Neonatal Opioid Withdrawal Syndrome Initiative

Action Period Call
September 28, 2022
12:00 – 1:00 PM CT
Welcome

- Please type your name and organization you represent in the chat box and send to “Everyone”
- Please also do for all those in the room with you viewing the webinar.
- Attendees are automatically muted to reduce background noise.
- You may enter questions/comments in the “chat” box during the presentation. We will have Q&A session at the end.
- Slides will be available via email and at https://www.alpqc.org/initiatives/nows/
- We are now recording
Agenda

Welcome & Updates  12:00 – 12:05

Do Less Harm: Stigma & Structure in Pregnancy and Parenting  12:05 – 12:45

Q&A  12:45 – 12:55

Next Steps  12:55 – 1:00
Updates

Welcome new member of the team!
Britta Cedergren, MPH, MPA
Program Director
Do Less Harm: Stigma & Structure in Pregnancy and Parenting

Mishka Terplan, MD, MPH, FACOG, DFASAM
Medical Director, Friends Research Institute
Do Less Harm:
Stigma & Structure in Pregnancy & Parenting

Mishka Terplan MD MPH FACOG DFASAM
Medical Director and Senior Research Scientist
Friends Research Institute
Adjunct Faculty and Substance Use Warmline Clinician
University of California, San Francisco
Shared Values

People who use drugs should be treated with dignity and respect when they seek health care.

Parenting is hard, and we support non-punitive approaches that allows the parent, infant, dyad, and family thrive together.
She Was Addicted and Her Son. She Wanted Freedom.

Lindsey Jarrett is now sober and on solid grounds, but her son remains in foster care.

By Jeneen Interlandi

Ms. Interlandi is a member of the editorial board.

Jan. 13, 2019

Lindsey Jarrett's son, Brayden, was a year old when the Child Protective Services of Dinwiddie, Va., took him to live with strangers. There are things about the months surrounding that moment that Ms. Jarrett can't remember — heroin has a way of erasing time. But this much is still etched in her mind: how he screamed and sobbed, the way his baby fists clutched at the nape of her shirt, the feel of his tiny body pressed so desperately against hers that the two had to be pried apart.

Some people should not be allowed to have children. I have no sympathy for her. You don't care about the child. Period.

There are consequences of being a junkie. You just don't return to life expecting all you had before.

The state needs to let the children from junkie parents as heroin is a tough addiction and one that she'll probably fail to beat based on statistics.
Stigma: the experience of being “deeply discredited” or marked due to one’s “undesired differentness.” To be stigmatized is to be held in contempt, shunned or rendered socially invisible because of a socially disapproved status.
Stigma Greater for Drug Addiction than Mental Illness
Stigma

Discrimination and Prejudice

Punishment
States where pregnant people have been prosecuted for drug use

The first known indictment of an American woman for drug use in pregnancy was in California in 1977.

Women prosecuted for drug use during pregnancy in all states but: DE, IO, ME, RI, VT

https://projects.propublica.org/graphics/maternity-drug-policies-by-state
“Whatever they do, I’m her comfort, I’m her protector.”
How the foster system has become ground zero for the U.S. drug war.
State Policies on Substance Use during Pregnancy

<table>
<thead>
<tr>
<th>Policy</th>
<th>Number of States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Use Considered Child Abuse</td>
<td>24+DC</td>
</tr>
<tr>
<td>Substance Use Grounds for Civil Commitment</td>
<td>3</td>
</tr>
<tr>
<td>Mandatory Reporting</td>
<td>25+DC</td>
</tr>
<tr>
<td>Targeted Programs for Pregnant Women</td>
<td>19</td>
</tr>
<tr>
<td>Pregnant Women Given Priority Access</td>
<td>17+DC</td>
</tr>
<tr>
<td>Pregnant Women Protected from Discrimination</td>
<td>10</td>
</tr>
</tbody>
</table>

Guttmacher Institute August 2022
Punitive Policies Related to Substance Use in Pregnancy Proliferated

Punitive Policies Associated with:
Increased Odds of Neonatal Abstinence Syndrome
Increased Odds of Low Birth Weight
Increased Odds of Preterm Delivery
Decreased Odds of any Prenatal Care and APGAR 7+

3. Carroll, The harms of punishing substance use during pregnancy. UDP, 2021
Punitive Policies Related to Substance Use in Pregnancy Proliferated

