Mother & Baby Substance Exposure Toolkit

Best Practice No. 31

A part of the California Medication Assisted Treatment Expansion Project

This version was published on 2020-09-04

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Ensure linkage to home visitation programs or that other in-home supports are in place

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

Overview

Prior to discharge, appropriate referrals to home-based services should be made, or if the patient has previously been referred, services should be confirmed. This may include Public Health Nursing, Early Head Start Programs, or any other program that provides evidence-based in-home supports to the family.

Why we are recommending this best practice

Home Visitation Programs have shown high rates of return on investment. By participating in prenatal and early childhood home visiting programs, families gain the necessary knowledge and resources to successfully parent. These programs not only provide one-on-one in-home support to the families, but also ensure that the family is linked to any additional resources and aid the family in ensuring that all medical care is followed. Especially within the first weeks of the newborn's life, it may be difficult for the parent to leave the house; by receiving services in the home, there is better ability to ensure that the family does not fall out of care.

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 serves 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.

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, speech therapy, and home visits. Referrals can be made by 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).

Strategies for Implementation

Ensure that staff is trained and has a full understanding of the availability of specific home visitation programs that are available to the population. It is optimal to refer the mother during prenatal care and to resume home visits following delivery.

Maintain resource listings and referral forms for home visitation programs in your area. These can be kept in a binder that is easily accessed by providers and staff or can be kept digitally. It is important to regularly review and update agency referral forms to ensure the accuracy of referrals.

- Readily available referral forms will streamline the referral process.

- Determine if the patient has already been working with a home visiting program.
  - If she has, ensure care coordination happens with that program so the home visitor is aware of the delivery and that no gap in services occurs.
  - If she had not been referred, ensure a referral is made and inform the patient.

- The key to this referral is ensuring that the patient buys in and that the family understands the kind of support a home visiting program can provide.

- Explore the availability of warm handoffs to programs prior to discharge. Sometimes a program might be able to do an intake while the patient is still admitted to the hospital.

Kayla

When Kayla found out she was pregnant at 11 weeks, she was offered a visit with a social worker but declined the meeting at that time. Prior to discharge of Baby M, another referral was made for public health nursing follow-up, and Kayla was able to understand how home visiting services could provide ongoing support to her and Baby M. They received monthly home visits from a public health nurse who supported the dyad in bonding, breastfeeding, and identifying other needs. The home visitor quickly identified that Kayla had challenges with transportation to her treatment appointments and was able to facilitate reliable transportation for her. Additionally, the home visitor was able to facilitate referral to a support group for new moms and provide additional resources for Kayla. The home visitor followed Kayla and Baby M for the entire first two years of Baby M's life.

Referring patients to home visiting services allows for evaluation of socioeconomic factors that may impact a patient's ability to seek care for themselves or their child. By identifying and working with the patient to address these factors, they can meet the dyad's basic needs, work on goal setting, and identify strengths that the mother already possesses. Additionally, ongoing follow-up with a home visitor can help to facilitate comprehensive and consistent medical care.

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. Local First 5 Commissions.
5. National Head Start Association.
6. Early Head Start.
7. California Head Start.
8. CalWORKS.
9. Healthy Start.
10. Early Start.
11. Palomar Home Health Services.
12. Comprehensive Perinatal Services Program.
13. Healthy Families America.

References

1. Breastfeeding, SB-402. California Legislature. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml? bill_id=201320140SB402. Accessed December 19, 2019.
2. Harrison CL, May A. Home visiting: improving children's and families' well- being. NCSL legisbrief. 2018;26(31):1-2.
3. Heckman, J., Holland, M., Makino, K., Pinto, R., & Rosales-Rueda, M. An analysis of the Memphis nurse-family partnership program. NBER. 2017. https://www.nber.org/papers/w23610. doi:10.3386/w23610.
4. Home Visiting. Human Resources and Services Administration. https://mchb.hrsa.gov/maternal-child-health- initiatives/home-visiting-overview. Accessed December 19, 2019.
5. MCPAP for Moms Toolkit. Massachusetts Child Psychiatry Access Project. www.mcpapformoms.org.
6. ACOG committee opinion no. 729: importance of social determinants of health and cultural awareness in the delivery of reproductive health care. Obstet Gynecol. 2018;131(1):e43-e48.
7. ACOG committee opinion no. 736: optimizing postpartum care. Obstet Gynecol. 2018;131(5):e140-e150.
8. Substance Abuse and Mental Health Services Administration. A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorder. https://store.samhsa.gov//system/files/sma16- 4978.pdf. Accessed December 19, 2019.

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Emillie began working in Lake County Public Health in 2015 as a Public Health Nurse in the California Children’s Services Program and Home Visitation Program, and has worked in different capacities in the department for the last five years. She currently provides oversight to the Maternal Child and Adolescent Health Program and the Nurse Home Visiting Program. As the MCAH Director, Emillie has works with a number of community stakeholders to address perinatal substance use in Lake County, and to create a recovery ecosystem where there is no wrong door into accessing services.

Jacqueline Rad

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Jacqueline Rad is the nurse manager for the Family Birth Center at Sutter Lakeside Hospital where she provides patient-centered care to mothers and newborns exposed to opioids, and teaches providers and nurses about the challenges these families face.

Mimi Leza

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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.