundation Webinar: “Expanding Access to Buprenorphine in Primary Care Settings”.
6. California Health Care Foundation. Everything You Need to Know About Buprenorphine.
7. Urban Institute: California County Fact Sheets: Treatment Gaps in Opioid-Agonist Medication Assisted Therapy (OA-MAT) and Estimates of How Many Additional Prescribers Are Needed.
8. UCSF Substance Use Warmline

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2. Apply for a Practitioner Waiver. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/medication-assisted-treatment/training-materials-resources/apply-for-practitioner-waiver. Updated April 16, 2020.

Holly Smith

MPH, MSN, CNM

Holly Smith is a certified nurse-midwife with 20 years experience in diverse practice settings. She is the project manager for the CMQCC/CPQCC Mother and Baby Substance Exposure Initiative. Previous to this role, she was a the lead editor for the CMQCC Toolkit to Support Vaginal Birth and Reduce Primary Cesareans, and a clinical lead for the CMQCC Collaborative to Support Vaginal Birth and Reduce Primary Cesareans, a large-scale quality improvement project with over 90 California hospitals. Her primary role as clinical lead focused on assisting southern California hospitals with the implementation of evidence-based practices to reduce cesarean. She is a hospital coach and steering committee member for the American College of Nurse-Midwives' Reducing Primary Cesareans Project, and expert consultant on various national and state quality improvement and health policy initiatives. Additonally she chairs the Health Policy Committee of the California affiliate of the American College of Nurse-Midwives and is a health policy consultant to the California Nurse-Midwives Foundation.

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Dr. Khan is an Addiction Medicine specialist and Chief of Addiction Medicine consult-liason service and outpatient specialty clinic at Ventura County Medical Center. He is the medical director of Prototypes Southern California which has hundreds of residential treatment beds as well as medical-withdrawal (detox) beds throughout Southern California. Dr. Khan is the Medical Director of the Ventura County Backpack medicine group, and Primary Care Hepatitis C Eradication Project. His niche is managing SUD in pregnancy and is a national speaker on this topic.

Identify community care resources for the mother and newborn

Best Practice No. 25

Outpatient, Labor and Delivery, Nursery/NICU, and Transition of Care

Overview

Identify community care resources for the mother and newborn and appropriate partner agencies and services in the community.

Why we are recommending this best practice

Providing adequate transitions of care pre- and postnatally that include outpatient support structures with expertise in addressing the needs of both mothers with opioid use disorder (OUD) or substance use disorder (SUD) and their exposed newborns can improve outcomes and support the development of protective factors that reduce or mitigate the effects of adverse life experiences for children and their families. Early interventions like home visits are a prime example of this.

Strategies for Implementation

- Involve the mother and newborn in outpatient support programs as early as possible, ideally prenatally for the mother. Descriptions of evidence-based programs can be found below.

- Each unit should maintain an updated list of outpatient resources (federal, state, and local) that families can access.

- Arrange a system to refer the mother and newborn to outpatient OUD/SUD treatment and recovery programs. The system should clarify who refers (physician, social worker, etc.) and when to refer (upon admission or discharge). Consider a default referral on admit orders.

- Inform and educate mothers on these referrals and highlight the benefits of these programs.

- Potential short-term and long-term neurodevelopmental delays exist for these infants. Early intervention programs, child protective services, and/or health care services are recommended to cover neurodevelopmental, psycho-behavioral, growth and nutrition, ophthalmologic, and family support assessments. Refer to **Best Practices #31 and**

#32 for additional information on these topics.

- The identification of key community care resources and supports for mom and baby should be incorporated into the Plan of Safe Care as described in **Best Practice #29.**

Pre-, Peri-, and Postnatal Programs: The programs described below begin services during pregnancy and cover the mother/baby dyad. Most pre-, peri-, and postnatal programs are federally funded. In California, many of these programs are also funded by local First 5 Commissions, which use money from a state excise tax on cigarettes and other tobacco products to fund programs from birth (i.e., during pregnancy) to five years of age. In addition to the ones listed in this toolkit, other evidence-based pre-, peri-, and postnatal programs can be found in the Resources section of this Best Practice.

- California Home Visiting Program (CHVP): CHVP oversees implementation of various evidence-based home visiting programs throughout California, including the Nurse-Family Partnership (NFP) and Healthy Families America (HFA), and currently 23 California counties have these evidence-based programs. State-level agency workgroups conduct needs assessments to determine the greatest need for and potential impact from these programs based on factors such as poverty rates, rates of child abuse and neglect, and the ability to find and enroll at-risk parents in particular areas.
    - ***NFP:*** Geared towards low income, first-time pregnant women. Care starts in pregnancy and follows the dyad until the child reaches two years of age. The mother must be referred before 28 weeks of pregnancy.
    - ***HFA*:** Geared towards low-income, at-risk families from birth to a minimum of three years.

- Early Head Start*:* Early Head Start provides preschool and home visiting services geared towards low-income, at risk families. This is one of the few programs that can be started either during pregnancy or after delivery and follows the dyad until the child reaches three years of age.

- CalWORKS: CalWORKS offers a new three-year home visiting pilot initiative that began in January 2019. It is supported by both state General Fund and federal Temporary Assistance for Needy Families dollars. The program provides up to 24 months of home visiting for pregnant and parenting people, families, and infants born into poverty.

- Healthy Start*:* Healthy start targets communities with infant mortality rates that are at least one and a half times the U.S. national average. Women and their families can be enrolled into Healthy Start at various stages of pregnancy, including pre- inter-, and post-conception. Each family that enrolls receives a standardized, comprehensive assessment.

Postnatal Programs: These programs are primarily geared towards infants and can be implemented in the postnatal period.