US Drug Policy: Less Punitive
State Policies Drugs + Pregnancy: More Punitive
Driven by Increasing Restrictive Reproductive Policies

1. Roberts, et al., *Forty years of state alcohol and pregnancy policies in the USA: best practices for public Health or efforts to restrict Women’s reproductive rights?* Alcohol and Alcoholism, 2017
2. Paltrow, *The war on drugs and the war on abortion: Some initial thoughts on the connections, intersections and effects.* Reproductive Health Matters, 2002
“Test and Report”: Provider Culpability

- Most reports (<1yr) come from hospitals and healthcare providers (HHS 2020)
- Positive test identifies exposure:
  - Not indication of health or ill-health in newborn
  - Not mentioned in AAP discharge criteria
  - Not injury or harm (AAP 2015)
- “Policies that require practitioners to respond to substance use and substance use disorder in a primarily punitive way, require health care providers to function as agents of law enforcement.” (ACOG 2020)

AAP 2015 https://pediatrics.aappublications.org/content/135/5/948
In place of punishment:
Questions to ask ourselves

• Why would a pregnant person use drugs?

• Are there alternatives to punishment?

• How can we do less harm?
In place of punishment:
Questions to ask ourselves

• Why would a pregnant person use drugs?

• Are there alternatives to punishment?

• How can we do less harm?
What happens when people who use drugs get pregnant?

National Survey Drug Use and Health 2015/2016 Past Month Use Data
All pregnant people are motivated to maximize their health and that of their baby-to-be.

Those who can’t quit or cut back – likely have a substance use disorder.

Continued use in pregnancy is pathognomonic for addiction.
The Pregnancy Box

- Addiction Life Course
- Reproductive Health Life Course
Punishment of Pregnant People Who Use Drugs

• Punishment for Addiction
  - Unethical, immoral and ineffective to punish people for the illness of addiction

• Punishment for Reproduction
  - Pregnancy increases the likelihood of prosecution, and enhances the penalty upon conviction
  - Drug use is misdemeanor while distribution/child abuse is felony
  - Pregnant people receive harsher sentences men or non-pregnant women for drug-related convictions
In place of punishment: Questions to ask ourselves

• Why would a pregnant people use drugs?

• Are there alternatives to punishment?

• How can we do less harm?
Alternative to Punishment: Addiction is a Medical and Public Health not Criminal Legal Issue

- Addiction is a Chronic Medical Condition
- Treatment Works
- Recovery is Possible
Methadone maintenance during pregnancy: Pregnancy, birth, and neonate characteristics

M. E. Straus, Ph.D.
M. Andresko, M.A.
J. C. Stryker, M.D.
J. N. Wardell, M.D.
L. D. Dunkel, B.A.
Detroit, Michigan

The records of 72 pregnant methadone addicts and 72 nonaddicted granzidans, all receiving prenatal care, were examined to determine the degree of obstetric risk associated with low dose methadone maintenance and dimensions of difference between addicted and nonaddicted newborn infants. Rates of pregnancy illness, pregnancy complications, as well as labor and delivery characteristics, did not differ between groups. Low birth weight (≤ 2,500 grams) was not more common among addicted infants, although neonatal weight loss was greater in this group. Most addicted newborns were symptomatic, but pharmacologic treatment was required in only 30 per cent of the cases. Low-dose methadone maintenance in conjunction with comprehensive prenatal care appears to reduce obstetric risk to a level comparable with that of nonaddicted women of similar sociomedical circumstances.

Narcotic Dependency in Pregnancy

Methadone Maintenance Compared to Use of Street Drugs

Barry Stimmel, MD, Karlis Adamsons, MD, PhD

1976

• The course of pregnancy and delivery in 28 women under closely supervised methadone maintenance (group 1) was compared with that of 57 women using heroin or methadone under less controlled circumstances (group 2) and with that of 30 women free of mood-altering medications (group 3). Women in group 1 had the lowest incidence of coexisting medical problems (P=.025), with an incidence of fetal distress not statistically different from that of women in group 3. Infants born to women in group 2 had the highest incidence of fetal distress (P < .05), with four congenital defects, one stillbirth, and one neonatal death. Symptoms characteristic of narcotic withdrawal occurred with similar frequency in group 1 and 2 infants, appearing earlier in children whose mothers were users of heroin.

These findings indicate that maintenance of the pregnant addict under closely supervised methadone therapy is compatible with an uneventful pregnancy and birth of a healthy infant whose withdrawal symptoms in the neonatal period are readily controllable.

