



ILPQC Mothers and Newborns Affected by Opioids (MNO) Workgroup

September 18, 2017

1:00 – 2:00 pm

Overview

- Welcomes
- Update from IDPH NAS Advisory Group
- Data Slides
- Literature Review:
 - OB and Exposure & Toxicology
- Smart AIMS and KDD
- Lit Review Schedule and Next Steps

New Project Coordinator

- Welcome to **Dan Weiss**, MPH, our new ILPQC Project Coordinator
- Dan has an MPH from UIC, experience working at Lake County Health Department, and a passion for maternal child health
- Started September 5, 2017
- Thanks for your patience and understanding as we work to develop our team!

MNO Workgroup Update: New Team Members



- 50 members of the ILPQC NAS Workgroup
- Special welcome to Tamela Milan
 - Will join Tracy as another Patient Family Advisor for MNO
 - Speaker for ILPQC 2017 Annual Conference
 - MCH outreach worker at Access Community Health Network

Save the Date!



ILPQC 5th Annual
Conference

Tuesday, December 19

Westin Lombard

Planning for speakers
with Neonatal, OB, and
patient perspectives on
opioids

OB Care for Women with Opioid Use Disorder

Patti Lee King, Barbara Parilla, Sherry Jones

MNO Next Steps

- Alignment with ACOG CO
<https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Opioid-Use-and-Opioid-Use-Disorder-in-Pregnancy>
 - Early universal screening
 - Brief intervention
 - Referral to Tx / Opioid agonist pharmacotherapy
 - Avoid/minimize use of opioids for pain
 - Adapt OB care
 - Safe prescribing practices
 - Postpartum support

CO Key Additional Points from Dr. Barb Parilla



- Single Item Screening for Opioid use in pregnancy
- Screening for depression using validated tool to capture other co-morbidities
- Physicians need to be more judicious about prescribing opioids

MNO Next Steps

- Alignment with AIM Opioid Bundle
<http://safehealthcareforeverywoman.org/patient-safety-bundles/obstetric-care-for-women-with-opioid-use-disorder/>
 - Readiness
 - Recognition and Prevention
 - Response
 - Reporting and Systems Learning

Recent trends in treatment admissions for prescription opioid abuse during pregnancy

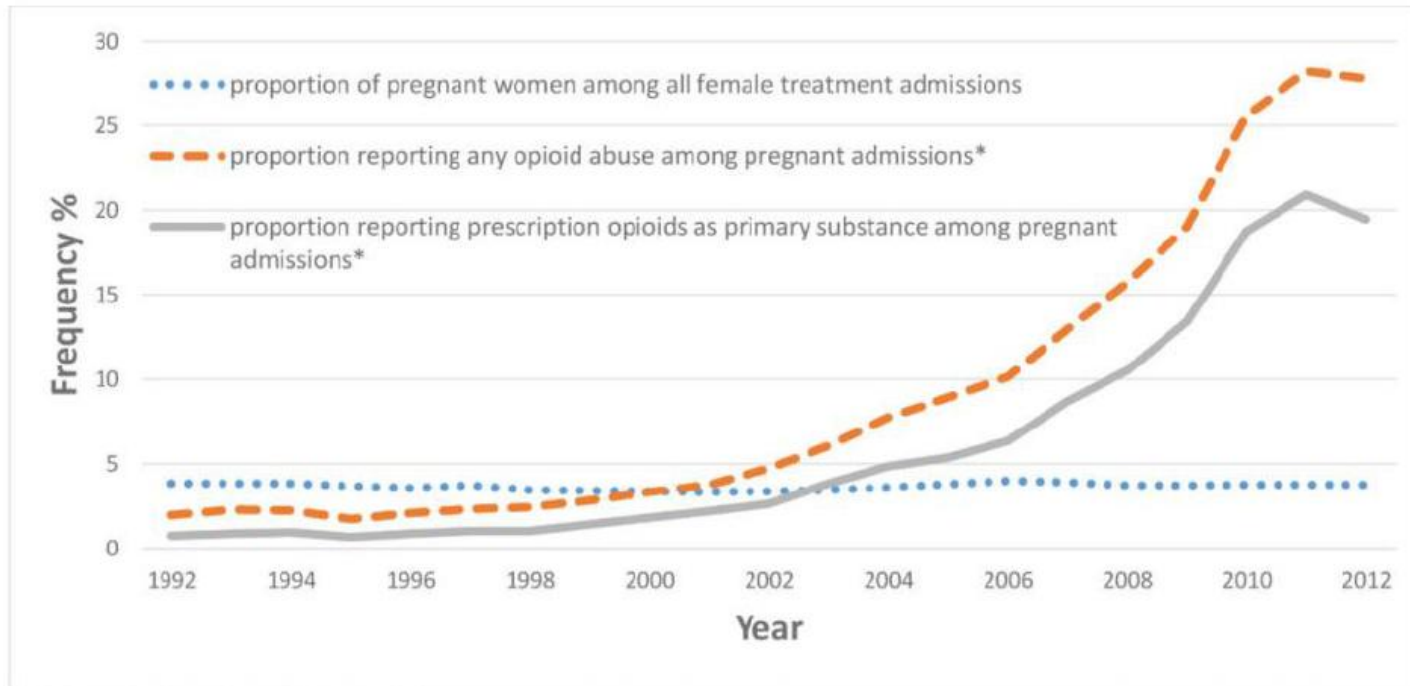


Caitlin E. Martin, M.D., M.P.H.^a, Nyaradzo Longinaker, M.S.^{b,*}, Mishka Terplan, M.D., M.P.H.^c

