Mother & Baby Substance Exposure Toolkit

Transition of Care

A part of the California Medication Assisted Treatment Expansion Project

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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.

References

1. Kocherlakota P. Neonatal abstinence syndrome. Pediatrics. 2014;134(2):e547-561.
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

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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

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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.

Tipu V. Khan

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Dr. Khan is an Addiction Medicine specialist and Chief of Addiction Medicine consult-liaison 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.

Implement opioid use disorder discharge checklists for all hospital-based points of entry

Best Practice No. 27

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

Overview

All collaborators for the Plan of Safe Care (refer to **Best Practice # 29**) should focus on interventions that take into consideration the safety and needs of both mother and newborn. While there has been extensive attention to a Plan of Safe Care for the newborn, a plan for the mother is equally important. The Plan of Safe Care should instill confidence in the mother in her ability to care for herself and her newborn; build trust and relationships with providers and other health and wellness partners; facilitate connections to resources; and ensure access to care that is inclusive of the mental, emotional, and physical aspects of opioid use disorder (OUD) postpartum and newborn health, and motherhood.

The following Plan of Safe Care discharge recommendations are best practice guidelines known to support the safety, recovery, and wellness of the mother/baby dyad, yet they should not limit the provision of resources, support, and/or interventions that may be necessary to overcome unique situations and challenges of individual mothers and newborns.

Every episode of care is an important opportunity to implement a Plan of Safe Care regardless of the point of entry or disposition (e.g., delivered or undelivered). Some patients have not received prenatal care, been referred to and/or participated in available support services, and may initially present to an emergency department or an alternate point of entry for care. Pregnant women presenting to the emergency department prior to 20 weeks gestation are traditionally declined by L&D units for interdepartmental transfer and, therefore, only receive care in the emergency department. Finally, not all pregnant women who present to labor and delivery (L&D) units will progress to delivery.

Why we are recommending this best practice

For some pregnant women, L&D units and emergency departments are the first providers of pregnancy-related care; in fact, these environments may be their only source of care during pregnancy. Providers should understand that:

- Recognition and identification of mothers with OUD at the earliest point of care will support efforts to protect the fetus from continued opioid exposure and sequela and will support maternal recovery and wellness.

- Reinforcement and assessment of the Plan of Safe Care during each episode of care is an opportunity to prevent program fallouts through reinforcement of positive

behaviors through praise and recognition of successes and the identification of challenges and barriers to participation, gaps of service/support, and new service/support needs.

- Transitions of care (e.g., hospital discharges) place the OUD screen positive mother/baby dyad at risk due to potential gaps in service, communication, and understanding of the Plan of Safe Care.

- Implementation of a discharge checklist supports the team and individuals responsible for this complex discharge by aiding memory, team communication, and consistency of practice. All elements of the discharge checklist should be evidence-based, taking into consideration the unique characteristics of the mother/baby dyad and the community into which they are being discharged.

- Postpartum women with OUD are at very high risk for perinatal mood and anxiety disorders and should be screened using the Edinburgh Postnatal Depression Scale or the PHQ-9 plus GAD-7 prior to discharge.

The Discharge Checklist (please see example in the Resources section of this Best Practice):

- Provides an opportunity to identify and implement opportunities for reinforcement of the OUD plan of care.

- Ensures consistency of best practices and equity of the services, referrals, and resources required to achieve and sustain recovery and wellness.

- Should support/encourage breastfeeding if not contraindicated.
    - Women should feel empowered to make an informed decision about infant feeding.
    - Women should be given complete information on the benefits of breastfeeding and the recommendations surrounding OUD and breastfeeding.

Strategies for Implementation

This is a critical portion of the toolkit and we have therefore provided especially detailed implementation steps.

- Identify and assess all hospital-based points of entry (inpatient/outpatient) used by the pregnant OUD patient (e.g., L&D, antepartum, emergency department).

- Engage hospital leadership and partner with department leaders to recruit at least one provider and staff champion from each identified point of entry for support and implementation of the standardized maternal OUD screen positive discharge checklist.

- Explain the importance of a discharge checklist with identified care providers and teams. Get their buy-in.
    - What is the goal?
    - What is the benefit of implementation for the patient, provider, and community?

- Assess culture and staff readiness for implementation of a checklist.

- Understand the roles and responsibilities for the discharge planning project.
    - Who comprises the care teams?
    - Where is discharge occurring?
    - Who is creating the discharge plan?
    - Who is facilitating the discharge?
    - Who is providing/managing care for pregnant and/or delivered mothers in the inpatient and outpatient settings?
    - Where is the discharge occurring (e.g., L&D, postpartum, antepartum, emergency department, medical/surgical unit)?
    - Who are the receiving teams for discharge (e.g., community, provider resource, service representatives)?

