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Opioid Use Disorder (OUD) in Pregnancy Initiative

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District XII
Tdap Vaccination Project
District II

Opioid Use Disorder (OUD) in Pregnancy Initiative
November 13, 2018

Linda Kinnane  
Department of District and Section Activities  
The American College of Obstetricians and Gynecologists  
PO BOX 70620  
Washington, DC 20024-9998

Dear Ms. Kinnane,

I am pleased to nominate ACOG District II’s Opioid Use Disorder (OUD) in Pregnancy Initiative for the Council of District Chairs Service Recognition Award. Over the past two years, the ACOG District II OUD in Pregnancy Task Force has been working to educate ob-gyns on the comprehensive management of pregnant patients suffering from opioid use disorder through development of a clinical bundle, establishment of a quality improvement collaborative and joining AIM. The goal is to increase providers’ implementation of best practices regarding management of addicted pregnant and postpartum women to improve maternal and infant outcomes. This project is generously funded by the New York State Health Foundation (NYSHF) and is being highlighted in their 2018 “Best of” collection of grantees.

Scope of the Problem in New York
More than 19,300 New Yorkers were admitted in the hospital for opioid abuse treatment in 2013, and from 2005-2014, admissions for heroin treatment among upstate NY residents increased by 115%. Findings from a provider knowledge, attitude, and practice (KAP) survey found that 62% of respondents felt there was not adequate training and resources in their area/region to appropriately manage opioid addicted pregnant and postpartum women. Respondents also noted limited comfort level with managing/treating pregnant women with OUD. ACOG District II has made examining and addressing this issue a priority in NYS.

Project Components/Summit
A major component of this initiative was an Opioid Addiction in Pregnancy Summit held on April 27, 2017 at SUNY Upstate Medical University. The goal of this summit was to advance community connections, leverage relationships with local public and private organizations, and to develop recommendations to ensure a seamless continuum of care for pregnant women with opioid use disorder. Over 50 stakeholders from across the state with various healthcare backgrounds participated in the event and in the development of a white paper which aimed to provide communities with actionable strategies to effectively manage OUD in pregnancy, thereby improving outcomes for women and infants throughout NYS.

Partnership with ACOG National
Simultaneous to the release of the District II white paper, ACOG launched the first national multi-state collaborative on Maternal Opioid Use Disorder as part of the Alliance for Innovation on Maternal Health (AIM) national program. District II partnered with ACOG national in a joint release of AIM and the District II white paper. As a result of the press release, Task Force Co-Chairs Drs. Leah Kaufman and David Garry, were interviewed by Newsday (a daily newspaper distributed in the greater metropolitan NYC area) with a report on November 15, 2017 regarding opioid abuse and special programs for pregnant women. In addition to Newsday, Crain’s Health Pulse in NY also picked up the story reporting on helping pregnant women overcome opioid addiction.
**Clinical Bundle**

Under the guidance of Drs. Garry and Kaufman, women’s health care experts developed an OUD in Pregnancy provider education bundle which emphasizes management of OUD in pregnancy through universal screening, management strategies, treatment services, and interventions to help decrease NAS severity. The Task Force is comprised of a diverse group of women’s health care providers who interact with pregnant women with OUD through the various stages of their pregnancy including, ob-gyns, pediatricians, social workers, addiction specialists, nurse midwives etc. The bundle builds upon not only the components of the National AIM opioid bundle, but also the work of many dedicated women’s health care providers across the state who have developed resources and implemented successful programs. The bundle is listed as an AIM resource, has been distributed to the Illinois Quality Collaborative, and requested for use by other states.

**Quality Collaborative**

ACOG District II and the NYSDOH New York State Perinatal Quality Collaborative (NYSPQC) have aligned efforts and are now participating as an AIM state on Maternal Opioid Use Disorder. Through this effort, 17 pilot hospital sites from across NYS are working to improve care for both pregnant women with OUD and infants with NAS. This project is designed to enable hospital teams to identify and disseminate strategies that will serve as a model for improving practice and outcomes. Participating hospital teams will be required to submit monthly data through a secure web-based system to track progress in achieving the project goals and we are beginning monthly coaching calls to offer education. This collaboration is crucial in forging new and lasting relationships, offering the most comprehensive education to the District II membership, and showcasing our joint work to statewide partners.

**Project Outcomes to Date**

The District II OUD in pregnancy bundle education has been distributed to well over 5,000 healthcare providers (including District II members) across the state through various outreach efforts and partner listservs and many more nationally. The education has been presented 18 times across the state from February-October 2018, to approximately 12 other states through national webinar requests as well as promoted to 20 other states through the AIM collaborative as it is listed as an AIM resource. The OUD education has had over 3,167 website hits since January 2018. There are currently 17 (goal was 10) pilot sites engaged in our NYS collaborative with 75+ attendees at the September kick-off meeting.

Our educational bundle has been presented in grand rounds across the state. The pre and post testing from grand rounds has shown marked improvement in knowledge base. For example, prior to the OUD education being presented at one institution, 33% of attendees selected universal screening with a verbal screening tool as the recommended method to screen women of childbearing age for substance use. However, following the education presented, this increased to 86%. In another instance, this same knowledge question increased from 47% to 100%.

We remain energized by the support, engagement and expertise provided by our Task Force members and key partners. The level of enthusiasm and commitment to this project is remarkable. To that end, I believe our OUD in Pregnancy Initiative and subsequent efforts across New York State are worthy of recognition for its dedication, passion, and tireless efforts. We look forward to continuing our efforts in this area through partnership with AIM and NYS Office of Alcohol and Substance Abuse to develop screening, brief intervention and referral to treatment video vignettes, our quality improvement collaborative activities, and rolling out our next provider education bundle focused on response. I humbly submit ACOG District II’s OUD in Pregnancy Initiative for the Council of District Chairs Service Recognition Award.