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*Cochran-Armitage Trend Test $p < 0.01$

Neonatal Abstinence Syndrome and Associated Health Care Expenditures

United States, 2000-2009

Stephen W. Patrick, MD, MPH, MS

Robert E. Schumacher, MD

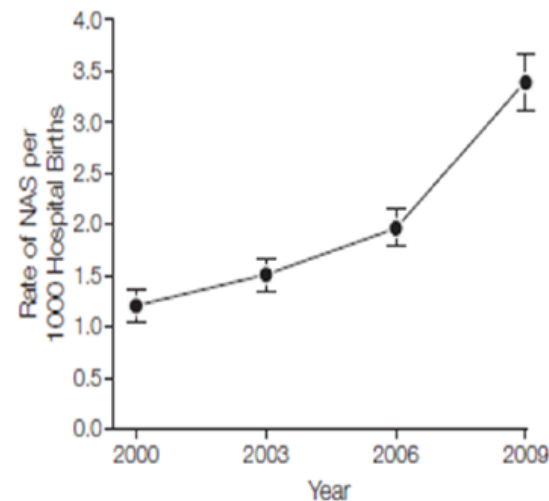
Brian D. Benneyworth, MD, MS

Elizabeth E. Krans, MD, MS

Jennifer M. McAllister, MD

Matthew M. Davis, MD, MAPP

Figure 1. Weighted National Estimates of the Rates of NAS per 1000 Hospital Births per Year

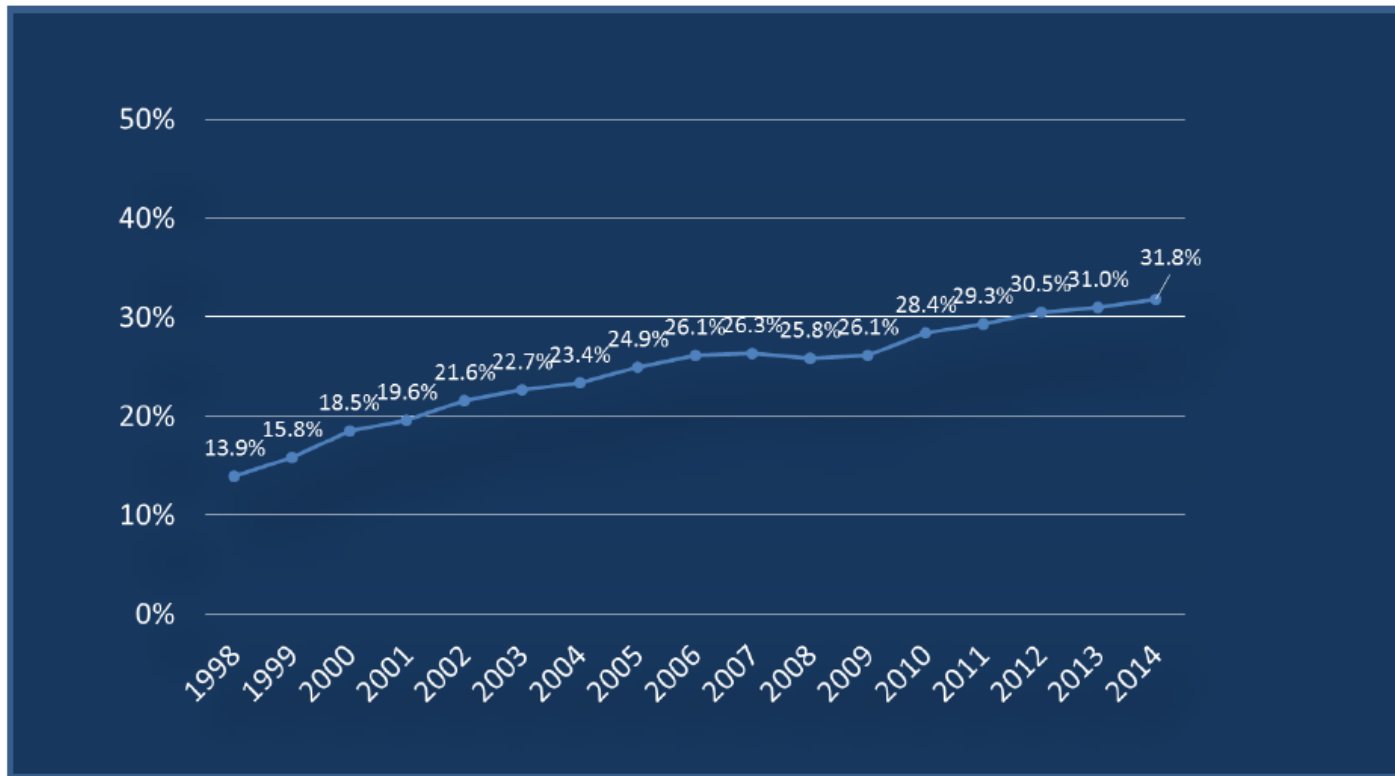


JAMA, May 9, 2012—Vol 307, No. 18

- 2002-2009:
 - Rate of NAS increased
- Cost of care 2009
 - NAS = \$53,400
 - All other births = \$9,500
- Proportion of NAS paid for from Medicaid
 - 2002 = 69%
 - 2009 = 78%