- Early Start: Early Start is California's early intervention program (i.e., Part C of the Individuals with Disability Education Act), providing early intervention services to at-risk infants and children less than three years of age who meet eligibility criteria based on the presence or risk of developmental disability. Services include infant education, occupational therapy, physical therapy, and speech therapy. Referrals can be made from the NICU or newborn nursery and are often coordinated by a social worker, although anyone can make a referral, including parents, medical providers, neighbors, family members, foster parents, and day care providers.

- Home Health Visits: A number of public and commercial insurance companies offer home health visits, usually in response to a medical need. If the patient does not have insurance, or if the patient's insurance declines to cover the home health visit, the county often will provide a public health nurse. Some counties or local areas have established their own system (e.g,. Palomar Home Health Services).

Resources

1. California Budget and Policy Center Report: Home Visiting is a Valuable Investment in California's Families.
2. Helping Hands: A Review of Home Visiting Programs in California.
3. Nurse Family Partnership.
4. Healthy Families America.
5. Local First 5 Commission websites and their local programs.
6. National Head Start Association.
7. Early Head Start.
8. California Head Start.
9. CalWORKS.
10. Comprehensive Perinatal Services Program.
11. Healthy Start.
12. Early Start.
13. Palomar Home Health Services.

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2. McQueen K, Murphy-Oikonen J. Neonatal abstinence syndrome. N Eng J Med. 2016;375(25):2468-2479.

Jadene Wong

MD

Dr. Jadene Wong is Clinical Assistant Professor of Pediatrics at Stanford University School of Medicine. She has practiced as a neonatal hospitalist at Lucile Packard Children’s Hospital Stanford for more than 10 years, and practiced in primary care outpatient community settings for more than 20 years. She is a member of the task force for the joint CMQCC/CPQCC Mother & Baby Substance Exposure Initiative. She is also the Newborn Clinical Lead for this project and mentors Central California hospitals participating in the initiative.

Katherine Weiss

MD

Dr. Katherine Weiss is a neonatologist at Rady Children's Hospital-San Diego and an assistant professor of pediatrics at UC San Diego. Previously, she was a clinical assistant professor of pediatrics for the University of Arizona.

Her areas of interest are in quality improvement, education and international health.

Codevelop a multidisciplinary peripartum plan of care for pregnant women on medication assisted treatment and ensure a warm handoff to the hospital

Best Practice No. 26

Outpatient and Transition of Care

Overview

Develop a patient-centered approach to developing a peripartum plan of care for pregnant patients with opioid use disorder (OUD) to facilitate continuation of appropriate medication assisted treatment (MAT) dosing, pain management and related needs.

Why we are recommending this best practice

A clear, informed plan developed with patients and relevant providers for the management of OUD in the peripartum period will avoid physiologic instability, facilitate patient buy-in, and optimize transitions of care.

Strategies for Implementation

- Develop a peripartum checklist for patients with OUD, ideally with multidisciplinary input, highlighting key patient health information, current MAT therapeutic regimen, contact information for providers, and recommended activities to prepare patients for the peripartum period in the hospital (please see the Resources section of this Best Practice: Sample Peripartum Checklist for Patients with OUD).

- Develop a protocol to utilize the peripartum checklist. Plan strategically for how to incorporate the designed checklist into prenatal care (ideally at the beginning of the third trimester, or at any time for late entrants into prenatal care) and how to share the checklist with the hospital at which a patient intends to deliver (e.g., faxing when checklist is completed, and/or at 36 weeks).

- Implement peripartum checklist. Ideally patients and providers would have updated copies of the checklist and it could be customized (e.g., more elaborated paper checklist for patients, abbreviated electronic text checklist for providers). Consider incorporating it into the electronic medical record.

Kayla

Kayla is now 38 weeks pregnant and doing well on buprenorphine. She calls your office complaining of leaking fluid. You advise her to go to obstetrical triage for evaluation. She is found to have ruptured membranes and is admitted by the laborist for induction. Kayla is quite uncomfortable and neglects to inform her care team that she is on buprenorphine. The staff is unable to retrieve her prenatal records. Twelve hours into her stay, she begins having significant pain, sweats, nausea, and chills. The nurse also notes some irregularities and changes in the fetal heart rate. Kayla finally states she is experiencing opiate withdrawal and requests buprenorphine. Unfortunately, the hospital does not have buprenorphine immediately available in the medication dispensing machine. Two extremely uncomfortable hours later, Kayla receives her buprenorphine and is finally comfortable again. By this point her records, including the consultation with the anesthesiologist, have been retrieved and her pain is managed with an epidural.

Failed communication to inpatient providers leads to fragmented care once the patient is admitted for labor. There are various ways that a warm handoff can be undertaken at the time of labor to ensure that patient care is not compromised. These include, but are not limited to, a third trimester patient review with the hospital team and/or a pre-registration exchange of critical information (including buprenorphine duration and dosage) that allows confidential information sharing with the medical staff, a prenatal care summary or card **specific to MAT** that allows the patient to confidentially inform hospital staff of her medication and dosage upon admission, and having the prenatal care provider discuss with the patient the importance of disclosing her MAT needs with hospital staff at the time of admission.

Resources

1. Sample Peripartum Checklist for Patients with SUD.

Martha Tesfalul

MD

Dr. Martha Tesfalul is currently a Maternal-Fetal Medicine Fellow at at the University of California, San Francisco. Having served as the Quality Improvement (QI) Chief in her final year of residency, she has a professional interest in health systems strengthening and health equity. She has received local, regional and national recognition for her efforts in clinical care, education, and research including awards from the Pacific Coast Obstetrical and Gynecological Society and the Foundation for the Society for Maternal-Fetal Medicine. In addition to her commitment to improving the care of pregnant patients in California, Dr. Tesfalul engages in QI-focused research in in the East African country Eritrea.

