NAS – Dyad Care Webinar

May 7, 2019

Through collaborative use of improvement science methods, reduce preterm births & improve perinatal and preterm newborn outcomes in Ohio as quickly as possible.

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Agenda

Time	Topic	Presenter
3:00 pm	**Welcome & Overview**	**Andrea Hoberman**
3:05 pm	**Mother-Infant Dyad Care – Environmental Scan**	**Michele Walsh**
3:20 pm	**Systems Inventory – Aggregate Results**	**Michele Walsh** **Andrea Hoberman**
3:40 pm	**Team Discussion**	**Andrea Hoberman** **All Teams**
3:55 pm	**Next Steps** • June Webinar on Parenting Education/Support and OUD	**Andrea Hoberman**

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MOMS+ Project
Key Driver Diagram (KDD)

Project Leader: Carole Lannon (PI)

Revision Date: *5/21/2018*

Global Aim

Optimize the health and well-being of pregnant women with opioid use disorder and their infants

SMART Aim

By June 30, 2019 we will:
Optimize maternity medical home to improve outcomes for pregnant women with opioid use disorder (OUD) as measured by:

- Increased identification of pregnant women with OUD
- Increased % of women with OUD during pregnancy who receive prenatal care (PNC), Medication Assisted Treatment (MAT) and Behavioral Health (BH) counseling each month
- Decreased % of full-term infants with Neonatal Abstinence Syndrome (NAS) requiring pharmacological treatment
- Increased % of babies who go home with mother

Population

Pregnant women with opioid use disorder

Key Drivers

Timely identification and tracking of pregnant women with opioid use disorders

- Complete a standardized screening tool on each patient to accurately identify and diagnose pregnant women with OUD (e.g. 5 P's, NIDA Quick Screen).
- Establish a coordinated referral system with BH providers, MAT providers, drug courts, prisons, homeless shelters, and ERs.
- Utilize a tracking system (e.g.. Database, spreadsheet) to follow pregnant women with OUD history/diagnosis and all babies with prenatal opiate exposure.
- Check OARRS per prescribing protocols.

Compassionate and coordinated care

- Complete training in trauma informed care and addiction as a chronic illness to provide non-judgmental support for pregnant women with OUD
- Designate a care coordinator to arrange referrals and ongoing communication between the trans-disciplinary care team.
- Provide immediate support/counseling at time of identification by OB/FP by using standardized interviewing techniques.
- Implement a process to prevent acute opiate withdrawal by initiating MAT
- Implement a standardized process for referral to appropriate/necessary resources for women with a positive screen for OUD.
- Coordinate care between OB, BH, MAT, NICU/Pediatrics by regularly reviewing shared patients (e.g. multi-disciplinary care conference, huddle).
- Tailor counseling and support for healthy behaviors based on patient-specific situation/need during pregnancy (sobriety, smoking cessation, stable housing and birth spacing (LARC)), with referral to community resources as needed to augment medical resources.
- Consider implementing or referral to OUD specific Centering Pregnancy© program

Empowerment of women through community based services

- Connect women to vocational training opportunities as applicable
- Involve community partners including referrals to faith-based organizations to support pregnant women with OUD (e.g. support groups, shelters, food pantries, etc.)

Supported mother/infant dyad post delivery

- **Coordinate Prenatal consultation for pregnant women with OUD with Neonatology/Pediatrics to discuss Neonatal Abstinence Syndrome (NAS)**
- **Ensure mom and baby have a Patient Centered Medical Home (post-delivery)**
- **Provide a warm handoff to pediatric care provider for infant post discharge (e.g. call/consultation and newborn/maternal summary)**
- **Provide lactation consultation (if applicable), post partum depression screening and contraceptive counseling**
- **Prenatal referral for pregnant women with OUD to Community Health Workers and/or home visitation programs (dependent on region)**
- **Postnatal referral or consideration to Help Me Grow and/or parenting classes**
- **Facilitate continuation and retention of OUD treatment and services during pregnancy and post-delivery occur (e.g. support of ongoing MAT maintenance services, training care providers to recognize signs of relapse and that mom is continuing in her treatment program)**
- **Coordinate with Department of Job & Family Services/Child Protective Services regarding reporting requirements and infant plan of safe care**