Sincerely,

Iffath Abbasi Hoskins, MD, FACOG
Chair, ACOG District II
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EXECUTIVE SUMMARY

The opioid epidemic is increasingly becoming one of the most important and influential public health issues of the 21st century. The American Congress of Obstetricians and Gynecologists (ACOG), District II has made examining and addressing opioid use disorder in pregnant women a priority in New York State (NYS). More than 19,300 New Yorkers were admitted to the hospital for opioid abuse treatment in 2013, and from 2005-2014, admissions for heroin treatment among upstate NY residents increased by 115%.[1] As the member organization for over 4,000 women’s health care providers in NYS, ACOG District II is committed to ensuring women across the state receive high quality care and support, including pregnant women struggling with opioid addiction.

ACOG District II, with support from the New York State Health Foundation (NYSHealth), has embarked on an initiative to educate women’s health care providers about the comprehensive management of pregnant women with opioid use disorder (OUD). As a byproduct of this work, ACOG District II aims to strengthen safety nets for pregnant women by working in concert with various state and local governments, including the New York State Office of Alcohol and Substance Abuse Services (OASAS), New York State Department of Health (NYSDOH), and community-based organizations, seeking clinical practice and public policy changes that increase and sustain access to addiction services.

A statewide educational summit was held in Syracuse, New York to provide multidisciplinary stakeholders with an opportunity to network and learn from their colleagues and develop key recommendations and solutions to improve management of opioid use disorder in pregnancy. This white paper is a summary of the key public health, policy and clinical recommendations that our expert participants developed.

This white paper aims to provide communities with actionable strategies to effectively manage opioid use disorder in pregnancy thereby improving outcomes for women and infants throughout New York State.

SUMMARY OF KEY RECOMMENDATIONS

1. Change perceptions of opioid use disorder through the use of a common language

2. Develop and offer multifaceted education and implementation tools to better assist women’s health care providers in caring for pregnant women with opioid use disorder

3. Create better engagement and communication among providers within the continuum of care and across service areas, including the justice system

4. Enhance patient and family engagement

Support for this work was provided by the New York State Health Foundation (NYSHealth). The mission of NYSHealth is to expand health insurance coverage, increase access to high-quality health care services and improve public and community health. The views presented here are those of the authors and not necessarily those of the New York State Health Foundation or its directors, officers, and staff.
THE EFFECT OF THE OPIOID EPIDEMIC ON WOMEN

The United States opioid epidemic has been on the rise with a significant increase in overdoses and deaths in recent years, many of which are due to opioids such as oxycodone and hydrocodone that are commonly prescribed to treat chronic pain or pain following surgery or injury. In fact, every three minutes, a woman shows up at an emergency room because of prescription drug misuse or abuse. In New York State a leading cause of pregnancy associated death is injury related to substance abuse.

Cesarean deliveries are the most common inpatient surgery in the United States with 1.3 million procedures performed each year, according to researchers. But, there is little data on how much medicine patients actually need to manage their pain. To that end, how many pills are prescribed varies from provider to provider. The path needed to address this national crisis is complex and multifaceted. Studies conclude that more attention is needed to limit the amount of leftover drugs that could wind up in the wrong hands.

From 1992-2012, the overall proportion of pregnant admissions in the US remained stable at 4%; however, admissions of pregnant women reporting prescription opioid abuse increased substantially from 2% to 28%. Furthermore, a Centers for Disease Control and Prevention (CDC) report noted that nearly 48,000 women died of prescription painkiller overdoses between 1999 and 2010 representing an increase of more than 400% since 1999 compared to a 265% increase among men.

Before prescribing opioids, ob-gyns and other women’s health care providers should ensure that opioids are appropriately indicated; discuss the risks and benefits of opioid use and review treatment goals; take a thorough history of substance use; and, review the Prescription Drug Monitoring Program to determine whether patients have received prior opioid prescriptions.

UNIVERSAL SCREENING

Pregnancy provides an important opportunity to identify and treat women with opioid use disorder. Early universal screening, brief intervention (such as engaging the patient in short conversations, providing feedback and advice), and referral for treatment of pregnant women with opioid use disorder improves maternal and infant outcomes. Therefore, it is essential that screening be universal and part of comprehensive obstetric care and completed at the first prenatal visit in partnership with the pregnant woman. Routine screening should rely on validated screening tools such as questionnaires like 4Ps, NIDA Quick Screen, and CRAFFT (for women 26 years or younger).

TREATMENT OPTIONS DURING PREGNANCY

Treating pregnant women poses unique challenges for health care providers, many of whom may not have substantial knowledge or experience with providing care to pregnant women using opioids. Treatment must be gender-specific, multidisciplinary, and comprehensive in nature and continued through the continuum of care, ideally from preconception to the postpartum period, including the formative childhood development stage. Regardless of experience, knowledge, or personal belief, ob-gyns have an ethical responsibility to treat patients with addiction with dignity and respect. It is important for physicians to understand that pregnant women with opioid addiction are more likely to seek prenatal care late in pregnancy, miss appointments, experience poor weight gain, and/or exhibit signs of withdrawal or intoxication.

Once a woman is identified with opioid use disorder, the patient and physician should work together to find the best possible treatment course.

For pregnant women with opioid use disorder, ACOG recommends opioid pharmacotherapy which is preferable to medically supervised withdrawal because withdrawal is associated with high relapse rates and can lead to worse outcomes. More research is needed to determine the safety, efficacy, and long-term outcomes of medically supervised withdrawal.
I. INTRODUCTION & BACKGROUND

Medication-assisted treatment (MAT) with methadone or buprenorphine is recommended to prevent complications from continued opioid use and narcotic withdrawal; to encourage prenatal care and drug treatment; to reduce criminal activity; and, to avoid risks to the patient of associating with a drug culture. This treatment is believed to have little long-term postnatal developmental impact compared to the impact associated with illicit drug use.

Neonatal Abstinence Syndrome (NAS) is an expected and treatable condition that can occur after prenatal exposure to opioids, including MAT, and characterized by hyperactivity of the central and autonomic nervous systems. It is important to realize that different populations of women can give birth to an infant with NAS: women with chronic pain maintained on medication; women who misuse prescribed medications; women in recovery from opioid addiction and maintained on methadone or buprenorphine (ie, MAT); women who are actively abusing or dependent on heroin, and women who misuse non-prescribed medication. Treatment options vary, but may include an extended hospital stay.

