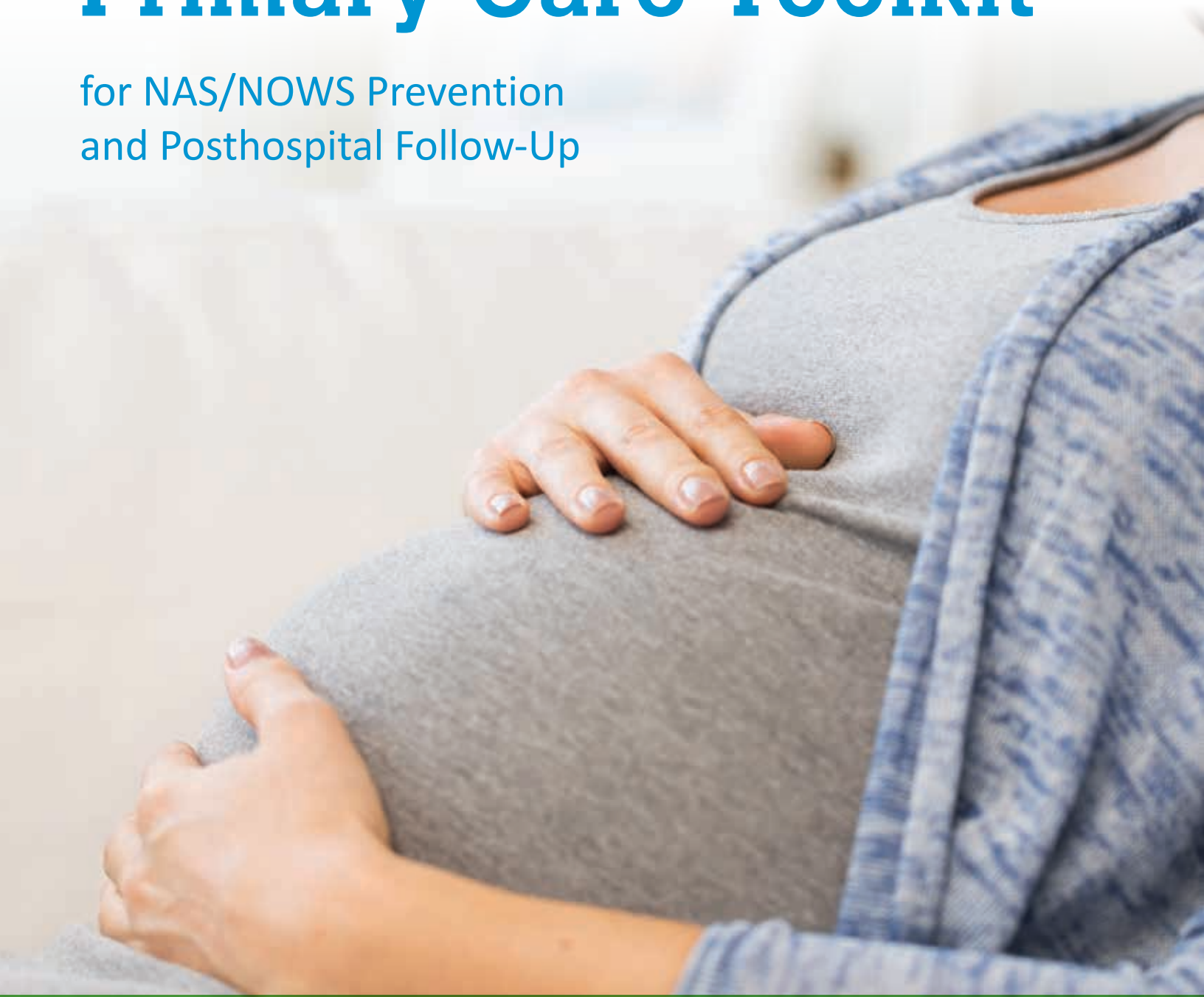


Primary Care Toolkit

for NAS/NOWS Prevention
and Posthospital Follow-Up



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Introduction

The dramatic increase in opioid use, misuse, addiction and babies born substance-exposed has given rise to multiple efforts to address these issues from many angles. No providers are better positioned to identify, refer to treatment and support efforts at recovery than primary care providers, including obstetricians, pediatricians and family practitioners, who see their patients regularly and with whom there is an established relationship. These providers are also in the best position to prevent neonatal abstinence syndrome (NAS)/neonatal opioid withdrawal syndrome (NOWS) by ensuring that women of childbearing age who are at risk delay pregnancies until they are in recovery or are stable in treatment programs. Providers do this by offering family planning options and education about how mothers can positively impact the outcomes for their babies should they become pregnant. Lastly, by understanding the nature of NAS/NOWS, providers can encourage the facilities in which they practice and those that care for substance-exposed newborns to adopt protocols aimed at avoiding additional exposure to opioid medications, stressing nonpharmacologic measures, and maintaining family bonds through rooming-in and breastfeeding when safe to do so.