The Opioid Crisis and Child Welfare

Parental AOD as Reason for Removal in the US, 1999 - 2004



Note: Estimates based on all children in out of home care at some point during Fiscal Year

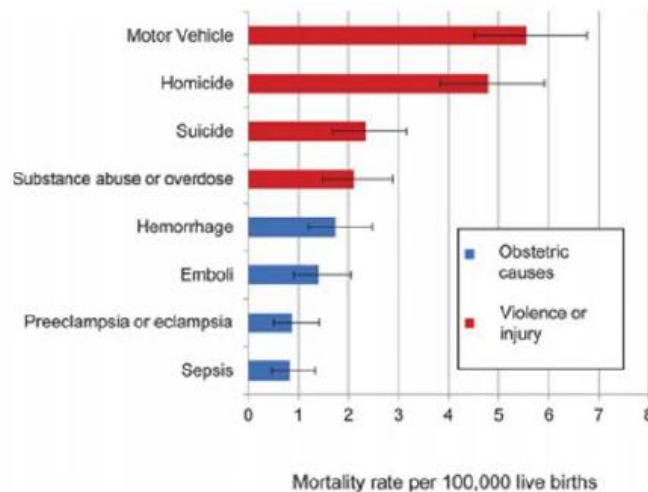
Source: AFCARS Data, 2014

The Opioid Crisis and Maternal Mortality

Original Research

Higher Risk of Homicide Among Pregnant and Postpartum Females Aged 10–29 Years in Illinois, 2002–2011

Abigail R. Koch, MA, Deborah Rosenberg, PhD, and Stacie E. Geller, PhD, for the Illinois Department of Public Health Maternal Mortality Review Committee Working Group



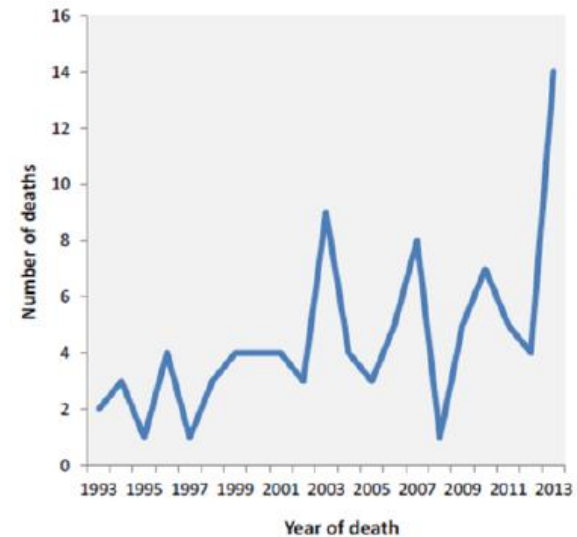


**Increase in Overdose Deaths
Among Pregnant Women and
New Mothers**

October 2014

Martin O'Malley, Governor
Anthony Brown, Lt. Governor
Joshua Sharfstein, MD, Secretary

Unintentional Overdose-Related Pregnancy-Associated Deaths, 1993-2013.



Overdose is more common cause of maternal death in US than obstetric causes

What do we need to do?

- Patient safety bundle
 - A structured set of evidence-based practices that when performed collectively and reliably -> improves patient outcomes
 - Instead of new guidelines, organizes *existing* guidelines into a form that aids implementation and consistency in practice
 - Descriptive vs. prescriptive – allows for local customization and appropriate clinical judgement

Obstetric Care for Women with Opioid Use Disorder

Multidisciplinary Team

- Mishka Terplan, MD, MPH
- Elizabeth Krans, MD, MSc
- Melinda Campopiano von Klimo, MD
- Lisa Cleveland, PhD, RN, PNP-BC, IBCLC
- Autumn Davidson, MD, MPH
- Daisy Goodman, DNP, CNM, HWNP, MPH
- Sue Kendig, JD, MSN, WHNP-BC, FAANP
- Deborah Kilday, MSN, RN
- Angela Kueck, Md
- Lisa Leffert, MD
- Elliott Main, MD
- Kathy Mitchell, MHS
- David O’Gurek, MD
- Ruth Ann Shephard, MD, MPH
- Kimberly, Sherman, MPH
- Nancy K. Young, PhD

4 Domains of Patient Safety Bundles

- **Readiness**
- **Recognition**
- **Response**
- **Reporting/ Systems Learning**



READINESS

Every patient/family

- Provide education to promote understanding of opioid use disorder (OUD) as a chronic disease.
 - Emphasize that substance use disorders (SUDs) are chronic medical conditions, treatment is available, family and peer support is necessary and recovery is possible.
 - Emphasize that opioid pharmacotherapy (i.e. methadone, buprenorphine) and behavioral therapy are effective treatments for OUD.
- Provide education regarding neonatal abstinence syndrome (NAS) and newborn care.
 - Awareness of the signs and symptoms of NAS
 - Interventions to decrease NAS severity (e.g. breastfeeding, smoking cessation)
- Engage appropriate partners (i.e. social workers, case managers) to assist patients and families in the development of a “plan of safe care” for mom and baby.