(JAMA 235:1121-1124, 1976)
Core Principle of PNC: Optimize maternal health via chronic disease management

Treated vs. Untreated Addiction

<table>
<thead>
<tr>
<th></th>
<th>No Addiction</th>
<th>Treated Addiction</th>
<th>Untreated Addiction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preterm Birth</td>
<td>8.7%</td>
<td>10.1%</td>
<td>19.0%</td>
</tr>
<tr>
<td>Low Birthweight</td>
<td>5.5%</td>
<td>7.8%</td>
<td>18.0</td>
</tr>
<tr>
<td>Fetal Death</td>
<td>0.4%</td>
<td>0.5%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Neonatal Mortality</td>
<td>0.4%</td>
<td>0.4%</td>
<td>1.2%</td>
</tr>
<tr>
<td>Post Neonatal Mortality</td>
<td>0.05%</td>
<td>0.03%</td>
<td>0.1%</td>
</tr>
</tbody>
</table>
Most People Receive no Treatment in Pregnancy

Table 3
Past year substance use disorder treatment receipt among reproductive age women in need of treatment.

<table>
<thead>
<tr>
<th>Substance use disorder diagnosis</th>
<th>Total*</th>
<th>Not pregnant nor parenting</th>
<th>Pregnant†</th>
<th>Parenting</th>
<th>P values‡</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>1st trimester</td>
<td>2nd trimester</td>
<td>3rd trimester</td>
</tr>
<tr>
<td>Any past year substance use disorder treatment need*</td>
<td>9.3% (8.4–10.2)</td>
<td>8.8% (7.7–9.8)</td>
<td>12.8% (8.7–16.9)</td>
<td>12.5% (7.3–17.7)</td>
<td>9.4% (4.7–14.0)</td>
</tr>
<tr>
<td>Alcohol use disorder</td>
<td>7.4% (6.6–8.3)</td>
<td>6.8% (5.9–7.7)</td>
<td>11.8% (7.2–16.5)</td>
<td>11.7% (5.8–17.6)</td>
<td>9.0% (3.3–14.7)</td>
</tr>
<tr>
<td>Illicit drug use disorder†</td>
<td>17.1% (15.5–18.7)</td>
<td>17.0% (14.8–19.2)</td>
<td>21.8% (13.9–29.6)</td>
<td>26.0% (15.1–36.8)</td>
<td>13.2% (5.4–21.0)</td>
</tr>
<tr>
<td>Opioid use disorder*</td>
<td>23.6% (18.9–28.2)</td>
<td>31.1% (27.0–35.1)</td>
<td>34.7% (20.7–48.7)</td>
<td>54.2% (30.2–78.1)</td>
<td>20.0% (3.5–36.5)</td>
</tr>
</tbody>
</table>

Martin, 2020, DAD
Racial Inequities in MOUD

<table>
<thead>
<tr>
<th>Variable</th>
<th>White NH</th>
<th>Black NH</th>
<th>Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methadone Dose</td>
<td>144.9</td>
<td>97.5</td>
<td>129.8</td>
</tr>
</tbody>
</table>

Table 2. Adjusted and Unadjusted Odds Ratios for Use of Medication and Type of Medication for Pregnant Women With Opioid Use Disorder

Racial inequity in methadone dose at delivery in pregnant women with opioid use disorder

Emily W. Rosenthal, Vanessa L. Short, Yuri Cruz, Cecily Barber, Jason K. Baxter, Diane J. Abatemarco, Amanda R. Roman, Dennis J. Hand

Department of Obstetrics & Gynecology, Thomas Jefferson University, Philadelphia, PA, United States of America

Department of Psychiatry & Human Behavior, Thomas Jefferson University, Philadelphia, PA, United States of America

Journal of Substance Abuse Treatment 131 (2021) 104942

Full model without race/ethnicity: 0.09, 0.06

Adjusted for race/ethnicity: 0.39 (0.30-0.51), 0.37 (0.28-0.49), 0.44 (0.36-0.53), 0.42 (0.35-0.52), 0.26 (0.18-0.37), 0.24 (0.17-0.35), 0.36 (0.28-0.46), 0.34 (0.27-0.44), 0.44 (0.30-0.66), 0.44 (0.30-0.65), 0.65 (0.50-0.85), 0.64 (0.48-0.83), 0.37 (0.25-0.55), 0.35 (0.24-0.50), 0.36 (0.28-0.47), 0.34 (0.26-0.45), 0.33 (0.25-0.46), 0.32 (0.25-0.41), 0.31 (0.24-0.42), 0.30 (0.23-0.41)
OBGYN Lacks Capacity to Treat OUD