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Dr. Khan is an Addiction Medicine specialist and Chief of Addiction Medicine consult-liason service and outpatient specialty clinic at Ventura County Medical Center. He is the medical director of Prototypes Southern California which has hundreds of residential treatment beds as well as medical-withdrawal (detox) beds throughout Southern California. Dr. Khan is the Medical Director of the Ventura County Backpack medicine group, and Primary Care Hepatitis C Eradication Project. His niche is managing SUD in pregnancy and is a national speaker on this topic.

Provide staff and provider education on opioid use disorder

Best Practice No. 34

Outpatient, Labor and Delivery, Nursery/NICU, and Education

Overview

Educate all providers and administrative staff about opioid use disorder (OUD) in pregnancy, strategies for caring for patients with OUD, and develop protocols that address all team members' roles.

Why we are recommending this best practice

Treatment of OUD is a multidisciplinary endeavor that begins with a patient's first encounter in the health care environment. For this reason, all staff need to have a strong foundational understanding of OUD as a chronic illness and must be provided with adequate training and tools to interact with patients in a way that does not undermine a patient's effort to seek care. Understanding the underlying stigma and biases that nurses and ancillary staff may unintentionally bring to the treatment of patients should be a primary focus of all inpatient, outpatient, and ambulatory care staff.

While the OUD epidemic affects women from all socioeconomic, racial, and cultural backgrounds, many caregivers and staff members have mistaken ideas about the reality of addiction. These misconceptions often result in a patient being denied needed treatment or alienated from the medical system before she has established care with a provider.

In all medical settings, it is important that the first contact a woman with OUD has with the health system is one that is free of stigma and alienating language, incorporates Trauma-Informed Care, and is tailored to the individual woman's needs. This initial meeting should be one that helps move a patient forward to an empowering relationship with her provider and toward medication assisted treatment (MAT) before her intrapartum period. If a patient is initiating care during the intrapartum period, it is equally important that the care is viewed by all staff as an opportunity to implement the best practices for mothers and newborns included in this toolkit during the postpartum period and beyond. Pregnancy provides a unique window of opportunity when a woman is highly motivated to enter treatment not only out of concern for the health of the fetus but also because during pregnancy, she can envision a different future for herself and her child.

Staff and provider training is key to disrupting the stigmatizing interactions that women with OUD encounter or perceive when they present for care. Recognizing OUD as a chronic illness is imperative to providing patient-centered care that establishes a trusting and safe environment. The first contact for these women in both inpatient and outpatient settings, often at registration or reception, needs to be free of stigmatizing behaviors and language. The subsequent encounter with a medical assistant or nurse is profoundly influenced by the presentation of the patient from the initial contact. Whether or not a patient has sought prenatal care, her parity, family structure, history, and other factors all influence how she is perceived and received. Many factors can contribute to initial perceptions of patients by

staff and nurses, and targeted interventions have been shown to significantly impact how women with substance use disorder (SUD) or opioid use disorder (OUD) are distinguished from other patients presenting for care.

Strategies for Implementation

- **Create Awareness of OUD in Pregnancy:** Determine appropriate avenues through which to educate office/clinic and hospital staff about OUD in pregnancy (e.g., emails, physical bulletin boards, staff meetings) with a focus on mitigation of discrimination and bias toward patients with OUD. Utilize content such as our "Education on OUD Tool" (Refer to the Resources section of this Best Practice).

- **Train Staff and Providers on Trauma-Informed Care**: Create opportunities for staff and providers to learn about Trauma-Informed Care.

- **Be Aware of Local Cultures**: Identify "cultural coaches" to help explain the nuances of local culture that may impact care and treatment.

- **Train Providers on Use of OUD Treatment Protocols**: Create opportunities for providers responsible for evaluating and treating pregnant patients to learn and ask questions about facility-specific OUD treatment protocols and to obtain a waiver to prescribe buprenorphine.

- **Train Nursing on Use of OUD Treatment Protocols:** Create opportunities for nurses responsible for caring for pregnant inpatients to learn and ask questions about the facility-specific protocol developed as well as how to use the Clinical Opiate Withdrawal Scale (COWS) and the Ramsay Sedation Scale (Ramsay Sedation Scale) in the care of patients with OUD and how to administer buprenorphine and methadone.

Deep Dive

Educating providers and staff about OUD may seem overwhelming at first, especially if the culture of care at your center has historically taken a punitive or judgmental approach to caring for mothers with a substance use disorder. Demystifying the educational "roadmap" can go a long way in giving clinical champions the most important starting points for educating the multidisciplinary health care team. This may consist of the following basic concepts:

- Every pregnant woman should be verbally screened for substance use at multiple points in care

- OUD is a chronic medical condition that can be treated

- Substance use is almost always connected to significant past trauma and/or Adverse Childhood Events (ACEs). A Trauma-Informed Care approach that emphasizes empathy and reduces stigma and bias is the standard of care and improves outcomes.

- MAT (methadone or buprenorphine) is the standard of care for pregnant women with OUD. Withdrawal is dangerous for both mother and fetus. MAT is linked to better maternal and neonatal outcomes and reduces overdose deaths.

- Education about the signs, symptoms, and treatment of NAS is critical. Non-pharmacologic treatment of NAS such as rooming-in, skin-to-skin contact, swaddling, and reducing external stimuli results in better support of the mother/baby dyad, reduced need for pharmacologic treatment, and shorter hospital stays.

- Treatment requires provider, peer, family, and community support. Systems of care for women with OUD should always address transitions from one location of care to another, including comprehensive discharge planning and the development of a Plan of Safe Care that ensures maternal continuation of treatment and recovery, and appropriate medical, developmental, and safety follow-up for the newborn.

- The overarching goal is to preserve the mother/baby dyad.

