Neonatal NAS Initiative Webinar

October 8, 2019
2:00-3:00pm
General Housekeeping

• Your line has been placed to mute to reduce background noise.
  – You can press *6 to unmute yourself.

• All collaborative members want to learn from your wins and challenges so please share!
Key Driver Diagram

Please watch the following VON Micro-lessons this month (October 2019): Lesson #12

Micro-lessons

Lesson 1: Improved Family-Centered Care at Lower Cost & Improvement Story: Using Standardization to Create High Reliability
Lesson 2: The Prescription Opioid Epidemic and Neonatal Abstinence Syndrome – A Public Health Approach
Lesson 3: Virtual Video Visit Chapter 1: Linking Antenatal with Outcomes
Lesson 4: Substance Use 101: Mythbusting
Lesson 5: Virtual Video Visit Chapter 2: The Face of Trauma
Lesson 6: Substance Use 101: Frequency and Neonatal Impact by Agent
Lesson 7: Standardizing Care to Improve Outcomes
Lesson 8: Screening and Obtaining a Complete Drug History for Substance Use in Pregnancy
Lesson 9: Presentation and Typical Course
Lesson 10: Non-Pharmacologic Strategies for Symptom Management
Lesson 11: Virtual Video Visit Chapter 3: The Birth Story
Lesson 12: Scoring, Reducing, Paediatrics
Lesson 13: Scoring: Cases, Controversies
Lesson 14: Withdrawal, Toxicology, and Controversies
Lesson 15: Lactation and the Substance-Exposed Mother-Infant Dyad
Lesson 16: Engaging Families in Feeding and Nutritional Support
Lesson 17: Developmental Outcomes of Substance-Exposed Infant
Lesson 18: Virtual Video Visit Two Stories of Recovery and the Long Road Home

Key Driver Diagram for VON NAS Initiative

SMART Aim

We aim to decrease length of stay among newborns diagnosed with NAS in participating GaPQC hospitals from 11.2 days to 10.1 days by 9/30/2021

Global Aim

Improve care for babies and mothers impacted by NAS

Interventions

Develop standard screening guidelines
Educate staff on scoring
Assess inter-rater reliability of scoring
Use Eat, Sleep, Console
Increase breastfeeding
Use non-pharmacologic bundles of care
Use a standard opioid treatment protocol
Back-transfer infants stabilized on treatment
Collaborate with support organizations/agencies
Provider education to reduce stigma
Across Systems – What We Do and How We Can Help
Wrayanne Glaze Parker, LPC, MAC, CACII, CPS, CARES
Language Matters

“Many of us have carried a message of hope on a one-to-one basis. This new recovery movement calls upon us to carry that message of hope to whole communities and the whole culture. It is time we stepped forward to shape this history with our stories, our time and our talents.” – William White, Author and Recovery Advocate
Georgia’s Definition of Recovery

Recovery is a deeply personal, unique, and self determined journey through which an individual strives to reach his/her full potential.

Recovery is not a gift from any system. Recovery is nurtured by relationships and environments that provide hope, empowerment, choices and opportunities.

Recovery belongs to the person. It is a right, and it is the responsibility of us all.
The Language of Recovery

• Words are important. The language we use and the stories we tell have great significance to all involved.

• They carry a sense of hope and possibility or can be associated with a sense of pessimism, both of which can influence personal outcomes.

• Reduce stigma and discrimination/prejudice.