<table>
<thead>
<tr>
<th>Year</th>
<th>N (%) X Waivered OBGYNs in US</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>181 (0.4%)</td>
</tr>
<tr>
<td>2020</td>
<td>560 (1.8%)</td>
</tr>
</tbody>
</table>

Comprehensive treatment and medication are rare and unavailable for most pregnant people with SUD.
CONCLUSIONS OF THE NATIONAL ACADEMIES COMMITTEE

1. Opioid use disorder is a treatable chronic brain disease

2. FDA-approved medications to treat opioid use disorder are effective and save lives

3. Long-term retention on medication for opioid use disorder is associated with improved outcomes

4. A lack of availability or utilization of behavioral interventions is not a sufficient justification to withhold medications to treat opioid use disorder

5. Most people who could benefit from medication-based treatment for opioid use disorder do not receive it, and access is inequitable across subgroups of the population

6. Medication-based treatment is effective across all treatment settings studied to date

7. Confronting the major barriers to the use of medications to treat opioid use disorder is critical to addressing the opioid crisis
Recovery is the Goal of Treatment

- Recovery is more than abstinence
- Building a life of integrity
- Connection to others
- Purpose
- Serenity
- Recovery is fully compatible with the use of medications
In place of punishment:
Questions to ask ourselves

• Why would a pregnant woman use drugs?

• Are there alternatives to punishment?

• How can we do less harm?
Do Less Harm: Language is Important

HELLO, I AM

Not my addiction

Research paper
Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms
John F. Kelly*, Cassandra M. Westerhoff
Center for Addiction Medicine, Department of Psychiatry, Massachusetts General Hospital, 60 Stanord Street, Boston, MA 02114, United States

"Substance Abuser"
Mr. Williams is a substance abuser and is attending a treatment program through the court. As part of the program Mr. Williams is required to remain abstinent from alcohol and other drugs. He has been compliant with program requirements, until one month ago, when he was found to have two positive urine toxicology screens which revealed drug use and a breathalyzer reading which revealed alcohol consumption. Within the past month there was a further urine toxicology screen revealing drug use. Mr. Williams has been a substance abuser for the past few years. He now awaits his appointment with the judge to determine his status.

"Substance Use Disorder"
Mr. Williams has a substance use disorder and is attending a treatment program through the court. As part of the program Mr. Williams is required to remain abstinent from alcohol and other drugs. He has been compliant with program requirements, until one month ago, when he was found to have two positive urine toxicology screens which revealed drug use and a breathalyzer reading which revealed alcohol consumption. Within the past month there was a further urine toxicology screen revealing drug use. Mr. Williams has had a substance use disorder for the past few years. He now awaits his appointment with the judge to determine his status.

Figure 1 Randomly assigned study vignettes describing the same individual as either a “substance abuser” or as “having a substance use disorder”.
Use Language That:

1. Respects the worth and dignity of all persons – “People-first language”
2. Focuses on the medical nature of SUD and treatment
3. Promotes the recovery process
4. Avoids perpetuating negative stereotypes and biases through use of slang and idioms

https://www.recoveryanswers.org/addiction-ary/
<table>
<thead>
<tr>
<th>Stigmatizing language</th>
<th>Preferred language</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addict, junkie, abuser</td>
<td>Person in active addiction</td>
</tr>
<tr>
<td></td>
<td>Person with a substance use disorder</td>
</tr>
<tr>
<td></td>
<td>Person in recovery</td>
</tr>
<tr>
<td>Addicted baby</td>
<td>Neonate with in-utero exposure to [substance]</td>
</tr>
<tr>
<td></td>
<td>Neonatal abstinence syndrome</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>Substance use or misuse</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder</td>
</tr>
<tr>
<td>Clean or sober</td>
<td>Abstantient</td>
</tr>
<tr>
<td></td>
<td>SUD in remission</td>
</tr>
<tr>
<td></td>
<td>Testing “negative” for [substance]</td>
</tr>
<tr>
<td>Dirty</td>
<td>Using [substance]</td>
</tr>
<tr>
<td></td>
<td>Testing “positive” for [substance]</td>
</tr>
<tr>
<td>Replacement or substitution therapy, medication-assisted treatment</td>
<td>Medication for opioid use disorder (MOUD)</td>
</tr>
<tr>
<td></td>
<td>Treatment</td>
</tr>
<tr>
<td>Getting or being high</td>
<td>Intoxicated</td>
</tr>
<tr>
<td></td>
<td>Under the influence of [substance]</td>
</tr>
<tr>
<td>Shooting up</td>
<td>Intravenous or injection drug use</td>
</tr>
<tr>
<td>Relapse</td>
<td>Return to use</td>
</tr>
<tr>
<td></td>
<td>SUD recurrence</td>
</tr>
</tbody>
</table>
Resisting Stigma and Discrimination By Speaking

