Mother & Baby Substance Exposure Toolkit

Education

A part of the California Medication Assisted Treatment Expansion Project

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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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2. Opioid use disorder and pregnancy FAQ. American College of Obstetricians & Gynecologists https://www.acog.org/- /media/For-Patients/faq506.pdf?dmc=1&ts=20190509T0049178971.
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

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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.

References

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Carrie Griffin

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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.

Lorena Watson

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Lorena Watson is a Family Nurse Practitioner. Her focus is rural health and providing compassionate patient-centered care in Lake County, CA. She coordinates and provides care for mothers with OUD through pregnancy and postpartum. Before becoming an FNP, Lorena was a labor and delivery nurse for 16 years.

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.

References

1. Substance Abuse and Mental Health Services Administration. Clinical guidance for treating pregnant and parenting women with opioid use disorder. https://store.samhsa.gov/product/Clinical- Guidance-for-Treating-Pregnant-and-Parenting-Women-With-Opioid-Use- Disorder-and-Their-Infants/SMA18-5054. Accessed December 19, 2019.

Lorena Watson

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Martha Tesfalul

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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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