• Language should be: Respectful, Clear and Understandable, Free of Jargon and Clinical Language, Confusing Data, Non-Judgmental, Hopeful and Carry a Sense of Unity.
Unicorns and Big Foot

- **Myth:** Once an addict/alcoholic, always an addict/alcoholic.
- **Fact:** There are more treatments, strategies, and community supports than ever before, and even more are on the horizon. Recovery from substance use disorder is not only possible today, but it is the expectation.
- **Myth:** I can't do anything for someone suffering from addiction/alcoholism.
- **Fact:** You can do a lot, starting with the way you act and how you speak. You can nurture an environment that builds on people's strengths and promotes good mental health.
Unicorns and Big Foot

- **Myth:** People with mental health challenges are violent and unpredictable.
- **Fact:** In reality, the vast majority of people who have mental health needs are no more violent than anyone else.
- **Fact:** Violence is not a mental health diagnosis
- **Myth:** Babies born with Neonatal Abstinence Syndrome (NAS) are addicts
- **Fact:** Addiction is a brain centered condition where symptoms are behaviors. Babies are dependent often on a substance – there are no “drug babies”
Myths become reality until we change it.
Language Matters

- DON’T say “he/she is an addict” – or don’t make them
- DON’T equate the person’s identity with a diagnosis. Use the term “a person living with”
- DON’T share false statistics or information (relapse, failure, abstinence vs. harm reduction, etc.)
- DON’T dictate one way to recovery – or judge when that isn’t the way someone chooses
- DON’T ask “What is wrong with you? – instead ask “What happened to you?”
- DON’T lump into one category
- DON’T relate the unsuccessful rate of programs to the individual’s failure – it may likely be our own
Addiction as a Brain Disorder

• Addiction is a brain centered condition where symptoms are behaviors
  • Continued use in spite of adverse consequences
• Physical Dependence is the chemical changes where the body “needs” a substance
  • Dependence is an adaptation of the body to counter act withdrawal syndrome
  • Tolerance is the brain’s reaction to specific drug is reduced by repeated use
  • Withdrawal is the adaptation or “allergic reaction” to the substance
Circuits Involved in Drug Abuse, Addiction and Recovery
Addiction

ADDICTION – a behavior
- Frequency of use
- Sources of drugs – where are they coming from?
- Changes in peers/activities
- Reasons for using
- Behaviors around use – irritable, defensive when confronted, not open to any suggestions
- Has to plan their life around use
- Cravings, urges that often drive behavior
- Compulsion, inability to weigh consequences
Dependence

DEPENDENCE

• Brain biology is dramatically changed from ‘normal/original’ state
• Neurotransmitters do not produce dopamine, endorphins without substance use – dynorphins are depleted
• Centered around avoiding withdrawal and sickness
• Pre-frontal cortex has been devastated by drug, limbic system is depleted almost entirely
Break it Down

- Dopamine (short term) – initial response from substance – use (takes longest to restore)
- Dopamine activates Endorphines (long term) – locks in memory and establishes preference – misuse
- Cravings/withdrawal is brain response to depletion of these chemicals – addiction, SUD
- Dynorphins – compulsion, patterns of use, “relationship” with substance
  - Restore through connection – the opposite of addiction
  - Women – oxytocin and bonding with their children/others
Why Can’t Addicts Just Quit?

Non-Addicted Brain

Addicted Brain

Because Addiction Changes Brain Circuits

Adapted from Volkow et al., Neuropharmacology, 2004.
BRAIN RECOVERY WITH PROLONGED ABSTINENCE

Healthy Person

METH Abuser
1 month abstinence

METH Abuser
14 months abstinence
CLINICAL GUIDANCE FOR TREATING PREGNANT AND PARENTING WOMEN WITH OPIOID USE DISORDER AND THEIR INFANTS

SAMHSA Guidelines
Pregnancy and Addiction

Pregnant women are motivated to maximize the health of their baby to be...
The 4th Trimester – The Most Critical Time

Now there are two
Mood changes, abnormal sleep patterns, physiological changes
Cultural/societal expectations of “super mom”
Care shifts away from mom to the infant

Healthcare shifts from medical to more social (WIC, food stamps, etc.) Medicaid may not continue
Mental health needs are especially high during 4th trimester
Suicide rate increases
Risk factor for recurrence also increase
Maternal Deaths – Pre and Post Natal