READINESS

Every clinical setting/health system

- Provide staff-wide (clinical and non-clinical staff) education on SUDs.
 - Emphasize that SUDs are chronic medical conditions that can be treated.
 - Emphasize that stigma, bias and discrimination negatively impact pregnant women with OUD and their ability to receive high quality care.
 - Provide training regarding trauma-informed care.
- Establish specific prenatal, intrapartum and postpartum clinical pathways for women with OUD that incorporate care coordination among multiple providers.
- Develop pain control protocols that account for increased pain sensitivity and avoidance of mixed agonist-antagonist opioid analgesics.
- Know state reporting guidelines regarding the use of opioid pharmacotherapy and identification of illicit substance use during pregnancy.
- Know federal (Child Abuse Prevention Treatment Act - CAPTA), state and county reporting guidelines for substance-exposed infants.
 - Understand “Plan of Safe Care” requirements.
- Know state, legal and regulatory requirements for SUD care.
- Identify local SUD treatment facilities that provide women-centered care.
 - Ensure that OUD treatment programs meet patient and family resource needs (i.e. wrap-around services such as housing, child care, transportation and home visitation).
 - Ensure that drug and alcohol counseling and/or behavioral health services are provided.
- Investigate partnerships with other providers (i.e. social work, addiction treatment, behavioral health) and state public health agencies to assist in bundle implementation.

RECOGNITION & PREVENTION

Every provider/clinical setting

- Assess all pregnant women for SUDs.
 - Utilize validated screening tools to identify drug and alcohol use.
 - Incorporate a screening, brief intervention and referral to treatment (SBIRT) approach in the maternity care setting.
 - Ensure screening for polysubstance use among women with OUD.
- Screen and evaluate all pregnant women with OUD for commonly occurring co-morbidities.
 - Ensure the ability to screen for infectious disease (e.g. HIV, Hepatitis and sexually transmitted infections (STIs)).
 - Ensure the ability to screen for psychiatric disorders, physical and sexual violence.
 - Provide resources and interventions for smoking cessation.
- Match treatment response to each woman's stage of recovery and/or readiness to change.



RESPONSE

Every provider/clinical setting/health system

- Ensure that all patients with OUD are enrolled in a woman-centered OUD treatment program.
 - Establish communication with OUD treatment providers and obtain consents for sharing patient information.
 - Assist in linking to local resources (e.g. peer navigator programs, narcotics anonymous (NA), support groups) that support recovery.
- Incorporate family planning, breastfeeding, pain management and infant care counseling, education and resources into prenatal, intrapartum and postpartum clinical pathways.
 - Provide breastfeeding and lactation support for all postpartum women on pharmacotherapy.
 - Provide immediate postpartum contraceptive options (e.g. long acting reversible contraception (LARC)) prior to hospital discharge.
- Ensure coordination among providers during pregnancy, postpartum and the inter-conception period.
 - Provide referrals to providers (e.g. social workers, psychiatry, and infectious disease) for identified co-morbid conditions.
 - Identify a lead provider responsible for care coordination, specify the duration of coordination and assure a "warm handoff" with any change in the lead provider.
 - Develop a communication strategy to facilitate coordination among the obstetric provider, OUD treatment provider, health system clinical staff (i.e. inpatient maternity staff, social services) and child welfare services.
- Engage child welfare services in developing safe care protocols tailored to the patient and family's OUD treatment and resource needs.
 - Ensure priority access to quality home visiting services for families affected by SUDs.

Obstetric Care for Women with Opioid Use Disorder

REPORTING & SYSTEMS LEARNING

Every clinical setting/health system

- Develop mechanisms to collect data and monitor process and outcome metrics to ensure high quality healthcare delivery for women with SUDs.
 - Develop a data dashboard to monitor process and outcome measures (i.e. number of pregnant women in OUD treatment at specified intervals).
- Create multidisciplinary case review teams to evaluate patient, provider and system-level issues.
- Develop continuing education and learning opportunities for providers and staff regarding SUDs.
- Identify ways to connect non-medical local and community stakeholders with clinical providers and health systems to share outcomes and identify ways to improve systems of care.
 - Engage child welfare services, public health agencies, court systems and law enforcement to assist with data collection, identify existing problems and help drive initiatives.

Exposure and Toxicology

Rita Brennan, Lisa Maloney, Steve Liao

Ethics of Perinatal Toxicology Screening



- Difficult to apply principles of ethics- two person; mother and fetus/neonate
- How is screening chosen? Who is screened?
- What are the goals of screening?