Methadone has long been the standard of care for MAT during pregnancy but buprenorphine is also considered an effective treatment option. While mothers treated with buprenorphine have been shown to drop out of treatment more frequently, their infants had shorter hospital stays and treatment times for NAS. Furthermore, combining MAT and prenatal care reduces the risk of obstetric complications and leads to better outcomes for the mother and her fetus. A multidisciplinary approach to care is integral for optimal health outcomes.

It is important to note that breastfeeding should be encouraged in women who are stable on their opioid agonists, who are not using illicit drugs, and who have no other contraindications, such as human immunodeficiency virus (HIV) infection. Women should be counseled about the need to suspend breastfeeding in the event of a relapse.

PROVIDER KNOWLEDGE AND TRAINING

ACOG District II’s opioid task force, consisting of medical experts from various specialties, created a knowledge, attitude, and practice survey that was disseminated to ob-gyns across New York State. In analyzing the data, preliminary results gathered are as follows:

- 62% of respondents felt there was not adequate training and resources in their area/region to appropriately manage opioid addicted pregnant and postpartum women
- 91% of respondents were not trained to prescribe buprenorphine and the majority of those not trained had no plans to become trained in the next several months
- Respondents had limited comfort level with managing/treating pregnant women with addiction and withdrawal
- There was a lack of awareness regarding current state regulatory requirements when receiving a positive drug test

The data highlights the need for ACOG District II and other partners to offer additional education and resources to the provider community to compassionately care for pregnant women with opioid use disorder.
II. OPIOID ADDICTION IN PREGNANCY SUMMIT

OVERVIEW
ACOG District II’s Opioid Addiction in Pregnancy Summit on April 27, 2017 brought together a multidisciplinary group of health care providers to identify challenges and propose solutions to support women and families struggling with addiction during pregnancy.

The panel discussion opened with a keynote from Lieutenant Governor Kathy Hochul who highlighted the opioid epidemic in New York and emphasized the new resources the state has committed to the opioid crisis. The medical director of OASAS, Dr. Charles Morgan, shared key resources, including the OASAS Treatment Availability Dashboard, where providers can search for a listing of available treatment beds at OASAS-certified substance use disorder treatment facilities, including facility location and contact information. A multidisciplinary panel of experts then presented in a “rapid fire” opening session about management approaches and treatment practices for women using opioids and identified key challenges for the summit participants to discuss. Each of the panelists care for women at various stages of pregnancy and interact with pregnant women using opioids. The presentations provided attendees with the perspective necessary to facilitate a rigorous discussion of key management challenges.

Following the presentations, multidisciplinary groups were formed to address key challenges using a framework of questions provided to them. The charge of each group was to propose solutions to an assigned challenge. See Appendix A for a full list of participants and Appendix B for speaker bios.

KEY RECOMMENDATIONS AND ACTIONABLE STRATEGIES
Following the discussion of challenges, each team proposed solutions to address the barriers and issues relative to the management of opioid use disorder in pregnancy. With several of the proposed solutions being applicable across multiple challenges, it became apparent that the proposed solutions could be analyzed through the lens of four key recommendations, each with its own actionable strategies. Using the work performed by summit participants, the key recommendations and actionable strategies are summarized hereafter. Actionable strategies are identified in two main categories:

1) **Health Care Provider Strategies** — tailored towards key health care stakeholders such as ACOG, hospital leadership, women’s health care providers, clinicians and obstetric teams. Health care providers and hospital systems may need to conduct internal assessments to determine how to tailor the recommendations to meet their own communities’ needs.

2) **Public Health and Policy Strategies** — geared towards public health organizations, including NYSDOH, OASAS, county health departments, and patient advocacy groups. Stakeholders can discuss improvement opportunities to coordinate and implement each strategy to achieve the proposed recommendations.
RECOMMENDATION 1: CHANGE PERCEPTIONS OF OPIOID USE DISORDER THROUGH THE USE OF A COMMON LANGUAGE

The stigma associated with opioid use disorder, and substance use in general, stems from significant biases apparent within the health care system. Stigma can isolate patients and can discourage them from seeking necessary care to treat their substance use disorder. Using supportive and compassionate language is one way to effectively promote empathy, dignity and respect throughout the health care system.

HEALTH CARE PROVIDER STRATEGIES

- Implement universal screening as part of comprehensive obstetric care and performed at the first prenatal visit.
  - Routine screening should rely on validated screening tools such as questionnaires like 4Ps, NIDA Quick Screen, and CRAFFT (for women 26 years or younger).
- Strive to use language that helps reduce stigma, accurately reflects science, promotes evidence-based treatment, and demonstrates respect for patients. For example, replace “drug abuser” with “person with a substance use disorder” and “in recovery” rather than being “clean.”
- Develop tools to educate multidisciplinary teams of providers on the use of non-judgmental and harm-reduction focused language and learn how to acknowledge and change implicit biases of providers. Engage all staff in training, including clinical, administrative, and all other office personnel.

PUBLIC HEALTH AND POLICY STRATEGIES

- Reframe opioid use disorder as a chronic disease rather than an inherent personal flaw. Develop a community-based strategy through media campaigns, public service announcements, and community outreach to shift how the public perceives addiction.
- Develop educational materials/videos for patients suffering from addiction that promote self-worth and integrity that can be used in provider offices.
- Recognize buprenorphine prescribers with a specific credential (eg, gold star) who are admired and respected by colleagues, insurers, and the public to reduce stigma for those who treat this vulnerable population.