Amerigroup NAS program

In response to the opioid epidemic, Amerigroup developed a comprehensive NAS program that seeks to improve outcomes for women and newborns affected by substance use disorders, including opioid use and misuse before and during pregnancy. The program includes primary and secondary interventions including efforts to prioritize screening for pregnant women, increase member engagement in treatment and recovery, increase access to reproductive counseling and preconception care, and increase familiarity of evidence-based standards of care for newborns with NAS.

Identification

Incorporated into the annual visit, screening for substance use and/or abuse can become routine just like height, weight and blood pressure. At each annual visit, beginning around age 12, patients should be regularly screened for substance use, including alcohol, tobacco and illicit drugs, using a standardized screening tool. After screening, whether positive for use or not, an opportunity opens up for discussion to support positive behaviors or to discuss substance use and the need for referral for further evaluation and/or treatment. Screening, brief intervention and referral to treatment (SBIRT) may be accomplished using a quick paper or online tool and in most states is reimbursable.

Adolescents, especially girls, who begin taking opioids before age 18 are at much greater risk for addiction, making early identification vital. Further, adolescents may respond to treatment differently than adults, and referral to providers with experience caring for this population is crucial as is ensuring strong family support whenever possible.

At the same time, tobacco use has been shown to worsen symptoms of NAS/NOWS, and smoking cessation should always be recommended when use is identified.

Treatment

The interconnection of trauma, behavioral health and mood disorders, and substance use/misuse is common. In order for treatment to be most successful, all of these needs must be addressed and met together, making it often necessary for those at risk to be cared for by therapists and providers who can counsel, support and prescribe medications as appropriate.

Exposure to opioids and other illicit drugs causes a depletion of dopamine in the central nervous system, leading to the behaviors of addiction such as craving and further drug-seeking in spite of harm. When appropriate, medication assisted treatment (MAT) will stabilize dopamine levels so that patients addicted to short-acting or illicit opioids can return to a more regular routine and level of functioning, allowing for better compliance and benefit of therapy.

Typically, methadone and buprenorphine are recommended for MAT in pregnant women. Detox during pregnancy is not felt to be safe as it is associated with a high rate of relapse, leading to very high rates of NAS/NOWS. However, for those women unable or unwilling to enter into MAT, detox should be supervised carefully and the pregnancy monitored closely. Once stable on MAT and no longer using illicit substances, the exposure to behaviors that put both mother and her baby at risk for HIV and hepatitis B and C infections will be significantly reduced.

Although babies born to mothers stable in treatment with either methadone or buprenorphine may still experience NAS/NOWS, their symptoms are often less severe, and mothers can be better prepared to care for their infants and remain united with them after delivery. Further, mothers who are stable in their treatment (and who are HIV-negative) are encouraged to breastfeed as breastfeeding has been shown to reduce the severity of NAS symptoms.

NAS/NOWS prevention and care — what you can do:

Avoidance of opioid use whether illicit or prescribed will prevent NAS/NOWS.

Caution should be used when prescribing opioids to women of childbearing age. If necessary, limiting use, especially to the first trimester in pregnant women, may be helpful in avoiding NAS/NOWS. For women who are using or misusing opioids but who are not yet pregnant, there may be the opportunity to offer long-acting reversible contraception so that pregnancy can be delayed until the woman has had the opportunity to enter or complete treatment for a substance use disorder. Should a woman become pregnant while using opioid substances, there are still many opportunities to decrease the risk and severity of NAS/NOWS. Pregnancy is the greatest motivator for women to amend their behaviors.

As stated earlier, smoking cessation has been shown to reduce the severity of NAS/NOWS. Stability in a treatment program and compliance with treatment for other behavioral health disorders is also valuable. Some antidepressants and especially benzodiazepines may exacerbate neonatal symptoms, and mounting evidence is showing that selective serotonin reuptake inhibitors (SSRIs) and serotonin and norepinephrine inhibitors (SNRIs) may lead to gestational hypertension and pre-eclampsia. These concerns must be balanced with the risk of untreated depression in the mother, which may also lead to poor neonatal outcomes.

Should an infant be born with NAS/NOWS, the environment in which he or she is cared for has been shown to have a significant impact on symptoms, need for pharmacologic treatment and hospital lengths of stay. Many studies have shown that rooming-in with the mother in a calm and quiet environment can lead to improved outcomes. In general, unless there are other medical issues requiring it, care in the neonatal intensive care unit may actually be detrimental to the baby's recovery and maintenance of the family unit. Whenever possible, birthing facilities should be encouraged to ensure mothers may room-in with their substance-exposed babies for the duration of their hospital stay. Facilities should provide parenting education, infant massage, encourage breastfeeding, and skin-to-skin contact between infant and mother. Per American Academy of Pediatrics recommendations, facilities should have a protocol in place to assess and care for substance-exposed infants and adhere strictly to that protocol.