Resources

1. Confronting the Stigma of Opioid Use Disorder and Its Treatment.
2. AMA Opioid Task Force Resources.
3. Words Matter: How Language Choice Can Reduce Stigma.
4. SAMHSA. Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants. HHS Publication No. (SMA) 18-5054, Rockville, MD, 2018. Factsheet #2 Initiating Pharmacotherapy for Opioid Use Disorder. Factsheet #4 Managing Pharmacotherapy Over the Course of Pregnancy.
5. Clinical Opiate Withdrawal Scale (COWS).
6. Ramsay Sedation Scale.
7. Education on OUD Tool.

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3. Committee opinion on opioid use and opioid use disorder in pregnancy. https://www.acog.org/Clinical-Guidance-and- Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Opioid- Use-and-Opioid-Use-Disorder-in-Pregnancy?IsMobileSet=false. Accessed December 15, 2019.

Jennifer Carraher

RNC-OB, PHN, MS

Jennifer Carraher is an obstetric and public health nurse with advanced practice specialization in perinatal women's health. She is also a medical sociologist with an extensive background in social theory and science and technology studies. Her current research includes health disparities, birth equality and intrapartum harm reduction. Jennifer remains a bedside nurse committed to care in San Francisco Bay Area communities.

Educate patients and families about opioid use disorder

Best Practice No. 35

Outpatient, Labor and Delivery, Nursery/NICU, and Education

Overview

Addiction is a chronic, relapsing condition. Pregnancy can motivate women to discontinue drug use, but abrupt discontinuation of opioids during pregnancy can have deleterious effects for both the mother and fetus. Patients and their families may not be aware that medication assisted treatment (MAT) is the standard of care for opioid use disorder (OUD) during pregnancy and may adopt risky strategies such as abrupt and complete cessation of opioids without realizing the risk to their pregnancy and to their recovery.

Why we are recommending this best practice

Patients need to be educated on different types of opioids to understand how they will affect their body. Understanding different types of opioids opens the discussion about withdrawal symptoms, warning signs to look for, and when to obtain medical help for withdrawal. Patients and their families need to fully understand the nature of addiction, the potential impact of continued opioid use during pregnancy, the recommended treatment for OUD during pregnancy and beyond, the need to address potential or co-occurring mental health conditions, the members of the treatment team involved in their comprehensive care, and the aim of partnering with them every step of the way.

Strategies for Implementation

- **Educate the patient on the definition of opioid use disorder (OUD).** Patients should be informed that OUD is defined as a pattern of opioid use characterized by tolerance, craving, inability to control use, and continued use despite adverse consequences.

- **Assess and educate the patient for potential causes of opioid use disorder, including but not limited to:**
  - Chronic pain
  - History of trauma
  - Opioid misuse

- **Assess the patient for co-occurring mental health conditions.** A preliminary assessment conducted on intake should be followed by a second assessment once patient's OUD is stabilized on MAT or another course of OUD treatment. For many women with OUD, what appears at first to be significant mental illness may resolve or lessen significantly once the OUD is addressed. Validated screening tools include GAD-7, MDQ, PHQ-9, ACE, and the Edinburgh Postnatal Depression Scale (See the **Resources** for more tools). Assess patients for:

- Depression
- History of trauma
- PTSD
- Anxiety
- Other psychiatric disorders such as bipolar, schizophrenia, and personality disorders

- **Educate the patient on the different types of opioids.** For short-acting opioids, such as heroin, withdrawal symptoms can occur 4-6 hours after ingestion, can peak at 1-3 days, and gradually subside over 5-7 days. For long-acting opioids, such as methadone or buprenorphine, withdrawal symptoms occur 24-36 hours after ingestion and may last days to several weeks.

- **Withdrawal Symptoms:**
  - Generalized pain
  - Muscle pain
  - Nausea
  - Vomiting
  - Diarrhea
  - Sweating
  - Rhinorrhea
  - Tearing and dilated pupils
  - Tremors
  - Restlessness and anxiety

- **Educate patients on why treatment during pregnancy is important and what it involves:**
  - Better outcomes for the patient and her newborn.
  - Abrupt cessation of opioids, and withdrawal, is harmful to the fetus.
  - Planning for safe care.
  - Connecting mother and newborn to resources to help them after discharge.
  - Helping the mother receive treatment that will help her and that is recommended for her and her newborn.

- **Develop an OUD management plan with the patient and her family:**
  - Review dose and appropriateness of current opioid use, and limit opioid prescribing for post-partum pain as detailed in **Best Practice #14.**
  - Discuss risks and benefits of opioid use, review treatment goals, review neonatal abstinence syndrome (NAS).
  - Take a thorough history and review the prescription drug monitoring program.
  - Ensure adequate resources for psychosocial support, substance abuse treatment programs, and locally available resources.
  - If appropriate and resources are available, discuss the potential for outpatient buprenorphine induction (refer to **Best Practice #10**).
  - Discuss harm reduction. Have resources available to discuss the use of naloxone, safe injection sites, needle exchange clinics and safe needle handling. See

Resources below for an infographic from the CDC regarding the cleaning of syringes.
- Discuss dangers of abrupt cessation of opioids.

- **Educate patient and family on use of naloxone (Narcan):**
  - Naloxone is used, along with other emergency medical treatment, to reverse the life-threatening effects of a known or suspected opioid overdose. Naloxone is in a class of medications called opioid antagonists. It works by blocking the effects of opioids to relieve dangerous symptoms caused by high levels of opioids in the blood. Naloxone will not reverse the effects of non-opioid drugs.
  - Naloxone comes as a liquid solution that can be sprayed into the nose, or as a liquid in a vial that can be injected into muscle. It is usually given as needed to treat opioid overdoses.
  - Keep the nasal spray available at all times to use in case of an opioid overdose. Be aware of the expiration date on the medication and replace it when this date passes. Some harm reduction kits include two doses of naloxone. Explain how the patient can continue to access naloxone so that it is always available.
  - Symptoms of an opioid overdose include excessive sleepiness, not awakening when spoken to in a loud voice or when the middle of the chest is rubbed firmly, shallow or stopped breathing, or small pupils (black circles in the center of the eyes). If someone sees a person experiencing these symptoms, he or she should give the first naloxone dose and then call 911 immediately. After giving the naloxone nasal spray, someone should stay with the patient and watch closely until emergency medical help arrives.
  - A **"Guide for Patients and Caregivers"** is available to print in pamphlet format. See the Resources section of this Best Practice.
  - Fentanyl: Whether taken knowingly or as a contaminant with other drugs, fentanyl's increased potency relative to other opioids may require the administration of greater doses of naloxone per overdose event.
  - Call 911 for any suspected overdose event.