DISCUSSION TAKEAWAY

Given the severity of the epidemic, it is time to address the barrier of stigmatization, both of patients and health care providers who manage them. Tools are needed to educate providers on the use of harm reduction language.
II. OPIOID ADDICTION IN PREGNANCY SUMMIT

RECOMMENDATION 2: DEVELOP AND OFFER MULTI-FACETED EDUCATION AND IMPLEMENTATION TOOLS TO BETTER ASSIST WOMEN’S HEALTH CARE PROVIDERS IN CARING FOR PREGNANT WOMEN WITH SUBSTANCE USE DISORDER

Obstetric care providers have a unique opportunity to make a substantive impact on the lives of opioid dependent women and their infants by providing a medical home for patients during pregnancy, facilitating care coordination among providers, and delivering comprehensive prenatal and postpartum care.22

While there has been an increase in programs available (e.g., American Society of Addiction Medicine (ASAM)/ACOG, Providers’ Clinical Support System, or NYSDOH AIDS Institute Office of Drug User Health) to train obstetric care providers on prescribing and dispensing buprenorphine, even once trained, there are still many barriers. Barriers include lack of clinical mentorship programs, lack of knowledge of reimbursement policies, and concerns on how to incorporate the management and treatment of this vulnerable patient population into their current office flow. Moreover, lack of accessible training and tools for providers on effective management of women with opioid use disorder in pregnancy has limited providers willingness to treat this population.

DISCUSSION TAKEAWAY

There are significant obstacles for providers in identifying, treating, and managing opioid use disorder in pregnant patients. Providers need more accessible education, implementation tools, and mentorship to be successful.
II. OPIOID ADDICTION IN PREGNANCY SUMMIT

RECOMMENDATION 2

HEALTH CARE PROVIDER STRATEGIES

Buprenorphine Training:
- Designate clinical support mentors for providers following completion of buprenorphine training. Mentors can assist newly trained prescribers and those in training with clinical questions, billing/coding, and other guidance. Mentors can also provide periodic follow-up to trainees to address barriers and challenges.
- Offer on-site implementation training to providers who complete a buprenorphine training course to provide “real life” guidance on incorporating this education into their current patient workflow.

Education on Opioid Use Disorder Management:
- Create “Opioid Use Disorder Management” educational materials or a toolkit to increase provider knowledge base on the science of addiction, specific treatment options, and management of acute withdrawal (eg, COWS scale).
- Educate providers on how to incorporate standard screening tools into practice utilizing ACOG’s and ASAM recommendations on screening and intervention (eg, Screening Brief Interventions and Referral to Treatment-SBIRT).
- Create a continuing medical education (CME) course for practicing providers on the management of opioid use disorder in pregnancy as an additional option for the New York State mandatory prescriber training program.
- Enhance medical school and residency training program curricula on opioid management and treatment during pregnancy (eg, SAMHSA Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders).
- Develop grand rounds curriculum to enhance awareness.

Opioid Prescribing:
- Educate providers on strategies to avoid or minimize the use of opioids for pain management, highlighting alternative pain therapies such as nonpharmacological (eg, exercise, physical therapy, behavioral approaches), and non-opioid pharmacologic treatments.

PUBLIC HEALTH AND POLICY STRATEGIES

- Create a statewide hotline (similar to New York State HIV/AIDS Hotlines) for providers who need assistance in administering buprenorphine medication (eg, broad dosage guidance, billing, etc.). Providers can also use this hotline for connecting with a mentor or sign up to become one themselves.
- Develop an online repository of educational materials, videos, and webinars in collaboration with OASAS, the Substance Abuse and Mental Health Services Administration (SAMHSA), and ASAM that is tailored toward NYS providers.
II. OPIOID ADDICTION IN PREGNANCY SUMMIT

RECOMMENDATION 3: CREATE BETTER ENGAGEMENT AND COMMUNICATION AMONG PROVIDERS WITHIN THE CONTINUUM OF CARE AND ACROS SERVICE AREAS, INCLUDING THE JUSTICE SYSTEM

The management and treatment of substance use disorder in pregnancy is a challenging and complex process that requires involvement and investment from a multidisciplinary team of health care providers. In general, a coordinated multidisciplinary approach without criminal sanctions has the best chance of helping infants and families suffering from opioid use disorder.23

One of the critical components of effective care across the continuum is ensuring that providers are aware of the various resources available to women and families facing addiction (eg, AMCHP WHEN Program, Safe Babies Court Teams: Zero to Three, NYS OASAS Treatment Services).

Furthermore, special attention should be focused on care for opioid addicted pregnant women with experience in the justice system. Care is inconsistent and women may face significant barriers in accessing the needed services that are most beneficial to their health — before, during, and after being incarcerated. With 70% of women in state prisons being substance users prior to incarceration, more focused attention on their health care needs is essential.24

DISCUSSION TAKEAWAY

Patients and providers are often unaware of what community and regional resources are available.

Case management services are not abundant, and case managers can be challenged by working with jails that have their own policies and procedures — some of which may be contraindicated for pregnant women with SUD.

Communities are encouraged to create local task forces across service areas to break down barriers specific to their region and ensure all women receive the appropriate care.
II. OPIOID ADDICTION IN PREGNANCY SUMMIT

RECOMMENDATION 3

HEALTH CARE PROVIDER STRATEGIES

• Identify provider champions who can promote education and encourage other providers and systems to become engaged.
• Identify a facilitator to train new staff, determine gaps in services, and bring teams together through hospital-based quality improvement programs (eg, The joint project between ACOG District II and New York State Perinatal Quality Collaborative (NYSPQC), SAMHSA Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders).
• Develop patient-specific care plans to enhance communication among treating providers that detail prenatal, labor and delivery, postpartum and newborn care as well as a plan of safe care after hospital discharge.
  – Representatives from all care disciplines who interact with the patient should be engaged in development of the plan, including obstetrics, pediatrics, neonatology, patient advocates, behavioral health, social worker/case managers, anesthesiology, and addiction specialists.
  – Identify a case manager to oversee transition of the patient.
  – Hold regular meetings to review cases and coordinate care management.
• Educate emergency medicine physicians about the unique care plans for opioid use disorder in pregnant women and create protocols/processes for caring for this population when presenting to the emergency department (ie, care management/coordination through the development of algorithms/visual aids).
• Educate all providers of the importance of universal screening and be aware of the resources available (eg, NYS OASAS Treatment Services).