Interventions

Key Driver: Supported Mother-Infant Dyad Post-Delivery

- Coordinate Prenatal consultation for pregnant women with OUD with Neonatology/Pediatrics to discuss Neonatal Abstinence Syndrome (NAS)
- Prenatal referral for pregnant women with OUD to Community Health Workers and/or home visitation programs (dependent on region)
- Provide lactation consultation (if applicable), post partum depression screening and contraceptive counseling
- Facilitate continuation and retention of OUD treatment and services during pregnancy and post-delivery occur (e.g. support of ongoing MAT maintenance services, training care providers to recognize signs of relapse and that mom is continuing in her treatment program)
- Coordinate with Department of Job & Family Services/Child Protective Services regarding reporting requirements and infant plan of safe care
- Postnatal referral or consideration to Help Me Grow and/or parenting classes
- Provide a warm handoff to pediatric care provider for infant post discharge (e.g. call/consultation and newborn/maternal summary)
- Ensure mom and baby have a Patient Centered Medical Home (post-delivery)

Understanding Best Practices

- Literature Based Evidence Review
- Stakeholder/Care Model Interviews
- NAS Team Focus Groups
- Systems Inventory

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Evidence Review – Clinical Question

- **P** *(Population)* Among neonates diagnosed with Neonatal Abstinence Syndrome (NAS)
- **I** *(Intervention)* what non-pharmacological interventions and/or programs are most effective
- **C** *(Comparison)* compared to current interventions to
- **O** *(Outcome)* improve mother-infant dyad?

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Evidence Summary

- Little research directly addressed this clinical question.
- Most identified evidence pertained to non-pharmacological interventions but failed to measure the effect the interventions had on the mother-infant dyad.
- Numerous systematic reviews of lower level evidence (mostly retrospective studies)

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Care Model Interviews

- Ron Abrahams, SHEWAY Clinic (Vancouver)
- Daisy Goodman – Dartmouth-Hitchcock Perinatal Addiction Treatment Program
- Martha Velez – Center for Addiction and Pregnancy, Johns Hopkins Bayview Medical Center
- Evette Horton and Kim Andringa – UNC Horizons Program
- Eileen Costello, SOFAR Clinic at Boston Medical Center (Presentation)

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Interview Questions

- What does ideal care look like in the peripartum and newborn period in the context of opioid use? What are the barriers to achieving this ideal?
- What processes/procedures does site employ to facilitate the maintenance of the mother-infant dyad? What works well? What could be improved?
- What type of residential treatment is available in your region?
- How is mother supported in treatment through your program?
- Are you able to determine the retention of baby in care? (i.e. Are well child visits attended?)

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Ideal Care

- Immediate access to appropriate level of care that the woman is willing to accept
  - Clear pathway to get needs met at site of identification
- Care must be non-judgmental, no stigma
- Shared decision making, women need to be educated and aware of what to expect
- Full assessment of psychosocial and behavioral needs, other mental health needs, and plan with provider who can treat pharmacologically and address behavioral health challenge.
- Address parenting in context of trauma and addiction
- Home visiting services
- Integrated, wrap-around services for mother and child

Barriers/Challenges

- For women, deciding whether to leave children to obtain treatment is a challenge.
  - Need care that will take ALL children (adolescents included)
- Care is often not timely
  - Need residential care that can take people immediately with their children.
- No care for partner to receive treatment
- If not doing residential program, transportation is a big barrier
- Finding safe, stable, affordable housing
- Disseminating evidence-based practices to providers
- Overdose is an issue
  - Need to use harm reduction models including naloxone, needle exchange

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Models for Maintenance of Mother-Infant Dyad

- Office based outpatient treatment
- Parenting program
- “One-stop shopping” – Pediatric, OB/Primary Care, Addiction Care, Mental Health all one building/center
- Drop in Clinic Model
- Patient’s trust in clinic
- Step-Down model

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Residential Care

- Some allow older siblings to stay with mom along with baby (and some don't)
  - Have to keep mother and baby together in treatment.
- Clear indication of need for more residential programming
- For pts who can manage in weekly program co-location is beneficial
- Need to provide services to children

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Retention of Mother in Care

- Track retention through weekly continuing care group
- If no stigma and non-judgmental care, women feel very comfortable coming to clinic and stay
- Integrated program is best for retention, but not every woman wants to go to this
- After pregnancy, biggest drop in care is between 6 weeks and 3 months and then plateaus
  - Who discontinues? People with most severe disease; some transfer to other programs closer to them; mostly people who needed higher level of care than they can provide