Trust-Building through clinical discussion

• What is the most important thing to you about treatment or recovery?
• What do you know about methadone?
• Do you have any fears or concerns from previous treatment experiences?
• What do you need to feel safe?
• What are you looking for in a provider?
• How do you feel your care is going so far?
Build Trust by Practicing Empathy

• Use people’s names
• Smile
• Listen
• Don't interrupt people
• Tune in to non-verbal communication
• Be fully present when you are with people
• Take a personal interest in people
First do no harm: practitioners’ ability to ‘diagnose’ system weaknesses and improve safety is a critical initial step in improving care quality

Mike English, Muthoni Ogola, Jalembe Aluvaala, Edith Gicheha, Grace Irimu, Jacob McKnight, Charles A Vincent

ABSTRACT
Healthcare systems across the world and especially those in low-resource settings (LRS) are under pressure and one of the first priorities must be to prevent any harm done while trying to deliver care. Health care workers, especially department leaders, need the diagnostic abilities to identify local safety concerns and design actions that benefit their patients. We draw on concepts from the safety sciences that are less well-known than mainstream quality improvement techniques in LRS. We use these to illustrate how to analyse the complex interactions between resources and tools, the organisation of tasks and the norms that

What is already known on this topic?

- Harm resulting from unsafe care is common and results in significant adverse health and economic consequences in high-income countries.
- Efforts to prevent or reduce harms often focus on identifying errors so that their specific causes can be addressed.
- More recently, attention has been turned to considering how harms arise as a product of complex interactions in systems.
**Policy Checklist: Screening For Substance Use Disorder**

Drug addiction affects all racial, ethnic, and sociodemographic groups. Universal screening for substance use disorder (SUD) with a standardized, evidence-based screening tool should be implemented at all locations that provide medical care to pregnant and birthing persons. Screening all birthing persons, regardless of substance use history, minimizes the potential for providers relying on subjective risk factors to determine who should be screened and may also decrease the stigma associated with SUD and screening.

Birthing facilities should include the following elements in their SUD/OUD screening-related policies, guidelines, and procedures.

<table>
<thead>
<tr>
<th>addressed in policy?</th>
<th>best practice to include in policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>screening, assessment and level of care determination</td>
<td></td>
</tr>
<tr>
<td>If all patients, regardless of history of substance use/reuse, will be screened.</td>
<td></td>
</tr>
<tr>
<td>• Clarify which tool will be used (4PS, 4PS Plus, NIDA Quick Screen, CRAFT (Birthing persons 12-26))</td>
<td></td>
</tr>
<tr>
<td>Whenever and where patients will be screened.</td>
<td></td>
</tr>
<tr>
<td>• For example: Screening is performed privately, at least once a trimester and upon delivery admission.</td>
<td></td>
</tr>
<tr>
<td>Process for screening, including:</td>
<td></td>
</tr>
<tr>
<td>• How it will be administered (print version, computer version, self-administered or administered by staff member)</td>
<td></td>
</tr>
<tr>
<td>• Who administers (which staff members)</td>
<td></td>
</tr>
<tr>
<td>• How/when results will be reviewed and documented</td>
<td></td>
</tr>
<tr>
<td>What happens when there is a positive screen related to: establishing a diagnosis</td>
<td></td>
</tr>
<tr>
<td>• For example: use a validated verbal assessment tool to establish the diagnosis and severity of SUD</td>
<td></td>
</tr>
<tr>
<td>• Possible tools: AUDIT-C (alcohol specific), ASSIST (Alcohol, Smoking, and Substance Involvement Screening Test), and DAST-10 (drug use)</td>
<td></td>
</tr>
<tr>
<td>What happens when there is a positive screen related to: brief intervention and referral to treatment</td>
<td></td>
</tr>
<tr>
<td>• Should include who intervenes, how they intervene, where and what level of care the patient will be referred, and who completes the referral</td>
<td></td>
</tr>
<tr>
<td>• Should include harm reduction strategies</td>
<td></td>
</tr>
<tr>
<td>• Should include process for warm handoffs, when appropriate</td>
<td></td>
</tr>
<tr>
<td>What happens when there is a positive screen related to: polysubstance use</td>
<td></td>
</tr>
<tr>
<td>• Patient education and referral to appropriate resources</td>
<td></td>
</tr>
<tr>
<td>What happens when there is a positive screen related to: reporting to DCFS</td>
<td></td>
</tr>
<tr>
<td>• Who reports and when</td>
<td></td>
</tr>
<tr>
<td>• How patients are informed of reporting and next steps</td>
<td></td>
</tr>
<tr>
<td>How patient autonomy, confidentiality, and integrity or patient-physician relationship is protected (to the extent allowable by laws regarding disclosure or substance use disorder).</td>
<td></td>
</tr>
</tbody>
</table>