PUBLIC HEALTH AND POLICY STRATEGIES

• Create a task force or coalition locally, convened by a hospital or local health department, to facilitate understanding of barriers and challenges and enhance communication and collaboration.
  – Hold roundtable discussions regularly
  – Utilizing Regional Health Information Organizations (RHIOs), and in compliance with applicable laws,* require certain elements of the patient’s health record, including social and psychological information, to be transferred from one service area to another.
• Educate local jails and help ensure that their policies facilitate access to medication-assisted treatment for pregnant women with opioid use disorder.
• Contraceptive counseling and access to contraceptive services should be a routine part of substance use disorder treatment among women of reproductive age to mitigate the risk of unplanned pregnancy.25
  – Ensure women have access to contraception in jails to avoid unintended pregnancy.
• Alleviate limitations of current Electronic Health Record (EHR) technology posing barriers to adequate universal screening for substance abuse.

* The substance abuse confidentiality regulations for Health Information Exchanges (HIEs) may be perceived as a barrier to the electronic exchange of health information. However, it is possible to electronically exchange drug and alcohol treatment information while also meeting the requirements of Part 2 of the consent requirement.
II. OPIOID ADDICTION IN PREGNANCY SUMMIT

RECOMMENDATION 4: ENHANCE PATIENT AND FAMILY ENGAGEMENT

Women’s health care providers have a responsibility to provide patient-centered compassionate care, educate others regarding the chronic disease of addiction and its effect on pregnancy, and promote social and legal change that enhances autonomy and clinical outcomes for both the mother and her child.26

Engaging couples or family members early in treatment and recovery can help address questions and concerns, alter interactions within the family and improve communication. Treatment can be provided with the individual family member or in multiple family groups, both of which provide a supportive environment to share common experiences and concerns.27

DISCUSSION TAKEAWAY

Including the patient and her family when developing a care plan is vital.

Finding ways to create healthy patient-provider connections can be achieved through a patient and family engagement bundle.
RECOMMENDATION 4

HEALTH CARE PROVIDER STRATEGIES

• Engage the patient and her family early on in the process and care plan.
• Allow a woman to describe her family dynamic and define who she would like to engage in the process.
• Create a patient and family engagement bundle for providers to assist in engaging the patient and managing their expectations such as:
  – Am I hurting my baby
  – Is MAT safe for my baby
  – What is the role of child protective services (CPS) and what requires a notification to CPS
  – Will my baby be taken away
  – What is NAS and its long-term effects
  – What will treatment look like
• Utilize motivational interviewing techniques and communicate positive stories of people with substance use disorders to engage the patient in her care (eg. Enhancing Motivation For Change in Substance Abuse Treatment).
• Provide written information for the patient and her family that addresses her key concerns.
• Hold a specific prenatal consultation visit to educate the patient and her family on the care of the baby following delivery, including discussion of:
  – What will happen to baby in the NICU
  – Can I breastfeed my baby
  – The NAS scoring system tool
  – Child protective services role

PUBLIC HEALTH AND POLICY STRATEGIES

• Develop provider education on the current Child Abuse Prevention and Treatment Act (CAPTA) requirements and the changes in the Comprehensive Addiction and Recovery Act (CARA) legislation related to the full continuum of care from primary prevention to recovery support, including significant changes to expand access to addiction treatment services and overdose reversal medications.
• Create opportunities for support resources such as peer mentors, family navigator programs, and group therapy centering programs. For example, a few hospitals have implemented CenteringPregnancy® programs specific to opioid use disorder. Peer navigator programs such as the OASAS Certified Recovery Peer Advocates (CRPA) also exist. This program is for those individuals who hold an OASAS-approved certification as a peer advocate. The Center for Court Innovation Patient Navigator program (a Women’s Health Education Navigation [WHEN] network partner) is another similar program. These programs work with patients one-on-one to identify health care and social service needs, and link clients to other organizations and services.
The summit identified practice gaps and generated a set of recommendations that revealed where actionable strategies can be applied. As a result, ACOG District II has identified top priority areas to maximize adoption and uptake of best practices for the management and treatment of opioid use disorder in pregnancy.

As mentioned in the key recommendations, it is important for all health care stakeholders to be included when developing and disseminating educational materials. Utilizing a multidisciplinary expert task force, ACOG District II’s opioid initiative will proceed with the creation of an educational toolkit for providers based on the ACOG National bundle on obstetric care for women with opioid use disorder. The toolkit will emphasize management of opioid use disorder in pregnancy, universal screening, treatment options, and coding and billing guidance.

ACOG District II is excited about pursuing our partnership with the NYSDOH New York State Perinatal Quality Collaborative (NYSPQC) to align efforts to participate in the Alliance for Innovation on Maternal Health (AIM) collaborative on maternal opioid use disorder. NYS will be one of several AIM states committed to improving maternal health outcomes in the United States. ACOG District II and the NYSPQC will select hospitals to pilot the collaborative’s interventions before rolling them out statewide.

Future programs should also incorporate the critical role contraceptives play, especially information on long-acting reversible contraception (LARC), as the ability for a woman to plan when to become pregnant significantly benefits her health as well as the health of her future children.

Pregnant women with opioid use disorder require careful attention and optimal care from a multidisciplinary team of providers knowledgeable about the unique circumstances of pregnancy and addiction. The challenges and strategies outlined in this white paper only scratch the surface of the problem and require the commitment of health care providers, public health professionals, policymakers, the public, and patients to advocate on behalf of women battling opioid use disorder in pregnancy in NYS. As the educational and scientific resource on women’s health care, ACOG District II encourages organizations and policymakers to utilize ACOG as a resource and to partner and work together to effectively support women and families.