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Retention of Baby

- Babies get a medical home through care center/organization's pediatric practice
- Primary care model – GPs see moms and babies, nurses do vaccinations
  - Obstetrics can provide moms contraception, but ideally should be primary care model
- Children can come to pediatric clinic can until they are 21

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Additional Considerations

- Anesthesia collaboration for appropriate pain management
- Need cost-benefit analysis for integrated care and to maximize Medicaid reimbursement
- Employ trauma-informed care
- Team effort

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SYSTEMS INVENTORY

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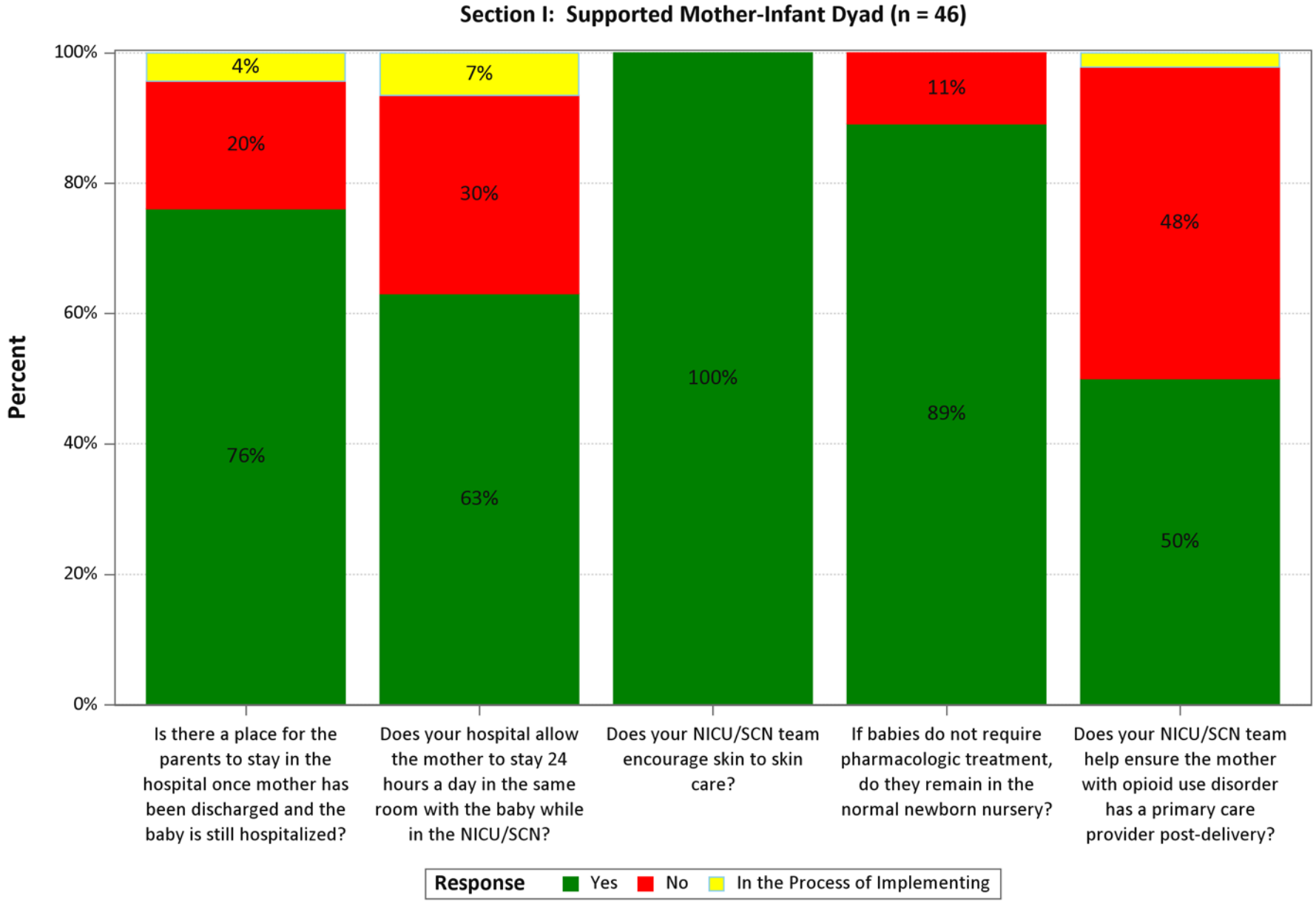
Section I: Supported Mother-Infant Dyad (n = 46)
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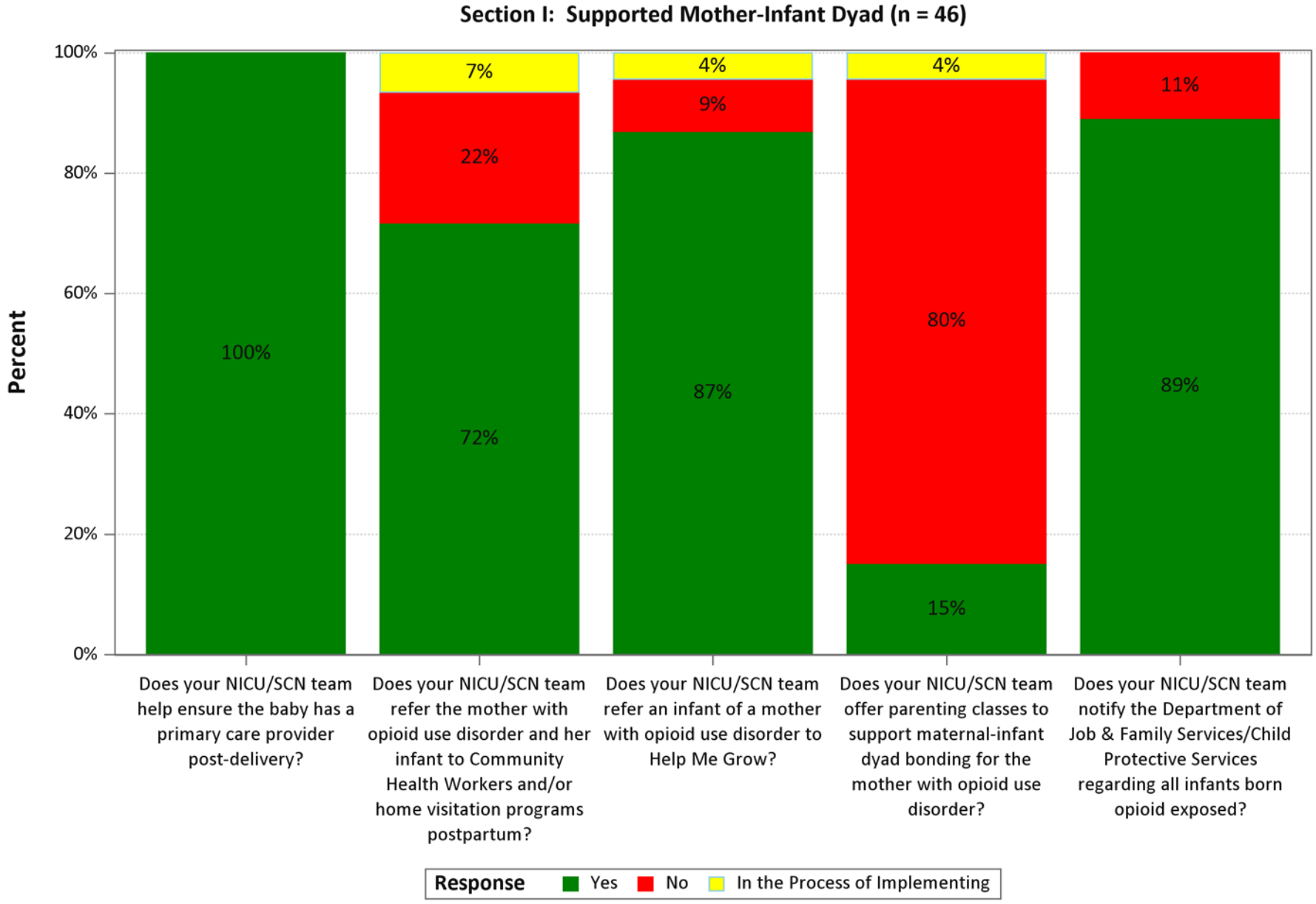
Is there a place for the parents to stay in the hospital once mother has been discharged and the baby is still hospitalized?
Does your hospital allow the mother to stay 24 hours a day in the same room with the baby while in the NICU/SCN?
Does your NICU/SCN team encourage skin to skin care?
If babies do not require pharmacologic treatment, do they remain in the normal newborn nursery?
Does your NICU/SCN team help ensure the mother with opioid use disorder has a primary care provider post-delivery?
Response
Yes
No
In the Process of Implementing