- As a team, create and/or adopt an evidence-based OUD discharge checklist (please see the Resources section of this Best Practice for an example)

- Circulate the OUD discharge checklist and provide education for all care providers responsible for discharge of the OUD mother and newborn.

- Use the teach-back method to ensure all staff understand:
    - Tool use
    - Goals of a successful maternal OUD discharge
    - Shared accountability of the tool and use of standard work
    - Resources available for support

- Monitor use of the OUD discharge checklist:
    - Regularly observe the process
    - Audit patient charts for standard work compliance and completion/support of the elements of the Plan of Safe Care.

- Encourage and sustain use of the OUD discharge checklist by providing feedback to staff about:
  - Successes and opportunities of tool use
  - Case outcomes

- Monitor outcomes:
  - Assess the discharge checklist and process early and often after implementation.
  - Ask for feedback related to successes, challenges, and barriers. Be open to feedback.
  - Use feedback and outcomes data to guide quick tests of change that support quality improvement.

Deep Dive

The checklist has quickly become the gold standard for high reliability health care organizations that want to provide exceptional, team-based care. For example, the Safe Surgery Checklist was adapted for use in U.S. hospitals in 2009 and quickly became the benchmark for improving quality and safety in the surgical suite. But are checklists enough to save lives?

In 2017, the *New England Journal of Medicine* published a report [1] on the BetterBirth Study, one of the largest maternal-newborn studies with over 300,000 women and their babies, that looked at maternal and newborn outcomes after implementation of the WHO Safe Childbirth Checklist. The checklist improved adherence to best practices that are associated with better outcomes; but in this large-scale study in India, there was no difference in perinatal mortality, maternal mortality, or maternal morbidity between the control and intervention groups, even though the intervention groups showed high adherence to the checklist protocols.

Checklists in and of themselves are not enough. A discharge checklist cannot simply be about "checking the box." The postpartum period is the most complex for mother and newborn, with multiple opportunities for relapse and the resulting sequelae. Therefore, the discharge checklist must be about providing better communication between all care providers; inpatient providers must better engage with their outpatient counterparts and community-based organizations who will be responsible for helping the patient navigate a complex pathway to recovery. ***It's about changing the system, not just checking a box.***

Reference: Semrau KEA, Hirschhorn LR, Marx Delaney M, et al. Outcomes of a Coaching-Based WHO Safe Childbirth Checklist Program in India. The New England journal of medicine. 2017;377(24):2313-2324.

Resources

1. Maternal-Postpartum Opioid Use Disorder Discharge Checklist.

References

1. Hudak ML, Tan RC. Neonatal drug withdrawal. Pediatrics. 2012;129(2):e540- 560.
2. MCPAP for Moms Toolkit. Massachusetts Child Psychiatry Access Project. www.mcpapformoms.org.
3. ACOG committee opinion no. 757: screening for perinatal depression. Obstet Gynecol. 2018;132(5):e208-e212.
4. Semrau KEA, Hirschhorn LR, Marx Delaney M, et al. Outcomes of a coaching-based WHO safe childbirth checklist program in India. N Eng J Med. 2017;377(24):2313-2324.

Elliott Main

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Dr. Main is the Medical Director of the California Maternal Quality Care Collaborative (CMQCC) and has led multiple state and national quality improvement projects. He is also the Chair of the California Pregnancy-Associated Mortality Review Committee since its inception in 2006. For 14 years, he was the Chair of the OB/GYN Department at California Pacific Medical Center in San Francisco. He is currently clinical professor of Obstetrics and Gynecology at Stanford University. Dr. Main has been actively involved or chaired multiple national committees on maternal quality measurement. In addition, he helps direct a number of national quality initiatives with ACOG, the CDC and Maternal Child Health Bureau (HRSA) including the multi-state AIM project. In 2013, Dr. Main received the ACOG Distinguished Service Award for his work in quality improvement.

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.

Continue to establish a therapeutic relationship with parents/caregivers once the infant has been born and empower parents to be involved with the care of their newborn

Best Practice No. 28

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

Overview

After delivery continue to establish a therapeutic relationship with parents/caregivers and engage and empower parents to be involved with the care of their newborn.

Why we are recommending this best practice

Involving parents in newborn care early will increase their confidence in and preparation for managing neonatal abstinence syndrome (NAS) symptoms, establish healthy attachment to their newborn, and allow both mother and baby to better succeed in the transition to home.

Strategies for Implementation

- Ideally, parents receive prenatal counseling and meet members of the newborn care team.

- Train staff to maintain a non-judgmental and supportive attitude and treat the mother as a parent first, not someone with a substance use problem.

- Provide consistency in care team members as much as possible.

- Ensure confidentiality by not discussing NAS or other clinical matters in front of other family members or friends unless the parents have explicitly consented.