Kayla

The midwife at one of Kayla's prenatal visits reassures her that no baby is born an addict. She educates her about how prenatal exposures to medications can lead to temporary withdrawal within newborns and that for opioid-exposed newborns there is an evidence-based treatment for NAS called Eat Sleep Console that makes her mothering and ability to console her baby the most important part of her newborn's treatment. Kayla seems relieved after the midwife shares this with her.

The midwife than speaks with her about how substance use is a chronic disease, similar to diabetes or hypertension, and like any other long-term process, it requires a wide-ranging treatment plan to ensure good health outcomes for her and her baby. She shares that the medication buprenorphine prevents relapse, decreases cravings and even helps some of the chronic pain. The midwife also suggests other mind-body techniques to help with chronic pain and substance use, such as counseling, physical therapy, and other manual therapies to decrease her pain and desire for pain pills. Kayla has relaxed more and is even starting to smile and make more eye contact with the midwife. She wants to know how long she'll have to be on a medicine like buprenorphine or methadone. The midwife tells her that although the medical literature indicates that Medication Assisted Treatment (MAT) is effective and the best treatment for OUD during pregnancy and postpartum, the optimal duration of treatment with MAT is unknown. Just as with other effective medications for chronic conditions, like insulin or blood pressure medicine, MAT is not usually prescribed with an expected end date. The midwife reassures her that breastfeeding is safe with either of these medication options and is in fact strongly encouraged to help diminish the symptoms associated with NAS. Lastly, she points out to Kayla that the clinic has a Seeking Safety group and she may want to attend to learn more about trauma and panic disorders.

Resources

1. A Guide for patients and caregivers regarding overdose and naloxone administration.
2. CDC infographic on cleaning syringes.
3. MBSEI Resource Library.

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DO

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Educate pregnant women about opioid use disorder in pregnancy and the hospital experience

Best Practice No. 36

Outpatient, Labor and Delivery, Nursery/NICU, and Education

Overview

Thoughts about labor and delivery, for most pregnant women, are riddled with questions and anxiety about the unknown. For the pregnant woman with opioid use disorder (OUD), there is an additional layer of stress, emotions, and anxiety related to childbirth and motherhood associated with her path to wellness and recovery. After having built relationships and trust with her prenatal care team, the thought of transitioning care to a new team of providers in the L&D unit can cause additional stress for the mother with OUD. She may or may not have already met or had an opportunity to build trust and relationships with this staff and may question their motives, feel judged, and begin to worry that her newborn will be taken from her or that her pain will not be managed due to her OUD status.

Providing education about expected health care services and processes is associated with social and psychological benefits including reduced fears and anxiety, and provides patients with an opportunity to ask questions, thus increasing a patient's overall knowledge related to the anticipated experience. Providing education on what to expect in the hospital during a prenatal care appointment can reinforce previously received childbirth education and/or facilitate education for those who were unable or chose not to attend.

The "what to expect in the hospital" conversation during a prenatal care appointment is an opportunity to introduce the new L&D team and to discuss goals and options for pain management and institutional screening and drug testing. It is also an opportunity to address and debunk any myths or untruths about the upcoming experience, especially regarding social and child welfare referrals and support. Transparency in the provision of information shows that providers care and facilitates continued engagement by the mother with OUD in the development of a Plan of Safe Care and self-management. Ultimately these efforts increase coping skills and support the increased likelihood of a positive labor experience.

Why we are recommending this best practice

Education and social support are the best ways to facilitate continued engagement with the Plan of Safe Care, recovery & wellness, positive progression through the continuum of care, and optimal patient experience.

Strategies for Implementation

- Include "what to expect in the hospital" in the prenatal checklist. The discussion should be scheduled for the third trimester.

- Present the topic of postpartum care coordination. The postpartum period represents a time of increased vulnerabilities, and women with OUD relapse and even overdose far more often in the postpartum period than during pregnancy. Relapse is a common part of addiction, and often someone with OUD will relapse several times before successfully quitting. Forty-nine percent of women with OUD treated with medication assisted treatment (MAT) in an initial pregnancy were not in treatment at the start of a subsequent pregnancy, even with specific transition plans for MAT continuation (including warm handoffs). Of those on MAT, only 37% of women had the same MAT provider for both pregnancies. Education for the family and the patient around this is very important. Patients often have "all or none" thinking, but slips and relapses commonly occur, and it doesn't mean failure. Stressful events are triggers for relapse, including loss of insurance and access to treatment, demands of caring for a new baby, sleep deprivation, and fear of losing child custody.
    - Discuss postpartum information, such as contraception and access to psychosocial support.
    - Emphasize that the first obstetrical follow-up visit is between weeks one and two.

- Engage hospital L&D staff and prenatal providers.
    - Recruit from both environments (clinic/provider office and hospital) to champion the collaboration.
    - Discuss important workflows and policies and ensure that prenatal care providers are sharing accurate information.
    - Discuss offering an opportunity to schedule a "meet and greet" that supports a warm handoff.
    - Understand the hospital's intrapartum pain management policies in order to educate the patient on pain control options and encourage transparency regarding OUD for optimal management of pain and symptoms.