Barriers: 24-Hr Rooming-in

- Space/design/layout limited for bed or chairs
- No privacy/Open bay NICU/no single rooms
- Not current policy


Section I: Supported Mother-Infant Dyad (n = 46)
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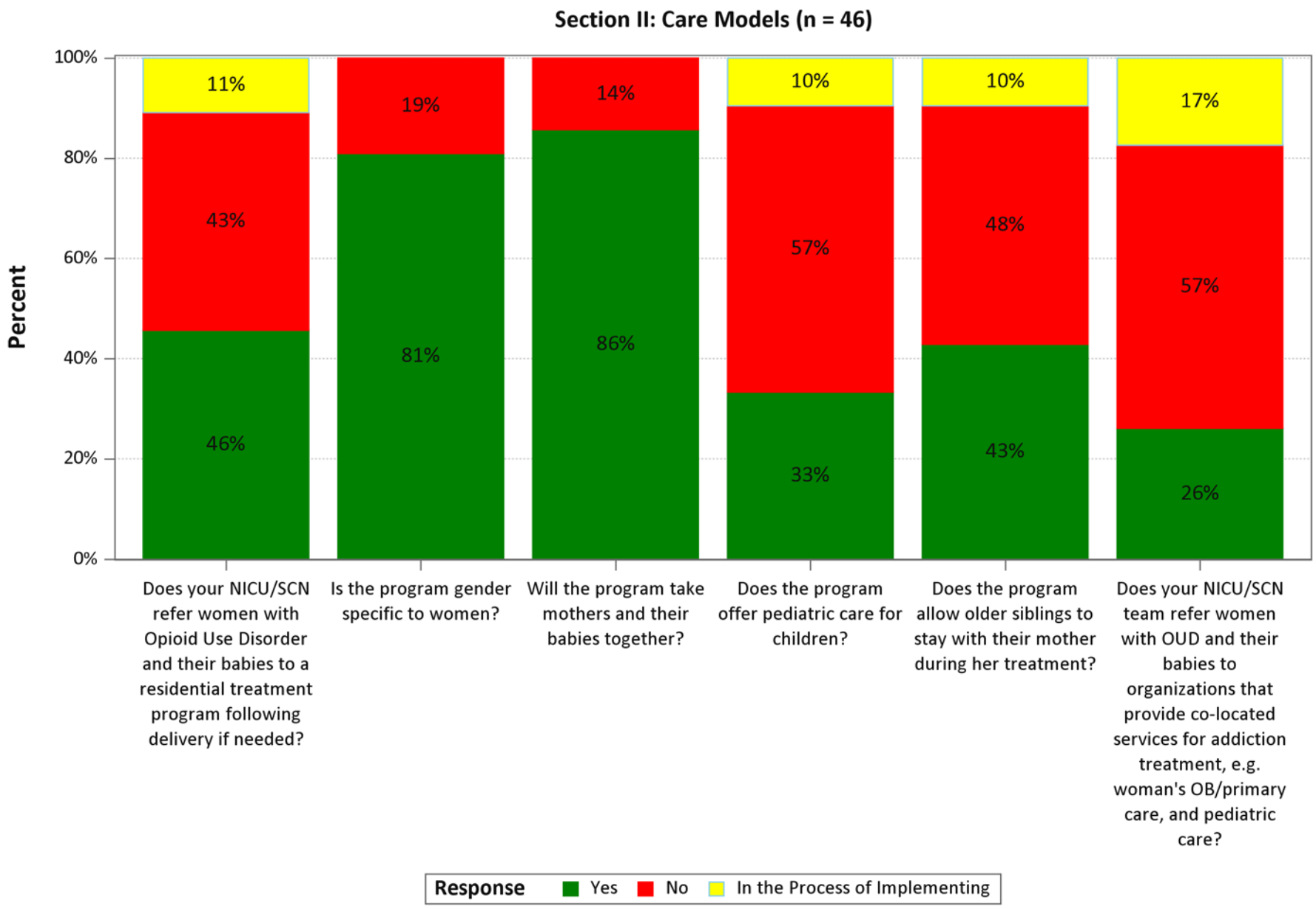
Does your NICU/SCN team help ensure the baby has a primary care provider post-delivery?
Does your NICU/SCN team refer the mother with opioid use disorder and her infant to Community Health Workers and/or home visitation programs postpartum?
Does your NICU/SCN team refer an infant of a mother with opioid use disorder to Help Me Grow?
Does your NICU/SCN team offer parenting classes to support maternal-infant dyad bonding for the mother with opioid use disorder?
Does your NICU/SCN team notify the Department of Job & Family Services/Child Protective Services regarding all infants born opioid exposed?
Response
Yes
No
In the Process of Implementing