- Promote positive maternal/paternal attachment to the newborn:
    - Engage the parents in the care of their newborn.
    - Encourage the parents to visit and help them maintain a quiet environment for the newborn.
    - Emphasize and reinforce positive attributes of the newborn and

maternal/paternal behavior.

- Consider providing a parent/caregiver diary so that the parents may record eating and sleeping information about their newborn.

- Consider posting a HIPAA-compliant sign at the bedside to remind parents and staff about general tips for calming their newborns, skin care, feeding, and other non-pharmacologic interventions.

- Consider providing a brochure or written guide about NAS for parents and standardizing the hospital's method of pre-natal and postnatal counseling.

Kayla

Since Kayla was identified as having been exposed to opioids during pregnancy, the pediatric team was notified prior to delivery. The pediatrician assigned to care for Baby M met with Kayla and started to build a relationship with her, describing Kayla's important role as a mother and the importance of skin-to-skin care and breastfeeding. In addition, due to her exposure, the pediatrician explained the plan for assessing Baby M for symptoms of NAS after delivery.

Training staff to maintain a non-judgmental and supportive attitude and treat the mother as a parent first is an important aspect of establishing a constructive therapeutic relationship with the family. This attitude should be present whether or not the baby develops NAS. Staff should not discuss confidential information in front of family and friends unless the mother has given explicit consent for that communication to occur.

Resources

1. ILPQC Newborn Care Diary.
2. NAS Symptom Diary.
3. NAS Parent Brochure used by NNEPQIN.
4. NAS Parent Guide used by OPQC.

References

1. Grossman MR, Berkwitt AK, Osborn RR, et al. An initiative to improve the quality of care of infants with neonatal abstinence syndrome. Pediatrics. 2017;139(6).
2. Wachman EM, Grossman M, Schiff DM, et al. Quality improvement initiative to improve inpatient outcomes for neonatal abstinence syndrome. J Perinatol.

2018;38(8):1114-1122.

Alexandra Iacob

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Dr. Alexandra Iacob is a Neonatal-Perinatal Fellow at University of California, Irvine (UCI) based out of UCI Medical Center and Miller Children's and Women's Hospital Long Beach. While in fellowship, she is also pursuing a Master in Public Health at Johns Hopkins University. She is passionate about improving neonatal outcomes across all socioeconomic classes via both quality improvement projects and policy efforts. She is particularly interested in neonatal abstinence syndrome and the impact it has on the mother, the baby, and the family as a whole.

Angela Huang

MPH, RNC-NIC

Angela Huang is a clinical nurse in the Neonatal Intensive Care Unit at Santa Clara Valley Medical Center, where she is also a nurse coordinator managing and leading quality improvement and research projects. She is actively involved in hospital-wide and county-wide opioid use reduction initiatives, specifically outcome improvement for mother/infant dyads with a history of substance use and exposure. Angela is also the co-chair for the CPQCC Maternal Substance Exposures Workgroup which is assessing the statewide scope of NAS and NAS management practices.

Kathryn Ponder

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Dr. Ponder is a neonatologist with East Bay Newborn Specialists, working in the neonatal intensive care units at the UCSF Benioff Children’s Oakland, John Muir Walnut Creek, and Alta Bates hospitals. She is also the director of the John Muir High Risk Infant Follow-Up clinic. She has revised her practice’s guidelines for the care of infants with Neonatal Abstinence Syndrome and is leading a quality improvement initiative at John Muir to implement these changes. She has previously conducted research and published in the fields of developmental/placental biology and maternal health. She continues to be interested in the developmental origins of disease and optimizing neurodevelopmental outcomes for infants.

Lisa Chyi

MD

Dr. Lisa Chyi is a practicing neonatologist at Kaiser Walnut Creek. She is co-chair for the CPQCC Maternal Substance Exposures Workgroup which is assessing the statewide scope of NAS and NAS management practices. She also helped develop the NAS management guideline and oversees NAS patient care for the Kaiser Northern California region.

Pamela Aron-Johnson

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Pamela has been at UCI Medical Center in Irvine, California for 35 years in several roles including staff nurse in the NICU for 17 years, Outpatient Nurse Manager for Primary and Specialty Services, and currently the Quality and Patient Safety Advisor for the NICU and OB departments. She is also a member of the Data Committee Advisory Group for CPQCC, and is the data nurse coordinator at UCI for both CPQCC and CMQCC.

Priya Jegatheesan

MD

Dr. Priya Jegatheesan is the Chief of Newborn Medicine and the Regional NICU Director for Santa Clara Valley Medical Center in San Jose, California, an institution committed to the medically underserved. Her main area of interest is outcomes and data-driven quality improvement. She established a comprehensive computerized database system in the SCVMC NICU that enables prospective data collection for quality improvement and research. She also actively participates in CPQCC's Perinatal Quality Improvement Panel and chaired the QI infrastructure sub-committee for 2 years. She became a member of the Society for Pediatric Research in 2014 and has actively participated in clinical research. She is currently the study site Principal Investigator for a NIH funded multi-center study evaluating ondansetron (5HT3 antagonist) for prevention of neonatal abstinence syndrome in newborns born to mothers who had chronic opioid use during pregnancy. She is a passionate champion for optimizing care of newborns exposed to substances during pregnancy to prevent neonatal abstinence syndrome by promoting mother-infant couplet care.