Pharmacologic therapy should only be used when all other nonpharmacologic techniques have been ineffective in sufficiently addressing the infant's symptoms. These are all recommendations that you can address with your hospital administrators so mothers and their substance-exposed babies receive optimal care. You also have the option of encouraging your families to deliver their babies in facilities that have adopted these best practices.

After the hospital

Many substance-exposed infants will continue to have symptoms for several months. These symptoms may be manageable at home but may lead to frequent calls from families or even visits to the emergency room. Babies may be fussy and irritable, difficult feeders, and have difficulty being soothed or sleeping. These babies may be at higher risk for abuse and neglect in those first few months after birth. It is crucial that families have a safe plan of care prior to hospital discharge so they know whom to call should they become overwhelmed. Good parenting education, including safe sleep practices while still in the hospital, can help families understand their infants' extra needs. The opportunity to room-in and care for their babies during the hospital stay provides another way to empower families and build their confidence in caring for their babies at home.

Families should be referred to early intervention programs at discharge to make sure babies stay on target with their development. Infants exposed to opioids, and particularly methadone, are at risk of visual disturbances including strabismus and acuity abnormalities and, therefore, should be referred for regular ophthalmologic follow-up. Visiting home nurses may be helpful in continuing to support families and address any new or ongoing needs. As always, families should be encouraged to make sure infants and children receive regularly scheduled immunizations and well-child checkups. At each well-child visit and at the mother's postpartum visit, she should be screened for postpartum depression; questioned about how her recovery is going; and asked if any assistance might be needed for safe housing, food or transportation. Interconception health and family planning options should be discussed.

Addiction is a chronic disease and providers should be prepared to support families throughout the recovery process.

From early identification and referral to treatment if appropriate, to making sure mothers and their babies receive the most supportive care in the hospital and long after discharge, primary care providers have the best opportunities to prevent and ameliorate the effects of substance exposure on mothers and their newborns. Open, nonjudgmental dialogue and active participation with your community resources and birthing facilities to encourage changes to practice will ensure your patients receive the care they deserve.

Bullet point recommendations for primary care providers

Neonatal abstinence syndrome (NAS)/neonatal opioid withdrawal syndrome (NOWS) can be avoided by preventing opioid use and misuse in women of childbearing age.

- Begin annual screening for substance use at age 12 using a standardized screening tool.
- Openly discuss screening results to support behaviors associated with negative screen results and candidly communicate the possible need for further evaluation or treatment for positive screens.
- Recommend smoking cessation programs and age-appropriate referrals.
- Be aware of the interconnection between substance use and behavioral health needs.
- Address the need for counselling and medication for anxiety and depression, but caution that medication interactions with opioid use may increase the likelihood and severity of NAS/NOWS.
- Support the use of medication-assisted therapy (MAT) to stabilize women who seek treatment for opioid use disorders, especially during pregnancy.
- Caution regarding detox during pregnancy, but for those who insist on doing so, ensure close follow-up and fetal monitoring.
- Educate and empower women about NAS/NOWS and roles they can play to reduce the likelihood and severity of symptoms in their infants.
- Encourage pregnant women with opioid use to seek out birthing facilities that promote the use of nonpharmacologic therapies, rooming-in and breastfeeding for substance-exposed infants.
- Work with your local hospitals to ensure they have implemented protocols that promote nonpharmacologic therapies, rooming-in, breastfeeding, infant massage, skin-to-skin contact, cuddler programs and parenting classes for families with histories of substance exposure.
- Insist that birthing facilities create plans of safe care prior to hospital discharge for families with substance exposure and that include safe housing; safe sleep education; scheduled well-child visits; ophthalmologic follow-up; referrals to early intervention; visiting home nurses; and the Women, Infants, and Children (WIC) program.
- Regularly screen mothers for postpartum depression and discuss interconception health and family planning options.
- Become familiar with resources in your community that can treat and support families with opioid use and misuse.
- Understand that addiction is a chronic disease that requires a patient, multifaceted approach.

If you would like more information on the Amerigroup NAS program, please call Provider Services at 1-800-454-3730.

Support for your patients

Our **Substance Use in Pregnancy OB Case Management** program can provide your at-risk pregnant Amerigroup patients with support and coordination throughout their pregnancy. A dedicated case manager will reach out by phone to pregnant patients with or at risk for substance use disorders to provide intensive, wraparound case management through eight weeks post-delivery. The case manager will support your patient by:

- Providing coordination for overall health and wellbeing including social determinants.
- Facilitating access to treatment.
- Preparing the member for delivery, NAS treatment, discharge and post-discharge newborn care.
- Providing interconception (family planning) coaching.