- Design an educational "what to expect in the hospital" curriculum unique to your hospital.

Kayla

Kayla is currently receiving prenatal care in an integrated care model. The prenatal care team includes nurse midwives and high-risk obstetricians to provide prenatal information and monitor the status of the pregnancy. Psychiatrists, mental health counselors, and addiction medicine professionals manage Medication Assisted Treatment (MAT) and develop relapse prevention strategies. Because multidisciplinary caregivers are co-located in the same space, Kayla can receive medical services, mental health care, and psychosocial support in one appointment. A streamlined process for scheduling improves retention and keeps Kayla engaged in her own care. Education opportunities are also provided in Kayla's management and include parenting classes, prenatal education, and classes that prepare her for challenges of caring for a baby who has been exposed to opioids in utero. Her care team prepares her for the hospital experience by aiding in preparation of admission paperwork and involving her in the plan of care for pain management. Kayla has an upcoming appointment with an anesthesiologist to discuss pain management and a tour of the hospital to follow.

Resources

1. NNEPQIN Checklist-Chart- Template (Prenatal Checklist).
2. MBSEI Resource Library.

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Dr. Martha Tesfalul is currently a Maternal-Fetal Medicine Fellow at at the University of California, San Francisco. Having served as the Quality Improvement (QI) Chief in her final year of residency, she has a professional interest in health systems strengthening and health equity. She has received local, regional and national recognition for her efforts in clinical care, education, and research including awards from the Pacific Coast Obstetrical and Gynecological Society and the Foundation for the Society for Maternal-Fetal Medicine. In addition to her commitment to improving the care of pregnant patients in California, Dr. Tesfalul engages in QI-focused research in in the East African country Eritrea.

Provide health care providers with stigma education/resources

Best Practice No. 37

Outpatient, Labor and Delivery, Nursery/NICU, and Education

Overview

Treatment of substance use disorder (SUD) is often eclipsed by the misperception that SUD is a personal weakness or a willful choice. Whether or not these misconceptions are consciously employed, they can have a dramatic impact on patient outcomes and adherence to treatment during recovery. Stigma can be experienced across several domains: self, social, and structural stigma. This toolkit focuses on structural stigma oriented toward health care professionals and systems-based approaches.

Providers who interact with OUD/SUD patients often cite them as their most challenging patients due to expectations of cooperation, aggression, demands, and low rates of treatment completion. It is therefore not uncommon for health professionals who interact with these patients to show unconscious bias whether or not they explicitly report negative attitudes. Stigma can come from staff interactions at all contact points and through materials provided in clinical settings.

Why we are recommending this best practice

Several studies have shown that perceived discrimination and stigma from providers has a significant impact on treatment completion by increasing the likelihood of dropout and decreasing retention. Whether or not adoption of stigmatizing beliefs is conscious, evidence shows that health professionals not trained to interact with patients with SUDs may avoid or shorten appointment visits or express less empathy to these patients. This may reduce quality of care and decrease patient retention.

Strategies for Implementation

Perform a language audit of all internal (EHR, protocols) and external (brochures, educational pamphlets) materials.
Designate a staff member to review all materials distributed or posted in the clinic regarding OUD/SUD to address any stigma-perpetuating language. An analysis of materials should identify the following terminology, and materials should be updated accordingly:

- **Diagnosis** - In alignment with DSM - 5, replace older categories of substance “abuse”, “drug habit”, and “dependence” with a single classification of “substance use disorder” (SUD) or “opioid use disorder”. Use clinically accurate terminology which reflects the treatable, clinical, and chronic nature of SUD and moves away from choice-based terminology.

- **Person-first language** – Discussing substance use should follow the accepted standard for discussing people with disabilities and/or chronic medical conditions. Replace “abuse”, “abuser”, “addict”, “druggie”, “alcoholic” with “person with SUD” or “person experiencing” with “person struggling.”

- **Testing and Toxicology** – Replace “clean” and “dirty” urine drug screens with “positive” and “negative” or “expected” vs. “unexpected” and use “consistent with prescribed medications.” “Person in Recovery” focuses on the process and acknowledges the consistent management of symptoms and stable conditions.

- **Medications** – Avoid using “replacement” and “substitution” therapy. Preferred are “Medication Assisted Treatment” (MAT), “pharmacotherapy for …”, and specifically “medications for OUD” (MOUD) or “medications for SUD”. Additionally, once an individual is receiving MAT, “medically indicated tapering” or “decreasing of dosage” (from buprenorphine or methadone) conveys that the medications might be noxious toxins leaving the body and should also therefore be replaced.

- **Maternal and Newborn** - Although not commonly employed in medical literature or materials, use of the language “crack baby,” “opioid baby,” or “drug-addicted baby” should be replaced with neonatal abstinence syndrome (NAS), for opioid or heroin exposure, and prenatal cocaine exposure, or colloquially “in utero exposure to [substance] …”.

Individual identification of stigma
Provide opportunities for individual identification of stigma:

- Formally through Implicit Associations Test– Mental Health, a test for unconscious bias in relation to mental health

- Informally through Stigma Self-Assessments

Addressing stigma: healing stigma through training and intervention
Broad education campaigns oriented toward changing public perception have been found to have limited impact on changing attitudes about opioid use disorder. However, targeted intervention with staff, medical personnel, and trainees has been shown to reduce stigmatizing language and behaviors. Contact-based interventions where individuals with SUD can humanize patients has been shown to significantly reduce stigmatizing ideology compared to education alone. When training is not immediately available, the Woll Healing Approach is recommended and has a self-directed workbook. Their approach addresses beliefs and accountability in order to heal the potential trauma and effects of working with OUD and SUD populations. Several training opportunities are available to educate medical

professionals and staff, some more informal than others. Potential training opportunities are listed below in order of feasibility and scale:

- Informal staff and patient-facing personnel (including health professional) intervention:
  - Focus on inadvertent ways personnel may be perpetuating stigma
  - Explore the perceptions personnel may hold towards the SUD population
  - Facilitate discussion on how to adopt alternative language

- Empathy training or defined stigma curricula:
  - Many regional Addiction Technology Transfer Centers have access to CME and CEU credit for completion of their curricula:
    - Addiction Technology Transfer Centers Network Center: https://attcnetwork.org/centers/global-attc/training-and-events-calendar
    - Pacific Addiction Technology Transfer Centers: https://attcnetwork.org/centers/global-attc/training-and-events-calendar
    - California Health care Foundation: https://www.chcf.org/topic/opioid-safety/
    - Acceptance and Commitment Training (ACT), a cognitive-based approach incorporating flexibility and mindfulness, has shown to significantly increase positive attitudes toward people with SUDs and decrease negative thoughts toward SUD clients among SUD providers.

- Medical trainee education:
  - Integrate stigma training in medical curricula. An upstream approach is shown to be among the most effective.
  - Trainee education can be effective in combating stigma by integrating understanding and efficacy into medical residency programming, with particularly positive outcomes for work with pregnant women. Self-reflection techniques and training rotations in specialized prenatal clinics has been shown to significantly increase the comfort level of working with this population and reduce negative ideology.
  - Many clinics and hospitals interact with or supervise clinical trainees. Integrating, introducing, or providing stigma reduction trainings to medical residents, fellows, and post-docs may be an effective tool.

Kayla

During mid-pregnancy, Kayla's midwife identifies a pattern of cancelled and missed appointments. It would be useful to explore with Kayla the reason for the pattern. A common assumption might be that she hasn't prioritized her prenatal care. However, through positive reframes of inquiry, you might uncover that she had a stigmatizing experience that may have included language barriers, rushed appointments, or judgmental attitudes from physicians at another clinic that currently influences her desire to seek health care from an unknown provider. Kayla may also be worried about disclosing her OUD and putting herself at risk for subsequent CPS involvement. Use possible reframes oriented toward determining prior stigmatizing experiences with health care providers and provide Kayla with reassurance. Determining why Kayla hasn't utilized clinical services can decrease her feelings of judgement at your clinic. It can also inform a more targeted approach for your interaction with Kayla directly, leading to a higher chance of care-seeking for prenatal care. It's important to understand that your practice operates within a larger health care landscape that stigmatizes and creates disincentives for care-seeking among substance using patients. Investigating your role and other stigmatizing contact points within a patient's lifetime can better inform care.

Resources

1. Toward an Addiction-ary; Language, Stigma, Treatment, and Policy.
2. Words Matter: How Language Choice Can Reduce Stigma.
3. Anti-Stigma Toolkit: A Guide to Reducing Addiction-Related Stigma.
4. Healing the stigma of addiction: A guide for treatment professionals.

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Educate pregnant women and families about neonatal abstinence syndrome and the newborn hospital experience

Best Practice No. 38

Outpatient, Labor and Delivery, Nursery/NICU, and Education

Overview

Provide education to pregnant women and families regarding neonatal abstinence syndrome (NAS), including both short-term effects and long-term consequences. Prepare pregnant women and families for an optimal hospital experience for their substance-exposed newborn by educating them on what to expect during their stay.

Why we are recommending this best practice

Educating pregnant women and families about what signs and symptoms of NAS to anticipate, and how to identify these symptoms in their newborn, can help them be active participants in the newborn's care immediately after birth.

- Short-term effects can appear within 1-5 days and most commonly within 2-3 days. Symptoms can include but are not limited to high-pitched cries, tremors, difficulty sleeping, poor feeding, and diarrhea. Depending on the severity, the newborn's hospital stay may be prolonged.

- Long-term effects can appear within months to years. These consequences may include problems with vision, motor skills, and behavior/cognition, sleeping disturbances, and ear infections. Early intervention programs can ameliorate these effects and provide surveillance for them.

Optimizing the newborn hospital experience can decrease the length of stay (LOS) and the need for pharmacotherapy. Evidence-informed practices include rooming-in, skin-to-skin contact, breastfeeding, decreasing environmental stimulation, and functional scoring of the newborn (engaging mothers to participate in scoring objective elements such as quality of cry, stool consistency, and tremulousness can be both empowering and helpful). Pregnant women and families who are informed in advance can be prepared to participate in these practices.

Strategies for Implementation

Conduct a prenatal visit to discuss newborn care and the newborn hospital experience. This can be accomplished in a variety of ways, including a pediatric provider appointment, hospital nursery/NICU visit, social worker appointment, group visit, community support

group, or public health nurse outreach. Areas of discussion should include the following:

- Rooming-in when available. Encourage close and frequent maternal contact if unable to room-in.

- Initiating early skin-to-skin contact with the newborn which promotes bonding, soothes the newborn, and aids in breastfeeding.

- Promoting breastfeeding if the mother is on a stable medication assisted treatment (MAT) regimen and has no contraindications. Breastfeeding is encouraged for mothers taking methadone or buprenorphine regardless of dose, as transfer into milk is minimal. Breastfeeding is associated with decreased severity of symptoms, less need for pharmacotherapy, and shorter length of stay. Refer to **Best Practice #9** for more information regarding breastfeeding.

- Decreasing stimulation by having limited visitors, reducing noise, and using low lighting.

- Using functional scoring to evaluate withdrawal (e.g., ability to eat, sleep, and be consoled). Refer to **Best Practice #19** for more information regarding functional scoring.

- Preparing the family for potential escalation of care based on the clinical pathway used by the hospital. Discuss the environment (e.g., NICU or Level 2 nursery), level of family involvement, role of pharmacotherapy, weaning protocol, and discharge criteria.