Develop a dyad-centered Plan of Safe Care

Best Practice No. 29

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

Overview

California Penal Code 11165.13 was amended in 1990 with language indicating that a "positive toxicology screen at the time of the delivery of an infant is not in and of itself a sufficient basis for reporting child abuse or neglect," but would require "…any indication of maternal substance abuse to lead to an assessment of the needs of the mother and child." According to California Penal Code 123605, the assessment must be established by protocol "…between county health departments, county welfare departments, and all public and private hospitals in the county…" More recently, in 2016, the federal Comprehensive Addiction and Recovery Act (CARA) amended the long-standing Child Abuse Prevention and Treatment Act (CAPTA) to require development of a Plan of Safe Care, a concept that encourages a comprehensive, multidisciplinary care plan that addresses the needs of both infant and mother/caregiver. While there is still discussion about the interpretation of these state and federal regulations, it is clear that the Plan of Safe Care shifts the response to maternal and infant substance exposure from one centered predominantly on newborn safety to one that anticipates the needs of the mother/baby dyad.

This Best Practice addresses the Plan of Safe Care for the dyad, regardless of whether the mother and newborn are discharged together, or parental rights have been temporarily suspended. Because evidence demonstrates that retention of the mother/baby dyad is preferable to separation, attention to her well-being is essential to the welfare of the dyad.

Key elements of a dyad-centered Plan of Safe Care are the development of structured protocols at the county and hospital level, comprehensive assessment of needs and assets, collaborative wraparound care, transparency, and the identification and engagement of community partners.

Why we are recommending this best practice

A dyad-centered Plan of Safe Care will facilitate positive outcomes for the mother and baby. Having these services in place during the pregnancy and certainly prior to postpartum discharge support mothers to acquire or optimize the skills necessary to provide a safe and nurturing environment for the dyad and family. There is an opportunity and an obligation to ensure new families have the best opportunities afforded them.

Strategies for Implementation

Structured Protocols: Although protocols may have been developed years ago in response to CA Penal Code 11165.13 and Health and Safety Code 123605, new evidence supports best practices that address the effects of adverse childhood events (ACE) on long term health and wellbeing, attachment and bonding, early intervention, the treatment of substance use disorder (SUD), and the role of protective factors in eliminating or mitigating risk in families and communities. While no one template fits all situations, domains covered in the Plan of Safe Care might include:

- Maternal primary, obstetric, and gynecological care, including interconception care and family planning
- Behavioral health and substance use prevention, treatment, and recovery
- Parenting and family support
- Infant and family safety, including intimate partner violence
- Infant health and child development, including primary care, early intervention, and infant and early childhood mental health (IECHM) services

The adoption and implementation of standardized protocols to develop, execute, and monitor a Plan of Safe Care for all women and children in need is critical. Further, the Plan of Safe Care protocol should reflect the collaborative expertise of key agencies at the county level (e.g., behavioral health and substance use treatment departments, social service departments, Child Protective Services (CPS), etc.), and multiple disciplines in the hospital and other health care settings (e.g., pediatric and OB/GYN health care providers, medical social work, etc.).

Collaboration: To provide a Plan of Safe Care for the dyad, community-based organizations and agencies must collaborate to make wrap-around services covering the above domains easily accessible. To address the needs of the mother, communities must come together to support her with a network of programs and providers that transcend stigma and engage mothers with respect and trust, are trauma-informed, and have expertise in the care of women with substance use disorders (SUDs). Similarly, addressing the needs of the infant should include providers and agencies skilled in high risk infant follow-up, Early Head Start and other early intervention programs, and primary care pediatric providers with expertise in managing infants exposed to substances or at risk for neurodevelopmental challenges. The mother/caregiver must be the core member of this partnership. The partnership should include:

- Primary care providers
- Medication assisted treatment (MAT) providers (office-based or narcotics treatment programs) or other treatment and recovery programs
- Public health nursing, including home visitation programs
- Behavioral health providers
- Peer support
- Board-certified lactation consultant if the mother desires to breastfeed or provide expressed breastmilk (and it’s not medically contraindicated)

Providing Transparency: From the initial meeting with the mother, clarity of purpose is fundamental, and expectations are based on how each individual program or service can meet the needs of the dyad. Assessment of the mother’s needs, with consideration for her self-efficacy, SUD treatment, and recovery, will support her goal attainment. Follow through with plans and interventions developed with her input will further a sense of security in the relationship. Communication between community supports should occur with full knowledge and consent from the mother and include her whenever possible. Community partners should maintain transparency with each other to avoid duplication of services and provision of conflicting information to the mother, which may confuse and overwhelm her.