Maternal Deaths in Georgia

- **1ST TRIMESTER**: 0
- **2ND TRIMESTER**: 2
- **3RD TRIMESTER**: 2
- **MONTHS 0-3 MONTHS**: 16
- **MONTHS 4-6 MONTHS**: 12
- **MONTHS 7-9 MONTHS**: 14
- **MONTHS 10-12**: 10
Components for Successful Recovery Effort

Home: Housing, Permanent Supportive Housing, Housing First, Recovery Housing

Health: Medical, Mental Health, Addictions (including Prevention), Clinical Care, Recovery Supports, Rehabilitation Services

Purpose: Jobs, Education, Community Service (giving back), Relationships, Leisure Time, Transportation, Child Care, Parenting, Family/Caretaking Roles

Community: Support Networks, Community Groups, Faith Community, Recovery Community Centers, Support Groups
**RECOVERY is the Goal**

- **Individualized and unique for each person**
- **Treatment episodes that include longer engagement and inclusion**
- **Cognitive behavioral therapy (CBT)**
- **EBP focused on specific topics (criminogenic thinking, trauma, stress, parenting, anger, life skills, etc.)** A holistic approach
- **Group counseling and psycho education - generational differences in learning must be considered**
- **Medication – Methadone, Bupenorphine for prenatal – Naltrexone. Suboxone may be option in 4th Trimester but continue whatever is working**
- **Coping skills – healthy lifestyle changes**
- **Support groups – AA, CA, NA, DTR, Celebrate Recovery, Reformer’s Unanimous, Smart Recovery, All Recovery – Peer Support**
- **Community involvement and service – CONNECTION IS THE OPPOSITE OF ADDICTION (and it replenishes Dynorphins)**
Women’s Treatment and Recovery Supports

- 21 WTRS Residential Sites
- 17 WTRS Intensive Outpatient Programs
- 14 Transitional Housing Programs
Priority Admission

- Admission priority is given to following:
  - Pregnant iv using Women
  - Pregnant women
  - IV Users
  - Women with DFCS/CPS involvement
  - Plan of safe care
  - All other women
    - Children under age of 12 live in residential unit with mom
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<td>Avita Community Partners</td>
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<td>678-866-8564</td>
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Addiction Recovery Support Centers

- The Mosaic Place 321 West Ave Cedartown, GA 30125 - Nikki Kemp feliciakemp@highlandrivers.org 678-246-4174
- LivingProof Recovery 408 Shorter Avenue NW, Rome, GA 30165 – Claudia Hamilton claudia@livingproofrecovery.org 706-204-8710
- The Zone 32 Fairground St NE, Marietta, GA 30060 – Melissa Owens missy@davisdirection.com 678-725-1298
- RCFF - The Connection 608 Veterans Memorial Boulevard Cumming, Georgia 30040 – Catherine Rosborough catherine@theconnectionforsyth.org 470-253-8564
- J's Place Recovery 1362 Juanita Ave, Gainesville, GA 30501 – Mary Paglia paglia@centerpointga.org 706-204-5945
- The Zone 32 Fairground St NE, Marietta, GA 30060 – Melissa Owens missy@davisdirection.com 678-725-1298
- LivingProof Recovery 408 Shorter Avenue NW, Rome, GA 30165 – Claudia Hamilton claudia@livingproofrecovery.org 706-204-8710
- The Zone 32 Fairground St NE, Marietta, GA 30060 – Melissa Owens missy@davisdirection.com 678-725-1298
- RCFF - The Connection 608 Veterans Memorial Boulevard Cumming, Georgia 30040 – Catherine Rosborough catherine@theconnectionforsyth.org 470-253-8564
- J's Place Recovery 1362 Juanita Ave, Gainesville, GA 30501 – Mary Paglia paglia@centerpointga.org 706-204-5945
Resources:

• SAMSHA Treatment Locator: https://findtreatment.samhsa.gov/
• GCAL: https://www.valueoptions.com/referralconnect/doLogin.do?e=Z2FjbSA
• RCO - https://www.gasubstanceabuse.org/recovery-community-organization
• GMHCN Warm Line: 1-888-945-1414
• CARES Warm Line: 1-844-326-5400
• OTP Providers: https://www.otpgeorgia.org/
QUESTIONS???