Kohsman, M.G. (2016).

Bias in screening

Ellsworth & Stevens (2010)

- Retrospective EMR study of 2121 maternal-infant dyads. Documentation of meeting criteria for screening.
- Findings: More black mothers screened than white mothers despite whether met criteria ($p < .001$)
- Concluded that provider use race in addition to risk factors for screening.
- Did not find higher positive results in black infants.

Maternal toxicology screening

Literature review

Maternal Screening: ACOG Statement



- Universal screening (ACOG, 2017)
 - Recommendations related to screening:
 - Early universal screening, brief intervention (such as engaging the patient in a short conversation, providing feedback and advice), and referral for treatment of pregnant women with opioid use and opioid use disorder improve maternal and infant outcomes.
 - Screening for substance use should be part of comprehensive obstetric care and should be done at the first prenatal visit in partnership with the pregnant woman. Screening based only on factors, such as poor adherence to prenatal care or prior adverse pregnancy outcome, can lead to missed cases, and may add to stereotyping and stigma. Therefore, it is essential that screening be universal.
 - Routine screening should rely on validated screening tools, such as questionnaires, including **4Ps, NIDA, Quick Screen, and CRAFFT** (for women 26 years or younger).
 - Urine drug screen should be performed only with the patient's consent and in compliance with state laws. Pregnant women should be informed of the potential ramifications of a positive test result

4 Ps

- **Parents:** Did any of your parents have a problem with alcohol or other drug use?
- **Partner:** Does your partner have a problem with alcohol or drug use?
- **Past:** In the past, have you had difficulties in your life because of alcohol or other drugs, including prescription medications?
- **Present:** In the past month have you drunk any alcohol or used other drugs?
- **Scoring:** Any “yes” should trigger further questions. (Ewing, H. 1990)

Ewing H. A practical guide to intervention in health and social services with pregnant and postpartum addicts and alcoholics: Theoretical framework, brief screening tool, key interview questions, and strategies for referral to recovery resources. Martinez (CA): The Born Free Project, Contra Costa County Department of Health Services; 1990.

NIDA Quick Screen†

Screen Your Patients

- Step 1. Ask patient about past year drug use—the NIDA Quick Screen (<https://www.drugabuse.gov/nmassist/>)
- Step 2. Begin the NIDA-Modified ASSIST
- Step 3. Determine risk level
- Conduct a Brief Intervention
- Step 4. Advise, Assess, Assist and Arrange (National Institute on Drug Abuse, 2017)

CRAFFT—Substance Abuse Screen for Adolescents and Young Adults‡



- **C** Have you ever ridden in a CAR driven by someone (including yourself) who was high or had been using alcohol or drugs?
 - **R** Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?
 - **A** Do you ever use alcohol or drugs while you are by yourself or ALONE?
 - **F** Do you ever FORGET things you did while using alcohol or drugs?
 - **F** Do your FAMILY or friends ever tell you that you should cut down on your drinking or drug use?
 - **T** Have you ever gotten in TROUBLE while you were using alcohol or drugs?
- **Scoring:** Two or more positive items indicate the need for further assessment. (Center for Adolescent Substance Abuse Research, Children’s Hospital Boston, 2009)

Universal Testing

Wexelblatt et al, J Pediatrics 2015

- Universal drug testing for all mothers in a community hospital (OH) with 3-fold increase in NAS over the previous 5 years.
- May 2012-Nov 2013 after implementing universal drug testing
- 159 (5.4%) reported positive (2956 maternal specimens tested)
- 96+ for opiates (3.2%) for all admissions.
- 19 of 96 (20%) opioid positive tests were in mothers without screening risk factors.
- 7 of these 19 infants required admission to SCN for NAS, 1 out of 7 required pharmacological tx.

Ryan et al. J Ob Gyn Canada, 2017

- A Canadian center implemented community-based prenatal monitoring protocol in 2014, which includes urine drug testing
- Comparing pre and post-implementation (N=215 vs. N=251)
 - Increase number of opioid-exposed patients
 - Reduction in the number of urine drug screenigs + for illicit opioids (50.2% vs. 29.1%, P<0.0001)
- No difference in c-section rate or preterm birth, birth weight, or APGAR scores

Universal vs. Selective Testing

Universal testing

- Advantage
 - Simplicity without bias; increase sensitivity
- Disadvantage
 - Violates Fourth Amendment rights. (Ferguson v City of Charleston, 2001) Supreme court ruled 6-3 against a public hospital from obtaining drug testing to prevent pregnant women from taking cocaine
 - “pregnant women must provide explicit consent for urine drug testing, and they also have the right to refuse testing”, supported by ACOG

Selective testing

- Advantage
 - Allow narrow focus on those at greatest risk; improve efficiency and specificity.
- Disadvantage
 - possibility of bias. “Behind the curtain effect”, example of orchestra audition.
 - (Chasnoff, NEJM, 1990), despite similar rate of substance use, black women reported 10x more than white women. Poor women also more likely to be reported.
 - (Ellsworth, Pediatrics, 2000). Drug screen rate among 2121 mother-newborn pairs. Neonates born to black mothers more likely to be drug tested when they met screening criteria (35.1% vs. 12.9%, $P < .001$) or not met the screening criteria (5.3% vs. 1.2%, $P < .001$).