Presently, guidance regarding interpretation of the federal and state legislation in this area

is not straightforward, and hopefully will be clarified soon. Counties vary in how they address the Plan of Safe Care requirement within their communities. In many instances, CPS will take the lead; however, if there is no CPS involvement, or CPS does not address the provision of services to the mother, the community should be ready to support mothers with trauma-informed programs and partners that employ the Five Protective Factors model (refer to the Resources Section of this Best Practice). If CPS engagement is anticipated, full understanding of the laws and resources will afford medical and other service providers the ability to have more transparent conversations with mothers.

Community Partners: The partners from the community may include: CPS, Cal-Works eligibility, behavioral health providers, peer support workers, hospital social workers, MAT providers, recovery programs specific to parenting women, First 5, mother-infant intervention programs (e.g., Minding the Baby or Parents as Teachers), Regional Center, Early Start, Medicaid, and Women, Infants and Children (WIC). Communities may identify and designate additional partners specific to their region.

Federal and State Child Welfare Regulations: In 2016, the Comprehensive Addiction and Recovery Act (CARA) amended the Child Abuse and Prevention Treatment Act (CAPTA) to require the development of a Plan of Safe Care for all children referred to their agency who are born affected by legal or illegal substance use, have withdrawal symptoms resulting from prenatal drug exposure, or have indications of Fetal Alcohol Spectrum Disorder.

In response to California Penal Code 11165.13, and the Federal CARA/CAPTA amendments, the California Department of Social Services (CDSS) All County Letters (17-92 and 17-107) state, “when investigating a referral, the county child welfare agency must assess and identify any safety threats to the child, including any safety threat posed by the parent’s substance abuse. The caseworker must document such safety threats when completing statewide safety assessment tools. This also includes the completion of a risk assessment. If the caseworker determines the caregiver has the protective capacity to mitigate such safety threats and/or risks with appropriate services while keeping the child in the home or placement, the caseworker shall develop a safety plan as described in CDSS Manual of Policies and Procedures, section 31-002(s) (2)… to permit the child to remain in the home with specific, timely actions that mitigate the identified safety threats.”

Initial Steps to Consider

- Contact the county Public Health Department (Maternal Child and Adolescent Health), Child Protective Services, and/or Hospital Council to determine if a current protocol exists for the identification of perinatal substance exposure and the development of Plans of Safe Care that is consistent with state and federal law.
- If a county-level protocol does not exist, or needs revisions, establish a county-level multidisciplinary Plan of Safe Care Committee. Stakeholders to engage might include champions from the aforementioned agencies, Pediatrics, Obstetrics, Midwifery, Family Medicine, Addiction Medicine, Psychiatry, Behavioral Health, Family Treatment Court, and community organizations that serve this population (essential for culturally appropriate and engaging care). Protocols should address at least the following:
    - Define which mothers and newborns will qualify for a Plan of Safe Care and whether it will be used only for substance exposed mothers and infants as mandated or for the many other families at risk (e.g., prematurity, intimate partner violence, mental health issues, etc.).
    - Identify who will oversee implementation of the Plan of Safe Care, and at which stage of the pregnancy the plan of safe care may be initiated. Current CDSS All

County Letters assign that responsibility to the local CPS agency regardless of whether the newborn is discharged in the care of the mother.
    - Identify key community-based organizations and resources and establish relationships including with primary care providers, substance use treatment and recovery providers, community resources for collaborative support of vulnerable families, home visitation, parenting classes, lactation support, addiction support (if needed), and early intervention services.
    - Outline ongoing care plans that identify family challenges and strengths (and tools to support those assessments, such as Protective Factors Survey 20 or 30), detail recommended/required resources and supports to ensure ready access to those services, and include contact information and appointments for benefit of the family and support network.
    - Prioritize continuity of care with maternal treatment and recovery providers and with infant care providers wherever possible and appropriate
    - Ensure that the Plan of Safe Care covers a sufficient duration to ensure a foundation of stability.
    - Include a comprehensive release of information consent signature page (see Delaware's Plan of Safe Care example) to facilitate timely information sharing and coordination between organizations to ensure shared understanding and accountability.

- Ensure that hospital protocols are in place for the identification of substance exposed mothers and infants and the development and implementation of Plans of Safe Care for the dyad. These should be consistent with local, state, and federal policies and regulations.

- Ensure families and providers are educated about the Plan of Safe Care, what to expect in the hospital and beyond, the focus on maintaining the mother/baby dyad, and the potential for CPS involvement.

- Engage the mother/caregiver in collaborative decision making around what supports are most valuable for them and any anticipated challenges for program participation while maintaining sobriety, work obligations, or court hearings.