ACOG District II would like to thank the panelists and participants at the summit for sharing their expertise. ACOG District II would also like to thank the Lieutenant Governor for taking the time to provide the keynote address and Dr. Charles Morgan for speaking at the summit. Their valuable input, along with that of all those in attendance including our District II Opioid Use Disorder in Pregnancy expert task force and co-chairs Leah Kaufman, MD, FACOG and David Garry, DO, FACOG, was essential in providing an appropriate and thorough examination of managing opioid use disorder in pregnancy in New York State.
V. REFERENCES

8. ACOG, Opioid Use and Opioid Use Disorder in Pregnancy.
11. ACOG, Opioid Use and Opioid Use Disorder in Pregnancy.
12. ACOG, Opioid Use and Opioid Use Disorder in Pregnancy.
14. ACOG, Opioid Use and Opioid Use Disorder in Pregnancy.
16. ACOG, Opioid Use and Opioid Use Disorder in Pregnancy.
18. ACOG, Opioid Use and Opioid Use Disorder in Pregnancy.
20. ACOG, *Opioid Use and Opioid Use Disorder in Pregnancy.*


23. ACOG, *Opioid Use and Opioid Use Disorder in Pregnancy.*


25. ACOG, *Opioid Use and Opioid Use Disorder in Pregnancy.*


VI. APPENDIX A: LIST OF SUMMIT PARTICIPANTS

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Kimberlee Bliek, MS, RN
Michelle Bode, MD, MPH
Erin Bortel, MSW
Carmen Bowling, MSN, RN
LuAnne Brown, RN, BSN, MSN
Sharon Chesna, MPA
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Lieutenant Governor Kathy Hochul, as the highest ranking female elected official in New York State and a former Congresswoman, has been, and continues to be, a fierce advocate for women and families across the state. In addition to serving as the President of the New York State Senate, Lt. Gov. Hochul serves as the Chair of the New York State Heroin and Opioid Abuse Task Force. As chair, she has convened several outreach sessions across New York State to hear from experts and community members in search of answers to the heroin crisis and to develop a comprehensive strategy for New York. Lt. Gov. Kathy Hochul also chairs the Regional Economic Development Councils and New York State’s Women’s Suffrage 100th Anniversary Commemoration Commission, and Co-Chairs the Community College Councils. The Lt. Gov. has traveled the state many times over to meet with elected officials, business leaders, and residents alike to discuss issues that are important to her, the Governor, and the people of New York.

Charles W. Morgan, MD, DFASAM, FAAFP, DABAM serves as Medical Director of the New York State Office of Alcoholism and Substance Abuse Services. Dr. Morgan is a Distinguished Fellow of the American Society of Addiction Medicine and also of the American Academy of Family Physicians, and has worked in the field of Addiction Medicine for over three decades. He did his graduate work in Human Genetics at Cornell University, and his residency work in Internal Medicine in Rochester, NY, and Anesthesiology at the University of Pennsylvania. Following that he completed fellowships in both Regional and Obstetric Anesthesia at the University of Pennsylvania and in Addiction Medicine at Willingway Hospital in Statesboro, Georgia. Dr. Morgan has lectured extensively and served on expert panels and committees on local, regional and national levels. He has taught residents, fellows, physicians, nurse practitioners, physicians’ assistants, counselors and other professionals throughout his career from across the country and other parts of the world, and has been recognized by the American Academy of Family Physicians for his teaching. Dr. Morgan’s expertise includes all levels of care including outpatient treatment, inpatient rehabilitation and detoxification, and extended care, as well as all modalities of treatment including medication supported recovery and recovery without using medications. Dr. Morgan has published various written materials on addiction and anesthesiology and serves as a reviewer for the Journal of Groups in Addiction and Recovery.

Leah Kaufman, MD, FACOG is the Residency Program Director and Vice Chair of the Department of Obstetrics and Gynecology at the SUNY Upstate Medical University in Syracuse, NY. She attended medical school in Syracuse before completing residency at the Long Island Jewish Medical Center where she was previously the Residency Program Director. When that program merged to form the Hofstra School of Medicine Program, she served as program director before returning to Syracuse. Dr. Kaufman has a long history of service to ACOG, serving on many district and national committees including the Committee on Scientific Program, the CREOG Education Committee of which she is Vice Chair, and the District II Advisory Council where she recently served as legislative chair and currently serves on the Executive Committee as secretary. In her role as legislative chair and clinically as a general ob-gyn, Dr. Kaufman has advocated for increased access and education surrounding the care and resources for women and children affected by the opioid addiction crisis.

David Garry, DO, FACOG is currently the Maternal Fetal Medicine Division Director at Stony Brook Medicine for the Department of Obstetrics, Gynecology and Reproductive Medicine. Dr. Garry works with ACOG as an FASD Champion in the effort to reduce alcohol exposed pregnancies. He has served as an ACOG advisor for “Women and Alcohol” through media interviews and blogs. In District II, Dr. Garry helped produce, “Think-Don’t Drink,” an FASD handbook for providers. Over the past year, Dr. Garry has set up and established a Maternal Opioid Management program at Stony Brook for the care of women with opioid addiction during pregnancy. He also works with local organizations in Suffolk County to manage pregnant and postpartum women to improve outcomes of pregnancy.
Michelle Bode, MD, MPH is the Medical Director of Clinical Informatics at Crouse Hospital in Syracuse, NY. Dr. Bode is also an attending neonatologist with the Neonatal Associates of Central New York. Certified by the American Board of Pediatrics in both Pediatrics and Neonatal-Perinatal Medicine, Dr. Bode is a leading expert on Neonatal Abstinence Syndrome. As such, Dr. Bode has given several presentations and speeches on the topic of NAS and other neonatal issues.

Paul Updike, MD is Medical Director of the Chemical Dependency Program and the St. Vincent’s Health Clinic at Sisters Hospital in Buffalo, NY. Board certified in Internal Medicine, Dr. Updike is also certified in Addiction Medicine and Pain Management. Through his work as Medical Director, Dr. Updike provides medical supervision for the Pathways Methadone Maintenance Program, has developed and directed team standards for monitoring patient treatment plans, and instituted Suboxone treatment which dramatically increased their capacity to treat opiate dependency. He is a frequent lecturer in the Western New York area on the topics of pain treatment and addiction medicine. Dr. Updike has also been involved in various initiatives to improve pain management skills of primary care physicians, increase access to treatment for opiate use disorder, and provide mentoring and education to primary care physicians on pain management and addiction.