What are we doing right?

What can we do better?

How can we work better together?
References:

• Mishka Terplan, MD MPH FACOG DFASAM Adjunct Faculty, Clinical Consultation Center, UCSF Addiction Medicine Consultant, Virginia Medicaid
• Dr. Merrill Norton Pharm.D.,D.Ph.,ICCDP-D Clinical Associate Professor University of Georgia College of Pharmacy Athens, Georgia
• “Our Stories Have Power” training by Faces and Voices of Recovery
• American Society of Addiction Medicine (ASAM). [https://www.asam.org/](https://www.asam.org/)
• SAMHSA Clinical Guide for treating pregnant women with OUD and their infants. [https://www.samhsa.gov/search_results?k=pregnant+opioid](https://www.samhsa.gov/search_results?k=pregnant+opioid)
• Centers for Disease Control (CDC) [https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm](https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm)
Beverly Knight Olson Children’s Hospital @ Navicent Health
Macon, Georgia

GaPQC
NAS Initiative
2019
• Our team started the journey with short meetings / emails in February and March to discuss our participation and identify core groups and staff to participate.

• First official meeting was in May. Meeting every 2 weeks.

• Decided all L/D, MB and NNICU staff would be involved and expected to complete modules.

• Identified our data person: NNICU was the chosen department.

• Our Neo’s had already started working on changing our screening process to minimize stereotyping.
• Initial meetings were really about our thoughts and identifying challenges and goals related to the initiative.
  o Staff buy in & participation, as well as changing the perceptions and culture.
  o MD buy in and willingness to support changing practices if necessary.
  o Inconsistencies in practice from both OB, Pediatrics and Neos.
  o How to keep mom and baby together without the option of rooming /nesting post maternal discharge.
What have we done as a Task Force?

June and July 2019

- Established our timeline for modules.
- Added NAS education early for our new NNICU nurses. Adding it to our annual competency requirements.
- Working on parent education handout for NAS to integrate them more into plan of care and help them understand the goal.

August and September 2019

- Set up a lunch and learn with representatives from DPH (Substance Abuse Director, a CARES counselor and staff from NE Ga. Medical Center) to help bring some information and insight from lived experiences.
- Offered CEUs to participants.
- Decided that NNICU would be our initial focus.
October Goals

- Place laminated guides at bedsides to help improve scoring.
- Tracking our positive drug screens on NNICU admissions and looking at maternal record to determine if we had not screened, would baby have been missed.
- Establishing consistent timing of scoring with our Neos and NPs. Timing of scoring has been found to be all over the board with our staff.
Accomplishments

• All staff are registered for the VON modules. 85% of NNICU staff is on target or ahead of timeline. Our Educator is tracking staff participation and sending reminders in our weekly news.

• Members from our Quality Department are also now completing the modules and will be coming on board the task force.

• Positive feedback from the Lunch and Learn. We had approximately 40 participants who were able to participate from different areas and hospitals.

• Provided us with resources and contacts in our region.
Challenges still ahead ...

• Pediatrician engagement in the initiative.
• OB providers participation.
• Changes and staffing issues limiting participation from the OB bedside clinicians.
• Inconsistencies in practices both maternal and neonatal.
• Culture change and changing perceptions and biases of staff.
• Involvement from DFACS to assist with the social aspect and providing moms with resources they need to seek a sober lifestyle.
• Resources in our referral areas and how to assist the OBs with connecting pregnant moms prior to delivery.
• Incorporating our Peds staff and Peds EC staff in identifying NAS in infants presenting in the ED or on Gen Peds floor that may be exhibiting symptoms.
• Improving our NAS scoring and reliability.
• Establishing protocols for use in both our Mother/ Baby unit and in the NNICU.
• Providing consistent care, education and support for all of the NAS babies and their mothers and families.
Reminders

• Technical Assistance call on October 16th from 3:30-4:30
• Watch Lesson #12 during October