Screening

- Universal Verbal Screening
 - Advantage
 - Endorsed by ACOG, AAP, AMA, CDC
 - Disadvantage
- Selective Verbal Screening
 - Similar to selective drug testing.

Principles for Healthcare workers:

- Healthcare workers should support: drug use is a medical condition, not moral failing.
 - A study (Abel et al, Am J Ob Gyn) in 2002: 45% of physicians savored statues that defined substance use during pregnancy as a form of child abuse
- Using the best questionnaires and applying them universally and uniformly, in a non-judgmental fashion.
- Testing should result in a medical “good”, not merely the capture and stigmatization of those with a disease.
 - Pregnant women should not be targets of opportunity
- Adhere to safe prescribing practices
- Encourage healthy behaviors
- Provide appropriate information
- Identify and refer patients with substance use disorders to addiction treatment professionals

Advocate

Although universal, voluntary screening would seem the most reasonable approach, physicians should advocate for that only as strongly as they advocate for social support and addiction care services for those subsequently identified. (Guttmacher Institute data, 2017)

- 24 states and the District of Columbia consider substance use during pregnancy to be child abuse under civil child-welfare statutes (MO/IL), and 3 consider it grounds for civil commitment.
- Only 19 states (MO/IL) have specialty drug treatment programs for pregnancy women
- Only 17 (MO/IL) provide them with priority access to treatment
- Only 10 (MO/IL) prohibit discrimination against pregnant women in publically funded programs.

Neonatal toxicology screening

Literature Review

Literature Review- Prospective Studies

Citation	Description of study/method	Population	Sample size	Setting	Major variables studied	Measurement	Data analysis	Findings	Conclusions	Drawbacks
Montgomery, DP, Plate, CA, Jones, M, Rios, R, Lambert, DK...Christensen, RD. (2008).Using umbilical cord tissue to detect fetal exposure to illicit drugs: A multicentered study in Utah and New Jersey. Journal of Perinatology, (28), 750-753.	Prospective analysis of cord tissue versus meconium	Delivered at participating hospitals. Met high-risk criteria for testing.	498 deidentified cords analyzed. Risk factors: history of previous pregnancy drug abuse proven, maternal report of drug abuse during pregnancy, no prenatal care, no permanent address, sexually transmitted disease and mother or father appear intoxicated, high or abusive.	Hospitals in Utah & NJ. Over 15 month period. All cords collected. Discarded if criteria not met.	Analyzed for amphetamines, opiates, cocaine, cannabinoids, and phencyclidine by ELISA assays	498 umbilical cord segments underwent mass spectrometry and ELISA.	Amphetamine- + predictive value 0.717 Opiates- +predictive value 0.884 Cocaine- + predictive 0.950 Cannabinoids- + predictive value 0.714	ELISA tests for cord tissue performed well. Negative predictive values >98% for each drug class (no drug detected).	Cord testing can be useful for detecting fetal exposure to illicit drugs.	Cannot quantify timing and exact quantities mother ingested.

Literature Review- Retrospective Studies

Citation	Description of study/method	Population	Sample size	Setting	Major variables studied	Measurement	Data analysis	Findings	Conclusions	Drawbacks
Oral, R. et al. (2014). Staff training makes a difference: improvements in neonatal illicit drug testing and intervention at a tertiary hospital. <i>Journal of Maternal-fetal & Neonatal Medicine</i> , 27 (10), 1049-1054.	Controlled, retrospective chart review	Newborn and mother dyads	1186 Pretraining group & 1861 post-training group		Impact of training on multiple outcomes associated w/ perinatal illicit drug use & in utero exposure	When a dyad's chart contained at least 1 risk factor, the dyad was designated "eligible for testing". If neo testing was not done, it was flagged as a missed	χ^2 test or Fisher's Exact test	With staff training on how to use established protocol, recognition of risk factors increased post training to significantly increased rates if perinatal maternal & neonatal illicit drug exposure. Statistically significant increases in : performing maternal testing, maternal positive drug testing, social worker involvement, maternal referral for substance abuse eval, maternal referral to mental health evaluation, infant drug testing, positive infant drug	Study led to increased number of documented drug exposed newborns. Emphasized importance of analyzing institution current protocol & staff training	
Marin, S. et al. (2014). Detection of neonatal; drug exposure using umbilical cord tissue and liquid chromatography time-of-flight mass spectrometry. <i>The Drug Monitor</i> . 36 (1). 119-124			57 cord samples & 37 meconium samples						TOF method detects drugs and meets/exceeds typical cutoffs and offers superior sensitivity and specificity compared w ELSIA w/ confirmation w mass spectrometry	
Palmer, K.L., Wood, K.E., Krasowski, M.D. (2016). Evaluating a switch from meconium to umbilical cord tissue for newborn drug testing: A retrospective study at an academic medical center. <i>Clinical Biochemistry</i>	Retrospective analysis		2072	2012-2015 meconium and cord samples. University of Iowa			ARUP labs	Meconium and cord samples provide equivalent detection of common drugs or metabolites		