- Explaining the potential for the newborn to be discharged without treatment if feeding and sleeping well with minimal or no signs of withdrawal after three days for opioids with a short half-life and 5-7 days for opioids with a long half-life. This period allows for adequate identification and monitoring of possible withdrawal symptoms, the onset of which may vary depending on the medication dose, the infant's metabolism, and the presence of polysubstance abuse. Refer to Table 1 in Reference #8 for detailed information regarding specific withdrawal patterns by substance. Refer to **Best Practice #30** for information on inpatient monitoring of newborns managed with a non-pharmacologic bundle of care.

- Preparing the family for potential involvement of Child Protective Services (CPS). In California, there are no laws mandating that prenatal substance exposure be reported to CPS, unless the required assessment identifies other factors that indicate significant risk to a child. If CPS involvement is warranted, they will determine a safe home

environment for the newborn. A safe and permanent home and family is the best place for children to grow up. CPS focuses on building family strengths and provides parents with the assistance needed to keep their children safe so that the family may stay together. CPS efforts are most likely to succeed when patients are involved and actively participate in the process. When concerns about risk factors don't rise to the level of an investigation by CPS, a Plan of Safe Care is developed upon hospital discharge (or perhaps earlier in the pregnancy when opioid use disorder is identified) to support treatment and recovery for the mother and enhance protective factors for the dyad. Alternatively, if CPS makes an initial determination of child neglect or abuse, they may create an agreement between a parent or caretaker that is called a safety plan and which may restrict a parent from having any contact or unsupervised contact with a child. CPS must make reasonable efforts to develop safety plans to keep children with their families whenever possible, although CPS may refer for juvenile or family court intervention and placement when children cannot be kept safely within their own homes. When children are placed in out-of-home care because their safety cannot be assured, CPS will work to develop a permanency plan as soon as possible.

- Providing pregnant women and families with educational handouts, such as the NAS Parent Brochures developed by the Illinois Perinatal Quality Collaborative (ILPQC) (see Resources below) and others available on the MBSEI website.

- Enrolling the newborn in early intervention programs and developmental follow-up clinics prior to discharge.

Deep Dive

Pediatric prenatal visits are a critical opportunity for health care professionals to provide pregnant women and their families with information about caring for their newborn. However, this opportunity is highly underutilized. The American Academy of Pediatrics (AAP) reports only 5-39% of all first-time parents and 5% of urban poor pregnant women attend a pediatric prenatal visit (Yogman, et al.). These prenatal visits are especially important when opioid exposure is involved as they allow providers to educate families about NAS and to prepare them for what to expect from their newborn's hospital experience.

All pregnant women with OUD should be strongly encouraged by the OB/GYN team to attend a pediatric prenatal visit. Local offerings may dictate the choice of who conducts this visit, and it may be offered individually or in a group setting. A nursery or NICU provider can speak directly to inpatient policies, parent involvement, and hospital treatment options. A pediatrician identified in advance can provide continuity and ongoing support after discharge. Social workers and public health nurses can provide education on available resources. It is best to hold the prenatal visit at the start of the third trimester. Providing educational handouts will allow families to review the information that was shared during the visit after they go home.

Reference: Yogman, et al. The Prenatal Visit. Pediatrics 2018;142(1).

Resources

1. NAS What You Need To Know.
2. Addiction Free CA.

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Educate clinical providers and staff about neonatal abstinence syndrome

Best Practice No. 39

Outpatient, Labor and Delivery, Nursery/NICU, and Education

Overview

Educate clinical providers and staff regarding:

- Neonatal abstinence syndrome (NAS) identification, evaluation, and treatment of the newborn.

- Supportive, non-judgmental interactions with parents.

Why we are recommending this best practice

Clinical providers and staff who have a strong foundation of knowledge can educate and support families. Positive provider and staff interactions with families of newborns with NAS contribute to better outcomes and a successful hospital experience. Please refer to **Best Practice #34**, **and** **Best Practice #37** for more information about provider and staff education on opioid use disorder (OUD).

Clinical providers and staff who have a strong foundation of knowledge can educate and support families. Positive provider and staff interactions with families of newborns with NAS contribute to better outcomes and a successful hospital experience. Please refer to **Best Practice #34** for more information about provider and staff education on OUD.

Strategies for Implementation

- CME and in-service training can provide the information and skills needed to educate clinical providers and staff.

- Families can play a valuable role in the care team. They should be encouraged to initiate skin-to-skin contact and participate in other aspects of care.

- Mothers should be encouraged to breastfeed if on a stable medication assisted treatment (MAT) dose. Breastfeeding is discouraged if the mother is using marijuana, and mothers should be counseled about the potential risk of exposure during lactation. Breastfeeding is contraindicated if the mother is taking illicit drugs or is infected with HIV.

- Patient care and communication of clinical information should be clear and consistent.

- Provider and staff interactions with families should be supportive and non-judgmental (see Resources section below).

- Providers and staff should be aware of external factors involved, such as a parent dealing with the disease of addiction and its treatment.

Baby M

During Baby M's hospitalization for NAS, Kayla reflects on both the positive and negative experiences she has had with providers and staff in the hospital. She notices that the interactions would set the tone for her mood that day and be reflected in the enthusiasm and confidence she had in caring for Baby M. She really liked when the hospital's policies and protocols were made clear to her, and she appreciated when providers and staff encouraged her to take a large part in Baby M's care. It made her feel successful when some of the nurses commented that Baby M was so much calmer when Kayla was holding him. On the other hand, Kayla felt less confident when the staff did not seem to know about the disease and treatment of OUD and could not relate to all the conflicting feelings she was experiencing. She became upset when she sensed that providers and staff were judging her negatively because of her OUD. She just wanted them to treat her respectfully as Baby M's mother and help her learn the best ways she could help care for him.

Resources

1. Language Matters Information Sheet.

2. Refer to Best Practice #34 (Educate patients and families about OUD) for resources relevant to educating families.

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