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**Top 5 Do No Harm Checklist**

1. Check your systems in which individuals navigate getting care. Change adversarial systems into supportive spaces.

2. Check the entire care team. From the front desk to physicians, everyone who interacts with patients should have an understanding of what harm is, why understanding it is important, and how to prevent it.

3. Check your biases. Understand that everyone is biased, including you. Understanding and addressing your own biases is a life-long journey.

4. Check each other. Sometimes the person causing the harm does not realize s/he is doing it.

5. Check your listening skills. Believe what people are telling you and know that listening is key to understanding and providing respectful care.

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*Developed through DC Equity Action Lab at DC Primary Care Association. Based on the Top 5 Do No Harm list created by Danyi Marcelle, CNM, MS, FACNM, Director of Midwifery at Community of Hope and Family Health and Birth Center. Contact the DC Primary Care Association for the full Do No Harm Guide.*
Evidence-Based AND Person-Centered
Do Less Harm

• **Evidence-Based**: Grounded in Science
  – Harms of illicit substances exaggerated; Effects of licit substances minimized
  – Overstate the importance of intrauterine exposure; Neglect the role of the care-giving environment

• **Person-Centered**: Ethical and Grounded in Human Rights
  – Reproductive Health as a Human Right - Right to determine whether and when to become pregnant, and raise children in safe and sustainable communities
  – Support autonomy and maternal subjectivity in decision making surrounding pregnancy
  – Remain attuned to the unique demands we place on pregnant and parenting people, their bodies and their minds
Thank You

Mishka Terplan       Mterplan@friendsresearch.org

Substance Use Warmline
Peer-to-Peer Consultation and Decision Support
10 am – 6 pm EST Monday - Friday
855-300-3595

Free and confidential consultation for clinicians from the Clinician Consultation Center at San Francisco General Hospital focusing on substance use in primary care.
Resources

• Buprenorphine waiver training for OBGYNs ASAM
  https://elearning.asam.org/products/treatment-of-opioid-use-disorder-course-obgyn-focus#tab-product_tab_overview

• ASAM buprenorphine mini-course
  https://elearning.asam.org/p/BupMini_2021#tab-product_tab_overview
Please feel free to **unmute** and ask questions

You may also enter comments or questions in the "chat" box
Next Steps

- Establish team meeting schedule (at least monthly)
  - Review NOWS toolkit, data collection forms, develop plan for data collection, discuss team roles.

- Newly enrolled teams:
  - Submit baseline survey if have not done so already.

- Update your NOWS Team Roster
  - [alpqc.org/initiatives/nows](http://alpqc.org/initiatives/nows) under “Key Documents” menu.
Important Dates

**Data Portal Office Hours:**

- September 27: 12:00 – 1:30 PM
- September 29: 8:30 – 10:00 AM

*Let us know if you did not receive the zoom link*

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**Reporting Due Dates:**

- September 30, 2022
  - Baseline (Current State) data - for April, May, June, July 2022

- October 15, 2022
  - Monthly data - for August 2022; normally due on last day of month
  - Quarterly data - for July-September 2022; normally due on last day of quarter