Sarah Reckess, Esq, is the Director of the Center for Court Innovation’s Syracuse office. Sarah oversees the development and implementation of problem-solving justice initiatives in Syracuse and Upstate New York. She oversees the Patient Navigator Programs in Syracuse and Buffalo, NY that provide one-on-one case management services to court-involved women who are pregnant or parenting an infant. She has planned and implemented a number of court-based programs that reduce recidivism, empower communities, and support justice system reform, including a juvenile diversion court for 16-17yos charged as adults, an employment services program for noncustodial parents who cannot pay their child support payments, an ESL court program for drug court participants, and a neighborhood-based restorative justice program that diverts cases from the Onondaga County justice system. She is a SAMHSA-certified Trauma-Informed Care Trainer and is also a facilitator for Community-Police Dialogues in the city of Syracuse in collaboration with the Syracuse Police Department. Sarah holds a J.D. with a concentration in Family Law and Social Policy from Syracuse University College of Law.

Kim Hober, MSSW, LMSW is a Senior Social Worker at the University of Rochester Medical Center where she provides assessment and treatment for obstetrical and gynecological patients. As a social worker, she collaborates with other teams, providers, and agencies to ensure patients receive proper treatment and often provides crisis intervention, treatment planning, and case management for ob-gyn and pediatric patients. Throughout her career in social work, Ms. Hober has worked with pediatric and obstetric patients in various capacities, including with high-risk patients struggling with addiction and newborns in the NICU. She has also provided education to pediatric and ob-gyn fellows, residents, and nurses regarding psychological issues in pregnancy and medically complex newborns.
ACOG District II
Opioid Use Disorder
in Pregnancy
Bundle – Part 1

Readiness, Recognition and Prevention

This education has been made possible through funding from the New York State Health Foundation (NYSHealth).
Disclaimers: The following material is an example only and not meant to be prescriptive. ACOG accepts no liability for the content or consequences of any actions taken on the basis of the information provided.

- This education is not exclusive to maternal opioid use disorder (OUD). The management approaches outlined within may also be effective in helping women with other substance use disorders.
- Each clinical setting must take into account the resources available within its own institution and community. Practices and institutions are strongly encouraged to review their existing policies and procedures for OUD in pregnancy management and modify them if necessary to maximize safe patient care.
Purpose

- Offer multi-faceted education and implementation tools to better assist women’s health care providers in caring for pregnant women with OUD
- Encourage better communication and engagement among providers across all of the services within the continuum of care, including the justice system
- Enhance the communication of OUD through the use of a common language
- Enhance patient and family engagement through education, common language; understand treatment and process
Opioid Use Disorder in Pregnancy: Know the Basics

First Steps
Physical Opioid Dependence

“Physical dependence is the physiological adaptation of the body to the presence of an opioid. It is defined by the development of withdrawal symptoms when opioids are discontinued, when the dose is reduced abruptly or when an antagonist (eg, naloxone) or an agonist-antagonist (eg, pentazocine) is administered.”


https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

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Opioid Addiction

• Primary **chronic disease** of brain reward, motivation, memory and related circuitry.
  - Dysfunction in these circuits leads to psychological, social, and spiritual manifestations.
• Reflected in an individual pathologically pursuing reward and/or relief by opioid use and other behaviors.
• Like other **chronic diseases**, addiction often involves cycles of relapse and remission.
• Without treatment, addiction is progressive and can result in disability or death.

Addiction and Other Chronic Conditions

Comparison of Relapse Rates Between Drug Addiction and Other Chronic Illnesses

- Drug Addiction: 40-60%
- Type 2 Diabetes: 30-50%
- Hypertension: 50-70%
- Asthma: 50-70%

Source: JAMA 284: 1689-1695, 2000

Created by ACOG District II in 2018
Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school or home.

- Alcohol Use Disorder (AUD)
- Opioid Use Disorder (OUD)
- Stimulant Use Disorder
- Hallucinogen Use Disorder (HUD)
- Tobacco Use Disorder
- Cannabis Use Disorder

Source: SAMHSA; https://www.samhsa.gov/disorders/substance-use
https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy
Created by ACOG District II in 2018
Opioid Use Disorder (OUD)

Opioid use disorder is a chronic, treatable brain disease that can be managed successfully by combining medications with comprehensive care and recovery support, which enables those with OUD to regain control of their health and their lives.

In 2014, an estimated 1.9 million people had an OUD related to prescription pain relievers and an estimated 586,000 had an OUD related to heroin use.

Sources: SAMHSA; https://www.samhsa.gov/disorders/substance-use

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy
Created by ACOG District II in 2018
DSM-V Diagnostic Criteria: OUD & SUD

A minimum of 2-3 criteria is required for a mild substance use disorder diagnosis, while 4-5 is moderate, and 6 or more is severe.

- Taking the opioid in larger amounts and for longer than intended
- Wanting to cut down or quit but not being able to do it
- Spending a lot of time obtaining the opioid
- Craving or a strong desire to use opioids
- Repeatedly unable to carry out major obligations at work, school, or home due to opioid use
- Continued use despite persistent or recurring social or interpersonal problems caused or made worse by opioid use
- Stopping or reducing important social, occupational, or recreational activities due to opioid use
- Recurrent use of opioids in physically hazardous situations
- Consistent use of opioids despite acknowledgment of persistent or recurrent physical or psychological difficulties from using opioids

*Withdrawal manifesting as either characteristic syndrome or the substance is used to avoid withdrawal (Does not apply when used appropriately under medical supervision)
*This criterion is not considered to be met for those individuals taking opioids solely under appropriate medical supervision. Source: APA 2013

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Created by ACOG District II in 2018
It Can Happen to Anyone

https://youtu.be/Pet6ugDj8CY

https://youtu.be/DbeVhMye9NQ

https://youtu.be/6NBNKvYSWPo

https://youtu.be/KtZLloQglys

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Created by ACOG District II in 2018
Prescribing Practices

In 2012, providers wrote 259 million prescriptions for opioids

- More than enough for every American adult to have a bottle of pills
- 20% of those with a pain-related diagnosis, acute or chronic, receive an opioid prescription
- Opioid prescriptions:
  - Have a place in pain management when used appropriately
  - Can lead to OUD

Source:
https://www.cdc.gov/vitalsigns/opioid-prescribing/
https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy
Created by ACOG District II in 2018
Where Pain Relievers Were Obtained for Most Recent Nonmedical Use among Past Year Users Aged 12 or Older: 2012-2013

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Created by ACOG District II in 2018
## Impact of Overdose Deaths in NYS

The drug-related death rate for women is 8.7 per every 100,000 people and 22 per 100,000 people for men. In both, the number of drug deaths have grown considerably – a 48% increase from 2010-2015 for women and an 83% increase for men.