- Consider using the Plan of Safe Care as a dynamic document that may evolve over time in response to regular assessments of the parent and infant health and well-being.

- Ensure sufficient monitoring of maternal depression and anxiety, continuing recovery, and parental capacity to meet her infant's and her own needs. There are many conflicting demands placed on these mothers such as attachment, sustaining employment, recovery, and the voluntary programs we recommend.

- Consider using a consultant or the complete reference below to implement of a Plan of

Safe Care.

The relationships we build across departments and in the community will afford us a greater support network, and transparency and accountability in caring for our most vulnerable new families during a peak emotional time. The dyad-centered Plan of Safe Care is an opportunity for providers to leverage community resources and ensure optimal support of new families impacted by substance use or other risk factors.

Kayla

In the past year, the hospital Kayla delivered at held a monthly meeting to develop and refine a thorough county-wide Plan of Safe Care (POSC). These meetings consisted of interdisciplinary representatives from the inpatient hospitals, outpatient clinics, CPS, community organizations, and health care system clients. They have been developing, refining, and organizing roll out plans for policies and procedures that link the practices of the entire community through the processes of urine toxicology, outpatient and inpatient screening, support opportunities, inpatient management, and ultimately the coordination and documentation of a POSC. The team has effectively kept their focus on keeping families intact and supporting the family as a unit.

After delivery, Kayla's primary care provider and primary outpatient social worker (SW) called a team meeting to review and adjust (as needed) Kayla's POSC. Kayla was involved in this meeting as it focused on her as the most important piece of Baby M's health and well-being. She was given time to ask questions, discuss concerns and invite any further support. Prior to this meeting, Kayla's traumatic life history was also briefly reviewed in the POSC as well as the services and safe guards that were already in place (MAT, GED attainment, and more).

Prior to Kayla's discharge, the outpatient SW, who is responsible for tracing the POSC and is the team member who best knows Kayla, provided further support. Kayla identified herself as early in sobriety and continuing to struggle with feelings of anxiety that were triggered in the role as a new parent. Kayla chose a supportive housing community resource that felt like the right fit for her family, and her primary SW assigned referrals to this program to be completed. The inpatient SW had met a representative from this community program at the monthly POSC meeting and felt comfortable describing their services and participation requirements. This added to Kayla's comfort to explore this option of support.

Resources

1. National Center on Substance Abuse and Child Welfare. A Planning Guide: Steps to Support a Comprehensive Approach to Plans of Safe Care. March 2018 Draft. Retrieved 4/10/19.

2. A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders.

3. Children and Family Futures presentation with national statistics, overall background,

concept of family-centered treatment and suggestions for the implementation of Plans of Safe Care.

4. Delaware Plan of Safe Care Template Example.
5. Vermont Plan of Safe Care Template Example.
6. National Center on Substance Abuse and Child Welfare. Child Abuse and Prevention Treatment Act (CAPTA) Substance Exposed Infants Statutory Summary.
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Dr. Heather Briscoe is an Assistant Professor at University of California, San Francisco based at Zuckerberg San Francisco General Hospital in the Department of Pediatrics. She is a pediatric hospitalist and is engaged in a number of projects around the interface of pregnancy and social complexity including an active role in the Plan of Safe Care Community Collaborative of San Francisco. She is particularly interested in how substance use policy affects pregnant women both positively and negatively with regard to utilization of prenatal care, access to needed resources, family unity & safety, and trauma-informed patient-centered care.

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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.

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Implement a warm handoff strategy to follow at time of discharge

Best Practice No. 30

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

Overview

Implementation of a warm handoff process at the time of discharge, when key information can be easily lost or forgotten, will reduce the risk of communication breakdowns that compromise patient safety and jeopardize a smooth and cohesive transition to care.

Why we are recommending this best practice

- Use of warm handoffs:
  - Increases patient safety through improved communications and provides an opportunity to question, clarify, and confirm information.
  - Builds partnerships for improved care, outcomes, and experiences.
  - Increases shared decision making and patient/family engagement.

- Use of standardized workflows (the most efficient method or approach that all follow):
  - Provides a structured communication tool and handoff process.
  - Decreases variation in practice.
  - Prevents omission of practice elements, ensuring every discharge/transition of care will benefit from all aspects of the warm handoff.
  - Allows for analysis of practice and process improvement when issues or gaps are identified.

Strategies for Implementation

- Collaborate with discharge caregivers, receivers, and patients to develop written standard work that supports next steps of the plan of care and meets the needs of all team members.

- Warm handoff standard work should:
  - Be in person (whenever possible) and in front of the patient and/or family.
  - Include an introduction by the discharging team member to the next care provider.
  - Include pertinent details related to prenatal care and the acute care stay.
  - Include a review of the discharge goals and plan.
  - Include a review of next steps and who is responsible.
  - Include a review of what is important to the patient/family.
  - Provide an opportunity for all participants, including patient and family, to question, clarify, and confirm information.