Recommended guides

We recommend the following guides for all women of reproductive age, including adolescents. They contain complete action plans, examples of screening instruments and explanations of effective brief interventions:

The American Academy of Pediatrics (AAP): Substance Use Screening and Intervention Implementation Guide

https://www.aap.org/en-us/Documents/substance_use_screening_implementation.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA): Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants

<https://store.samhsa.gov/shin/content/SMA18-5054/SMA18-5054.pdf>

Northern New England Perinatal Quality Improvement Network (NNEPQIN): A Toolkit for the Perinatal Care of Women with Opioid Use Disorders

<http://www.nnepqin.org/a-toolkit-for-the-perinatal-care-of-women-with-opioid-use-disorders/>

State of Texas recovery and support services

The dramatic increase in opioid use, misuse, addiction and babies born substance-exposed has given rise to multiple efforts to address these issues in the state of Texas. Below is a list of helplines that can help your patients find local recovery and support services:

Texas 2-1-1

1-877-541-7905

www.211texas.org

Texas 2-1-1 keeps an accurate and comprehensive database that you can use to find health and human services to meet the needs of your patients, including resources for substance use recovery.

Texas State Mental Health Hotlines

www.dshs.state.tx.us/mhsa-crisishotline

Local Mental Health Authority Crisis Hotlines are available 24/7 or by calling 211. Helpline staff offer confidential support and resource referrals, including self-help groups, outpatient counseling, medication-assisted treatment, psychiatric care, emergency care and residential treatment.

Substance Abuse and Mental Health Services Administration National Helpline

1-800-662-4357

www.findtreatment.samhsa.gov

SAMHSA's National Helpline is a free, confidential, 24/7, 365-days-a-year treatment referral and information service (in English and Spanish) for individuals and families facing mental and/or substance use disorders.

Reference list

1. Committee on Obstetric Practice, American Society of Addiction Medicine, “Opioid Use and Opioid Use Disorder in Pregnancy”, ACOG Committee Opinion. Number 711, August 2017.
2. Committee on Underserved Women and the American Society of Addiction Medicine, “Opioid Abuse, Dependence and Addiction in Pregnancy”, Committee Opinion 524, reaffirmed 2014.
3. Wright, T.E., et al, “The Role of Screening, Brief Intervention and Referral to Treatment in the Perinatal Period”, Special Report: American Journal of Obstetrics and Gynecology. November 2016.
4. Levy, J.L., Williams J. F., Committee on Substance Use and Prevention, “Substance Use Screening, Brief Intervention, and Referral to Treatment”, American Academy of Pediatrics Clinical Report: Guidance for the Clinician Rendering Pediatric Care. Pediatrics, volume 138, number 1, July 2016.
5. Brown, R.T and Ryan, S., editors, “Substance Use and Abuse among Adolescents”, Adolescent Medicine: State of the Art Reviews. American Academy of Pediatrics. April 2014. Volume 25, number 1.
6. Hassan, A., et al., “Primary Care Follow Up Plans for Adolescents with Substance Use Problems”, Pediatrics. Volume 125, number 1, July 2009.
7. Siqueira, L.M., Committee on Substance Abuse and Prevention, “Nicotine and Tobacco as Substances of Abuse in Children and Adolescents”, Technical Report: American Academy of Pediatrics. Pediatrics. Volume 139, number 1, January 2017.
8. Behavioral Health Coordinating Council Subcommittee on Prescription Drug Abuse, “Protecting Our Infants Act: Final Strategy”, Department of Health and Human Services. August 2017.
9. Patrick, S.W., Schiff, D.M., Committee on Substance Use and Prevention, “A Public Health Response to Opioid Use in Pregnancy”, American Academy of Pediatrics. Pediatrics. Volume 139, number 3, March 2017.
10. Hudak, M.L., Tan, R.C., The Committee on Drugs and The Committee on Fetus and Newborn, “Neonatal Drug Withdrawal”, Pediatrics. Volume 129, number 2, February 2012.
11. Kocherlakota, P., “Neonatal Abstinence Syndrome”, Pediatrics. Volume 134, number 2, August 2014.
12. Hall, E. S., et al, “A Multicenter Cohort Study of Treatments and Hospital Outcomes in Neonatal Abstinence Syndrome”, Pediatrics. Volume 134, number 2, August 2014.
13. Volpe Holmes, A., et al, “Rooming-In to Treat Neonatal Abstinence Syndrome: Improved Family-Centered Care at Lower Cost”, pediatrics. Volume 137, number 6, June 2016.
14. Grossman, M.R., et al, “An Initiative to Improve Quality of Care of Infants with Neonatal Abstinence Syndrome”, Pediatrics. Volume 139, number 6, June 2017.