Neonatal Testing Summary



Specimen	Advantages	Disadvantages
Urine minimum 1-10ml (based on lab used)	<ul style="list-style-type: none"> • Kidneys concentrate drugs/metabolites in urine (Bell, 2016) • Non-invasive • Quick results (Bell, 2016) 	<ul style="list-style-type: none"> • Shortest window of detection (Cotton, 2012) • Limited ability to concentrate urine may result in false negatives (Bell, 2016) • 1st void can be missed (Bell, 2016) • Failure to catch the first urine decreases the likelihood of a positive test • Urine bag issues: skin and adherence (Bell, 2016) • Potential absorption of substances on cotton/rayon balls (if this method used, no studies on it) (Bell, 2016)
Meconium minimum sample 0.5-4g	<ul style="list-style-type: none"> • Non-invasive • Wide window of detection, 2nd & 3rd trimester (Bell, 2016 & Cotton, 2012) • Easier to collect than urine 	<ul style="list-style-type: none"> • Time consuming, multiple collections & collectors (Bell, 2016; Palmer, 2016) • Meconium may be passed prior to delivery • Potential contamination w urine/ transitional stool resulting of false positive from antepartum/intrapartum exposure (Bell, 2016) • Baby may be discharged prior to result (Bell, 2016) • Inadvertent disposal of specimen by families (Bell, 2016) • most useful when history & clinical presentation strongly suggests neonatal withdrawal but the maternal urine screening is negative. (AAP, Pediatrics 2012) • Requires storage during collection (Palmer, 2016). If meconium sample stored at room temperature, it decreases cocaine and cannabinoid levels by 25% per day (Hamden, 2016) • Meconium may be discarded if late identification of risk factors (Palmer, 2016) • Delayed collection in preterm (Palmer, 2016)

Neonatal Testing Summary



Specimen	Advantages	Disadvantages
Umbilical Cord 10cm portion, prepped	<ul style="list-style-type: none"> • Noninvasive • Cord is considered bio waste • No risk of contamination or missed specimen (Bell, 2016) • Wide window of detection, like meconium (Bell, 2016) • Easy collection and rapid turnaround of results • Avoids medications given to baby post-delivery (Palmer, 2016). • Appears to have increased sensitivity for amphetamines vs meconium (Bell, 2016) • testing of cord using drug class-specific immunoassays was shown to be in concordance w/ testing of paired meconium specimens for detection of amphetamines, opiates, cocaine and cannabinoids (AAP, 2012). • Testing for buprenorphine (Subutex), and designer stimulants (“bath salts”) is available • Cord can be stored for several weeks (Palmer, 2016). • Can be sent when symptoms present, after meconium has passed (Palmer, 2016). 	
Hair 20-50 mg hair	<ul style="list-style-type: none"> • Able to be tested until approx. 3 months after birth (Delano & Koren, 2012) 	<ul style="list-style-type: none"> • Considered invasive because quantities may be limited (Cotton, 2012) • Sample size needed may not be present at birth • Detect 3rd trimester exposure (Delano & Koren, 2012)

Summary

- Best practice is a combination of universal maternal screening and use only selective testing when high-risk factors identified.
- Every pregnant women needs to be screened as part of prenatal care.
- Evidence-based protocol for identifying high-risk factors.
- Healthcare worker education is needed.

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Reddy, U., Davis, J.M., Ren, Z., Greene, M.F. (2017). Opioid Use in Pregnancy, Neonatal Abstinence Syndrome, and Childhood Outcomes Executive Summary of a Joint Workshop by the Eunice Kennedy Shriver National Institute of Child Health and Human Development, American College of Obstetricians and Gynecologists, American Academy of Pediatrics, Society for Maternal-Fetal Medicine, Centers for Disease Control and Prevention, and the March of Dimes Foundation. *Obstetrics & Gynecology* 2017;130:10–28) doi: 10.1097/AOG.0000000000002054

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MNO Next Steps

MNO To Dos



- Review of literature by NAS topic area (Aug-Oct)
- Apply QI Science to develop Draft QI Aims, Measures, Key Drivers Diagram (Oct-Dec 2017)
- Identify sample process flow to identify gaps between identification and referral to services for mothers and newborns (Jan-Mar 2018)

MNO Next Steps

- Alignment with IL Opioid Action Plan - prevention, treatment, rescue:

<http://dph.illinois.gov/sites/default/files/publications/Illinois-Opioid-Action-Plan-Sept-6-2017-FINAL.pdf>

and ACOG

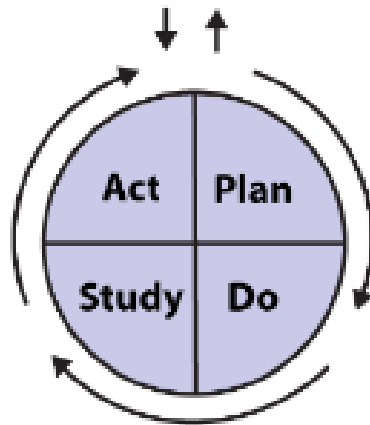
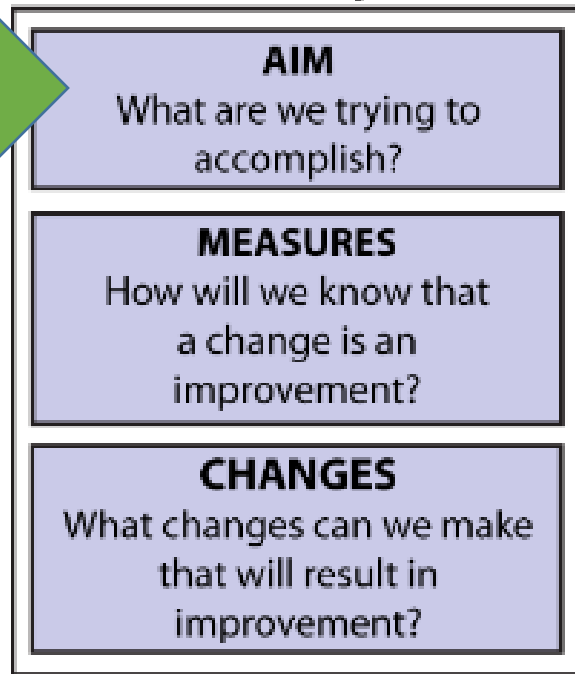
- Use of PNP by perinatal providers
- Use of safe prescribing practices for routine cesarean and vaginal birth
- Increase access to treatment for moms and services for newborns

QI Review

Set your aim

The Model for Improvement

Question 1



SMART AIMS

S	Specific
M	Measureable
A	Actionable
R	Relevant
T	Time bound

Example: TN Perinatal Quality Collaborative

The aim of this project is to improve the health of infants admitted to the NICU for management of Neonatal Abstinence Syndrome in Tennessee. We seek to optimize our management by attaining high reliability (>90%) processes for NAS scoring, NAS treatment initiation and weaning, and post-NAS discharge preparation by December 2013.

MNO Literature Review Updates



- All lit review groups (team lead and group members) have been emailed
- Team Leads: Email your group members and divide up the work
- Slides are due a week before your group presents
- ILPQC will email a reminder to the team lead a month before your slides are due
- Groups are listed on the next slide

Literature Review Groups

Topic	Month	Group Leader	Group Members
Families at Risk	Aug.	Terry Griffin	Elaine; Maliha
OB	Sep.	Carol Burke	Sherry; Barbara; Jaye; Tamara
Exposure/Toxicology	Sep.	Rita Brennan	Lisa; Steve
NAS Assessment Tools	Oct.	Mary Puchalski	Mary; Phyllis; Steve; Chris
Non-Pharma Treatment	Oct.	Sue Horner	Leslie; Meg
Pharma Treatment	Nov.	Venkata Majjiga	Ann; Chris
Discharge and Follow Up	Nov.	Kenny Kronfrost	Donna; Elyssa; Jennifer

Literature Review Google Drive



1. ILPQC NAS Workgroup Google Drive

2. Literature Review Topic Folders

My Drive > ILPQC NAS Initiative Workgroup

Name	Owner	Last opened ...
Tennessee	me	Jul 13, 2017
Massachusetts	me	Jul 13, 2017
Ohio	me	Aug 9, 2017
General Resources	me	9:09 AM
Literature Review Topics	me	2:07 PM
NAS Workgroup Contact Information	me	Aug 21, 2017

My Drive > ILPQC NAS Initiative Workgroup > Literature Review Topics

Name	Owner	Last opened ...
Exposure/Toxicology Reports	me	Aug 1, 2017
Discharge and Follow-Ups	me	Aug 1, 2017
NAS Assessment Tools and Scoring	me	Aug 15, 2017
OB	me	Aug 15, 2017
Families at Risk	me	Aug 17, 2017
Non-pharmacological Treatment	me	Aug 22, 2017
Pharmacological Treatment	me	8:49 AM

3. Inside Lit Review Folder: References & Slides

My Drive > ILPQC NAS Initiative ... > Literature Review Top... > Exposure/Toxicology Reports

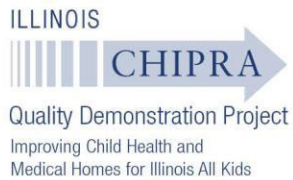
Name	Owner	Last opened ...	File size
Exposure/Toxicology Reports	me	Jul 31, 2017	-
References	me	2:08 PM	-

Literature Review Resources

- Look at the resources in the Google Drive
 - Resources have been pulled from other state's toolkits
- Review national professional guidelines and resources from SAMSHA, CDC, ACOG, AAP
- Questions: email info@ilpqc.org
- <https://drive.google.com/drive/folders/0B9NgXbOG8bl0X2Y1dmNwY054NHM?usp=sharing>

Next Call: October 16nd, 2017
1:00pm-2:00pm

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