Kayla

The hospital caring for Kayla has both an inpatient and outpatient social worker who routinely meet to discuss cases and prepare for postpartum discharges. Both social workers rely on a newly developed, structured process for the warm handoff. The process was developed by a multidisciplinary group of stakeholders in the maternity and newborn departments, similar to the group that developed the Plan of Safe Care recommendations that are included in the discharge checklist. It was quickly realized that the discharge checklist was necessary but not sufficient to complete the warm hand off in the transition from inpatient to outpatient care. A standardized communication tool outlines the warm handoff process for each patient that: occurs in person with the patient, verbally reviews the discharge checklist and Plan of Safe Care, outlines who is responsible for specific next steps of the process, provides an introduction to the next care provider whenever possible, and provides an opportunity for the patient and family to ask questions and clarify any missing information.

Kayla agreed to meet with the outpatient social worker who will oversee her and Baby M's Plan of Safe Care. Contact with Kayla's post-discharge caregiver was completed, based on Kayla's preferences, and a comprehensive transmission of medical records was underway. The nurse caring for Kayla was able to attend part of the warm handoff meeting to review the discharge checklist and complete all medication reconciliation oversight. Kayla was discharged feeling supported.

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

Best Practice No. 31

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.
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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.

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Ensure referral and linkage to other necessary services/resources at discharge

Best Practice No. 32

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

Overview

Other community agency referrals are needed to ensure that both the mother's and newborn's basic needs are met. These referrals can include WIC, family resource centers, parenting classes, the Department of Social Services, support groups, local treatment centers at a level of care appropriate to the patient's assessed needs, peer support, and recovery groups.

Why we are recommending this best practice

A collaborative and multidisciplinary approach to providing support to mothers and newborns affected by opioid use disorder (OUD) is necessary to ensure that the dyad has all basic needs met. Other service providers and agencies can influence a woman's decisions for care and treatment. A more comprehensive approach to supporting the family is taken when multiple agencies and service providers are engaged.

Strategies for Implementation

- Ensure staff training on local resources and eligibility criteria, as well as the referral process.

- Routinely engage hospital social work to support these activities.

- Maintain or ensure access to a comprehensive listing of resources for easy reference when needs are identified.

- Determine if an agency is providing services to the family that include case management and care coordination.
    - If there is an agency that is already involved with the family, ensure access and determine the needs and gaps in services that the family may have.

- Identify agencies that may be available to address the needs of the family.

- Make direct referrals whenever possible; ensure that the referral is received by the

agency or program.
    - Make follow-up outpatient appointments for postpartum follow-up.
    - “The American College of Obstetricians and Gynecologists recommends a revised approach to postpartum care, including a postpartum visit within the first three weeks postpartum and a comprehensive exam at or before 12 weeks after delivery (ACOG, 2018). However, women with substance use disorders (SUDs) may benefit from additional support. Providers should consider scheduling an initial postpartum visit within 1-2 weeks after delivery, and biweekly until at least 6 weeks” (SAMHSA, 2018; Alliance for Innovation in Maternal Health, 2018).

- Inform the patient of the referral and provide contact information and information regarding the services to which they are being referred. This includes reporting to CPS.
    - When there are no safety concerns, the provider should try to openly discuss referrals to Child Protective Services (CPS) and reassure the parent that it may be an opportunity for the family to receive additional support. This should only be done when deemed safe and when the conversation would benefit the family.
    - Utilize warm handoffs. Refer to **Best Practice #30**.

- Schedule follow-up appointments before discharge.
    - Appointments should include, but are not limited to:
        - Recommended routine maternal appointments at one to two and six weeks postpartum.
        - Public health and/or home health home visit within three days of discharge.
        - Recommended routine newborn appointments within 24-72 hours after discharge.

- Where possible, provide or engage care navigators to support mothers in accessing service referrals and identifying additional needs.

Kayla

Prior to discharge, the L&D staff review several community-based resources where Kayla may be able to receive services. Since Kayla is separated from Baby M, who is still in the NICU, the discharge nurse refers Kayla to WIC to obtain a breast pump so that she can establish that her milk supply. When Kayla attends her WIC appointment, she is also provided with lactation support and education. By the time Baby M is discharged from the NICU, Kayla has established her milk supply and is ready to begin breastfeeding Baby M. Additionally, Kayla can schedule a follow-up appointment with WIC for lactation support or any other issues that may interfere with successful breastfeeding.