Section II: Care Models (n = 46)
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Does your NICU/SCN refer women with Opioid Use Disorder and their babies to a residential treatment program following delivery if needed?
Is the program gender specific to women?
Will the program take mothers and their babies together?
Does the program offer pediatric care for children?
Does the program allow older siblings to stay with their mother during her treatment?
Does your NICU/SCN team refer women with OUD and their babies to organizations that provide co-located services for addiction treatment, e.g. woman's OB/primary care, and pediatric care?
Response
Yes
No
In the Process of Implementing

Barriers: Referral Residential or Co-Located Care

- Limited/No Availability/No local services/Not enough resources in community
- Not NICU's job/Mother not patient (Social service/case management makes referral)
- Social Services and Children's Services become involved/CPS takes over case
- Unaware of any programs
- Not a delivery hospital
- Obstetrician, Social Worker workload
- Pediatric care and OB care are not centrally located

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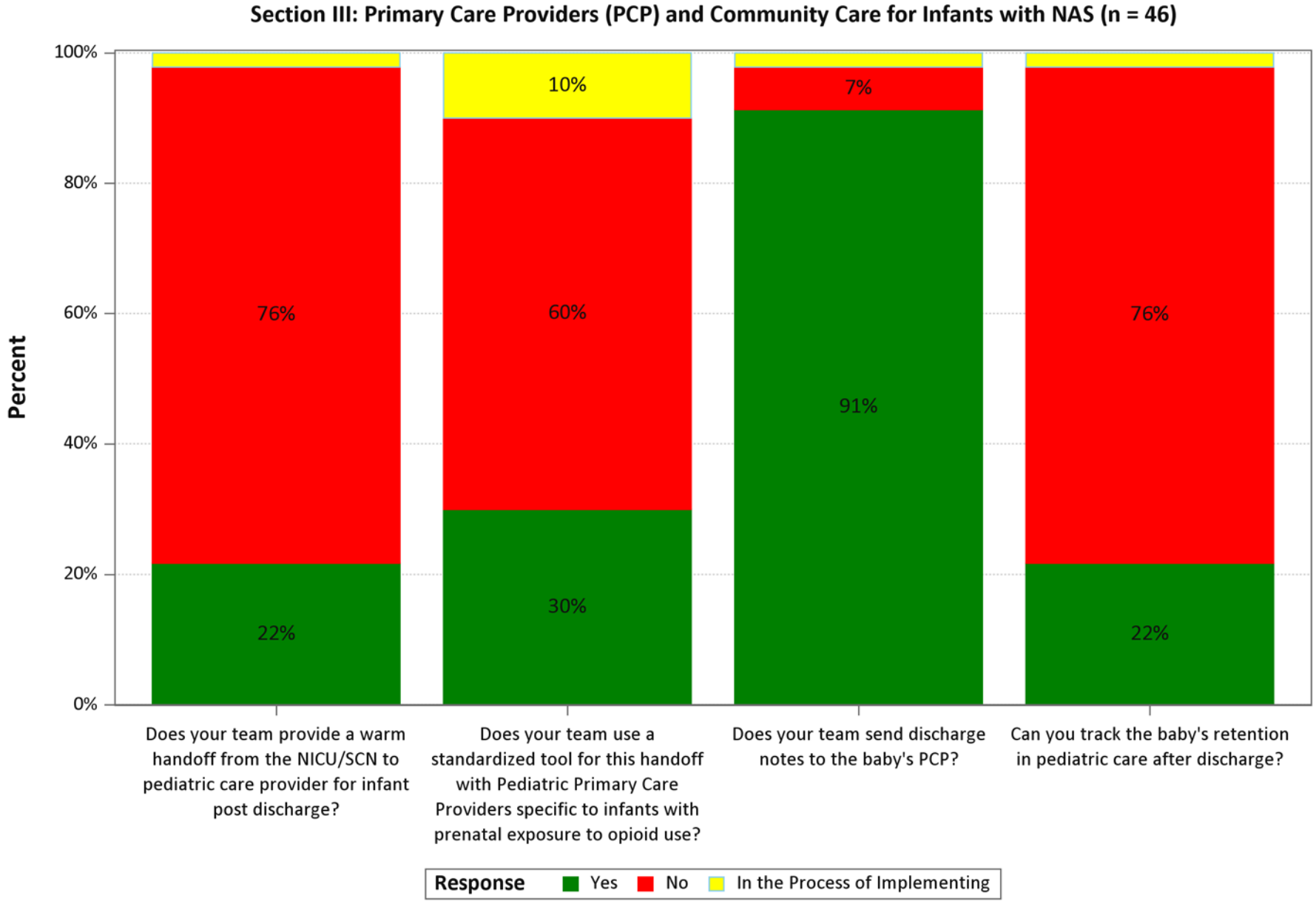
Section III: Primary Care Providers (PCP) and Community Care for Infants with NAS (n = 46)
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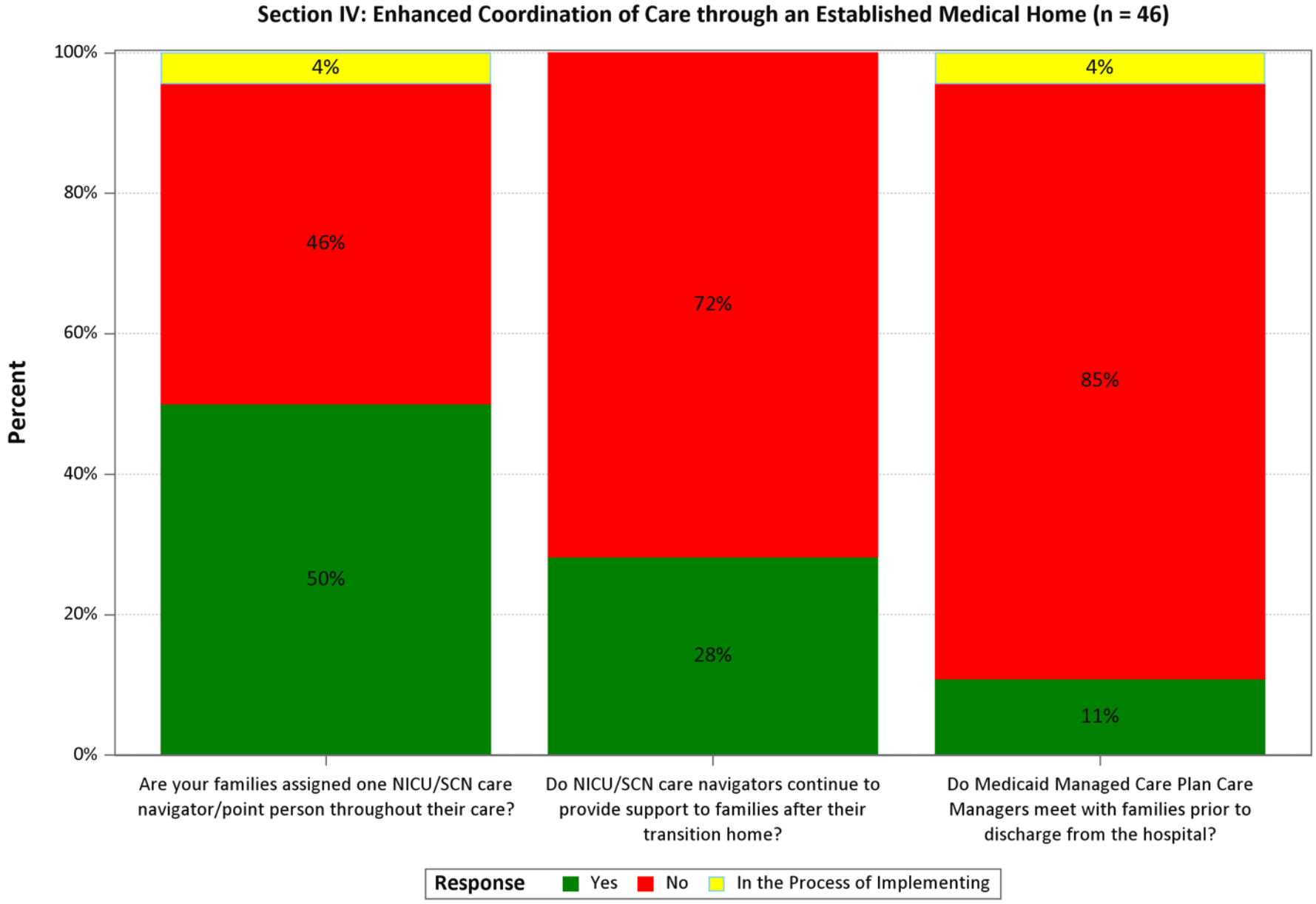
Does your team provide a warm handoff from the NICU/SCN to pediatric care provider for infant post discharge?
Does your team use a standardized tool for this handoff with Pediatric Primary Care Providers specific to infants with prenatal exposure to opioid use?
Does your team send discharge notes to the baby's PCP?
Can you track the baby's retention in pediatric care after discharge?
Response
Yes
No
In the Process of Implementing