- October 31, 2022
  - Monthly data - for September 2022
    - Resume regular monthly reporting schedule: reporting on last day of the month
<table>
<thead>
<tr>
<th>Process &amp; Outcome Measures</th>
<th>Measurement Period</th>
<th>Reporting Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Did the infant have evidence of opioid withdrawal?</td>
<td>April, May, June, July 2022</td>
<td>September 30, 2022</td>
</tr>
<tr>
<td>B. Was a non-pharmacologic guideline used throughout the infant’s hospitalization?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Did infant receive pharmacologic treatment?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. If infant received pharmacologic treatment, for how many days did the infant receive treatment (Birth is day “0”)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. How many days old was the infant at discharge (Birth is day “0”)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Was a Collaborative Discharge Plan completed prior to discharge?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. If not born at your facility, how many days old was infant when transfer was received?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H. Was the infant readmitted for any cause within 10 days of discharge?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Was the patient on Medication for Opioid Use Disorder (MOUD)? (e.g. on prescribed methadone/Subutex/etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Was the patient referred to addiction services prior to maternal discharge?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Was Narcan counseling documented in the medical record prior to patient discharge?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Find data forms, including ICD-10 codes, on our website at [www.alpqc.org/initiatives/nows](http://www.alpqc.org/initiatives/nows), under the “Data Resources” menu.
# Data Reporting

## MONTHLY Measures

<table>
<thead>
<tr>
<th>Process &amp; Outcome Measures</th>
<th>Measurement Period</th>
<th>Reporting Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. A: Did the infant have evidence of opioid withdrawal?</td>
<td>Aug 2022</td>
<td>Oct 15 2022*</td>
</tr>
<tr>
<td>B. Was a non-pharmacologic guideline used throughout the infant’s hospitalization?</td>
<td>Sep 2022</td>
<td>Oct 31, 2022</td>
</tr>
<tr>
<td>C. C: Did infant receive pharmacologic treatment?</td>
<td>Oct 2022</td>
<td>Nov 30, 2022</td>
</tr>
<tr>
<td>D. D: If infant received pharmacologic treatment, for how many days did the infant receive treatment (Birth is day “0”)</td>
<td>Nov 2022</td>
<td>Dec 31, 2022</td>
</tr>
<tr>
<td>E. How many days old was the infant at discharge (Birth is day “0”)</td>
<td>Dec 2022</td>
<td>Jan 31, 2023</td>
</tr>
<tr>
<td>F. Was a Collaborative Discharge Plan completed prior to discharge?</td>
<td>...</td>
<td>...</td>
</tr>
<tr>
<td>G. If not born at your facility, how many days old was infant when transfer was received?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H. Was the infant readmitted for any cause within 10 days of discharge?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Neonatal

### Obstetrical

| A. Was the patient on Medication for Opioid Use Disorder (MOUD)? (e.g. on prescribed methadone/ Subutex/etc.) | | |
| B. Was the patient referred to addiction services prior to maternal discharge? | | |
| C. Was Narcan counseling documented in the medical record prior to patient discharge? | | |

* Normally data due on last day of the following month.

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## Data Reporting

### QUARTERLY Measures

<table>
<thead>
<tr>
<th>Structure Measure</th>
<th>Measurement Period</th>
<th>Reporting Due*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Hospital has implemented education practices for hospital staff for reducing stigma in opioid-exposed newborns (OENs)</td>
<td>July – Sep 2022</td>
<td>Oct 15, 2022*</td>
</tr>
<tr>
<td>2. Hospital has implemented education practices for hospital staff for scoring OENs</td>
<td>Oct – Dec 2022</td>
<td>Dec 31, 2022</td>
</tr>
<tr>
<td>3. Hospital has implemented standardized non-pharmacologic guidelines for OENs</td>
<td>Jan – Mar 2023</td>
<td>Mar 31, 2023</td>
</tr>
<tr>
<td>4. Hospital has implemented standardized practices of when to transfer infants with NOWs to a higher level of care</td>
<td>Apr – Jun 2023</td>
<td>Jun 30, 2023</td>
</tr>
<tr>
<td>5. Hospital has implemented standardized pharmacologic guidelines for infants with NOWS</td>
<td>July – Sep 2023</td>
<td>Sep 30, 2023</td>
</tr>
<tr>
<td>6. Hospital has implemented standardized protocols/guidelines for Collaborative Discharge Plan for mothers and infants</td>
<td>...</td>
<td>...</td>
</tr>
</tbody>
</table>

* Normally data due on last day of the quarter

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Thank You

Next Meeting:
Wednesday, October 26, 2022
12:00 – 1:00 PM CST

info@alpqc.org