Resources

1. A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders.
2. Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants. SAMHSA, 2018.
3. Alliance for Innovation in Maternal and Child Health.
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Communicate directly with the outpatient primary care provider prior to the newborn leaving the hospital to review the hospital course and discuss follow-up

Best Practice No. 33

Nursery/NICU and Transition of Care

Overview

The treating physician within the hospital setting should communicate directly with the outpatient primary care provider (pediatric or family medicine provider) prior to the newborn leaving the hospital to review the hospital course, inform the primary care provider of social issues, discuss feeding plans, and ensure timely follow-up appointments are available within 24–72 hours of discharge from the hospital. In addition to the primary care provider, scheduling of home visit(s) by a nurse and/or social worker is ideal if available (see **Best Practices #25, #29 and #31**).

Why we are recommending this best practice

- Newborns exposed to illicit or non-medicinal uses of substances during pregnancy are at risk of withdrawal, as well as ongoing neurodevelopmental and other challenges. They require high risk or other close follow-up care to ensure early identification of and intervention for potential adverse outcomes.

- Primary care providers should be aware of the current feeding regimen to ensure that the newborn continues to receive adequate caloric intake for growth and development and to adjust as necessary.

- Newborns who are initially breastfed by women on medication assisted treatment (MAT) and whose mothers stop breastfeeding may be at higher risk of experiencing a recrudescence of withdrawal symptoms. Although the risk is minor, as breastmilk concentrations of both methadone and buprenorphine are low, primary care providers should be informed.

- Subacute signs of neonatal abstinence syndrome (NAS) may last up to six months.

- Drug exposure in utero is a marker of environmental risk. Caretaker involvement, family resources, and community resources are protective factors that can improve long-term outcomes for children.

Strategies for Implementation

Consider a NAS discharge checklist for inpatient providers and primary care providers caring for exposed newborns, which should ideally be incorporated into the electronic health record.

Baby M

Baby M no longer needs pharmacologic therapy and will be ready to go home soon. In preparation for that transition, the pediatrician who has cared for Baby M in the hospital calls the pediatrician who will care for Baby M as an outpatient. During the phone call, the pediatrician describes Kayla and Baby M's social and medical history, summarizes the hospital course, and suggests all aspects of care after discharge.

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Angela Huang

MPH, RNC-NIC

Angela Huang is a clinical nurse in the Neonatal Intensive Care Unit at Santa Clara Valley Medical Center, where she is also a nurse coordinator managing and leading quality improvement and research projects. She is actively involved in hospital-wide and county-wide opioid use reduction initiatives, specifically outcome improvement for mother/infant dyads with a history of substance use and exposure. Angela is also the co-chair for the CPQCC Maternal Substance Exposures Workgroup which is assessing the statewide scope of NAS and NAS management practices.

Kathryn Ponder

MD, MMS

Dr. Ponder is a neonatologist with East Bay Newborn Specialists, working in the neonatal intensive care units at the UCSF Benioff Children's Oakland, John Muir Walnut Creek, and Alta Bates hospitals. She is also the director of the John Muir High Risk Infant Follow-Up clinic. She has revised her practice's guidelines for the care of infants with Neonatal Abstinence Syndrome and is leading a quality improvement initiative at John Muir to implement these changes. She has previously conducted research and published in the fields of developmental/placental biology and maternal health. She continues to be interested in the developmental origins of disease and optimizing neurodevelopmental outcomes for infants.

Lisa Chyi

MD

Dr. Lisa Chyi is a practicing neonatologist at Kaiser Walnut Creek. She is co-chair for the CPQCC Maternal Substance Exposures Workgroup which is assessing the statewide scope of NAS and NAS management practices. She also helped develop the NAS management guideline and oversees NAS patient care for the Kaiser Northern California region.

Pamela Aron-Johnson

RN

Pamela has been at UCI Medical Center in Irvine, California for 35 years in several roles including staff nurse in the NICU for 17 years, Outpatient Nurse Manager for Primary and Specialty Services, and currently the Quality and Patient Safety Advisor for the NICU and OB departments. She is also a member of the Data Committee Advisory Group for CPQCC, and is the data nurse coordinator at UCI for both CPQCC and CMQCC.

Priya Jegatheesan

MD

Dr. Priya Jegatheesan is the Chief of Newborn Medicine and the Regional NICU Director for Santa Clara Valley Medical Center in San Jose, California, an institution committed to the medically underserved. Her main area of interest is outcomes and data-driven quality improvement. She established a comprehensive computerized database system in the SCVMC NICU that enables prospective data collection for quality improvement and research. She also actively participates in CPQCC's Perinatal Quality Improvement Panel and chaired the QI infrastructure sub-committee for 2 years. She became a member of the Society for Pediatric Research in 2014 and has actively participated in clinical research. She is currently the study site Principal Investigator for a NIH funded multi-center study evaluating ondansetron (5HT3 antagonist) for prevention of neonatal abstinence syndrome in newborns born to mothers who had chronic opioid use during pregnancy. She is a passionate champion for optimizing care of newborns exposed to substances during pregnancy to prevent neonatal abstinence syndrome by promoting mother-infant couplet care.