Section IV: Enhanced Coordination of Care through an Established Medical Home (n = 46)
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Are your families assigned one NICU/SCN care navigator/point person throughout their care?
Do NICU/SCN care navigators continue to provide support to families after their transition home?
Do Medicaid Managed Care Plan Care Managers meet with families prior to discharge from the hospital?
Response
Yes
No
In the Process of Implementing

Top Barriers to Ideal Care

- Lack of resources/programs in community for mom and baby
- Space/layout of the SCN (open unit, no single beds or place for mom to stay with baby) to encourage rooming-in
- Engagement of mothers/unwilling to stay 24 hours with their infant/visitation sporadic by the mothers
- Stigma/lack of education/personal bias
- Staffing and resources

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Top Barriers to Ideal Care (Cont.)

- Adequate partnership between the patient, health care plan, department of health/state agencies
- Lack of exposure to mothers antepartum
- Lack of ability for mother to get treatment at same time as infant
- “The mother isn't our patient”
- Pain control and what can or cannot be done for mother
- Trust from the mothers for the Healthcare team
- Safety of infant at discharge and of infant and mother while in mother's postpartum room

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Poll Question: Improvement

- What areas of improvement would be your top two priorities for the maternal-infant dyad in the context of opioid use?
  - 24 Hour Rooming-in
  - Ensuring continuity of care post-discharge (pediatric)
  - Ensuring continuity of care post-discharge (maternal)
  - Parenting classes to support maternal-infant dyad bonding
  - Referral to residential and/or co-located services
  - Warm handoff from NICU/SCN to pediatric provider
  - Family meeting with MCP Care Managers prior to discharge

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Poll Question: Barriers

- What are your top two barriers to ideal care for the maternal-infant dyad?
  - Lack of resources/programs in community for mom and baby
  - Space/layout of the NICU/SCN
  - Staffing and resources
  - Engagement and/or trust from mothers
  - Stigma/lack of education for staff
  - Adequate partnership between the patient, health care plan, department of health/state agencies

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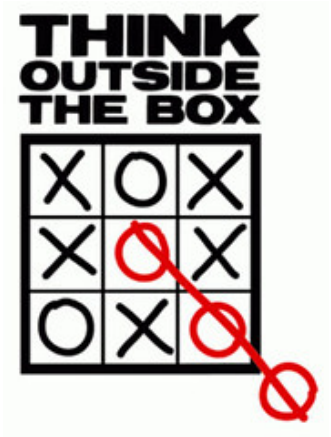
Discussion/Questions

- What works well to support maternal-infant dyad care at your site?
- Why did you choose your top priority area for improvement or barrier to ideal care?
- Thinking outside the box…what would be an ideal way to support the mother-infant dyad?



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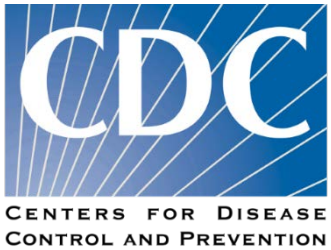
It takes a village…



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The views expressed in this meeting are solely those of the authors and do not represent the views of state or federal Medicaid programs.