### Drug Deaths by Sex in New York State 2010-2015

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
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</tr>
</thead>
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<tr>
<td>Female</td>
<td>601</td>
<td>701</td>
<td>735</td>
<td>821</td>
<td>826</td>
<td>891</td>
</tr>
<tr>
<td>Male</td>
<td>1,159</td>
<td>1,448</td>
<td>1,527</td>
<td>1,662</td>
<td>1,684</td>
<td>2,118</td>
</tr>
</tbody>
</table>


https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Created by ACOG District II in 2018
New York State Opioid-Related Deaths

New York State overdose deaths involving any opioid, crude rate per 100,000 population

Screening vs. Testing

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 with a validated verbal tool.

A positive biochemical drug test result is not in itself diagnostic of OUD or its severity.

- Urine drug testing only assesses for current or recent substance use; therefore, a negative test does not rule out sporadic substance use. Also, urine toxicology testing may not detect many substances, including some synthetic opioids, some benzodiazepines, and designer drugs.


https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Created by ACOG District II in 2018
Urine drug testing has been used to detect or confirm suspected opioid use, but 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, including any mandatory reporting requirements.

Limitations of urine toxicology:
- Typically does not test for alcohol or tobacco use
- Potential for false positive and false negative results
- Increases risk for possible child welfare involvement
- Test results do not assess parenting capabilities
- Often applied selectively
- Lab cut-off points for sensitivity

Sources:
ACOG. Opioid Use and Opioid Use Disorder in Pregnancy. Opinion No. 711.

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy
Assess all pregnant women for SUDs.

- 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.
- Early universal screening, brief intervention (such as engaging the patient in a short conversation, providing feedback and advice), and referral for treatment (SBIRT) of pregnant women with OUD improve maternal and infant outcomes and should be incorporated into the maternity care setting. (see appendix, slides 65-70 for screening tools)

Who can perform SBIRT?
Physicians, nurse practitioners, licensed midwives, physician assistants, nurses, health or substance use counselors, prevention specialists, and other health or behavioral health staff.

ACOG Patient Safety Bundle

Obstetric Care for Women with Opioid Use Disorder

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 care” for mom and baby.

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.

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Created by ACOG District II in 2018
READINESS
(Every Patient / Family)
Readiness

• Stigma/bias/discrimination
• Chronic disease
• Treatment
• Education
• Family/patient engagement
• Care coordination
• Multidisciplinary care coordination
• Antenatal, intrapartum, postpartum planning
• Pain control
• Know guidelines and statutes
• Know best resources
Enhance Patient & Family Engagement

Provide education to promote understanding of OUD as a chronic disease.
• Engage the patient, her partner, family, or other support (if she desires) early in the process and care plan.
• Encourage the patient to describe the dynamics of her support network and identify who she would like to participate in her care.
• Create a bundle (toolkit) to assist with patient and family engagement and to help manage the patient’s expectations such as:
  o Am I hurting my baby?
  o Is Medication-assisted treatment (MAT) safe for my baby?
  o Will my baby be taken away from me if I am using? Are there issues with specific drugs?
  o Breastfeeding recommendations – refer to ACOG guidelines
  o What is Neonatal Abstinence Syndrome (NAS) and what are the long-term effects of NAS? (see appendix, slide 73 for NAS resources)
  o What is the role of child protective services (CPS) and what requires a notification or a report to CPS? (see appendix, slide 83- CAPTA flowchart)
Enhance Patient & Family Engagement

- Utilize motivational interviewing techniques, include trauma-informed care, and communicate positive stories of people with OUD to engage the patient in her care (see appendix, slide 75 for SAMHSA resource)
- Provide written information for the patient and her family that addresses her key concerns (assess patient health literacy to improve comprehension)
- Schedule a prenatal consultation with a neonatologist, NNP, MFM, or social worker to provide the patient facts about what happens at the particular institution or with the NICU to educate the patient and her family on the care of the baby following delivery, including discussion of:
  - Neonatal Assessment
  - Breastfeeding recommendations
  - The NAS scoring system tool – empower patient by reviewing components of assessment systems, discuss the limitations of the tool and strategies for engaging mother in the process
Reduce Stigma

Change perceptions of OUD through the use of a common language and emphasize that SUDs are chronic medical conditions that can be treated.

- Stigma, bias, and discrimination negatively impact pregnant women with OUD and their ability to receive high quality care.
- Strive to use language that helps reduce stigma, accurately reflects science, promotes evidence-based treatment, and demonstrates respect for patients. For example, replace “drug abuser” with “person with a substance use disorder” or “in recovery” rather than being “clean.”
- Develop tools to educate multidisciplinary teams of providers on the use of non-judgmental and harm-reduction focused language and learn how to acknowledge and change implicit biases of providers.

Engage all staff in training, including clinical, administrative, and all other office personnel.

Source: Drug Policy Alliance
https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy
Created by ACOG District II in 2018
# Words Matter

## X Don’t Use
Dehumanizing, demeaning, demoralizing, language, such as:

- **Addict**
- **Get clean, Clean drug test**
- **Crazy vs. “normal”**

## Use
People-first language that confers respect, such as:

- **When speaking generally, say: person who uses drugs.** When talking about a specific issue, say: **person who has a problematic relationship with drugs.**
- **When referring to the newborn, they are not born addicted rather they have prenatal substance exposure.**
- **Stay away from this term, which implies that a person was previously “dirty.” Instead say: a person who formerly used drugs.** When possible, ask the person directly how they refer to themselves and their journey. If referring to a test, say: **test was negative, test was not positive for substance**
- **Avoid using terms that refer to mental illness – unless that’s truly what's being discussed. Instead: celebrate difference and diversity of experiences and approaches.**

Words Matter

**X Don’t Use**

Dehumanizing, demeaning, demoralizing, language, such as:

- Junkie, Crackhead, Zombie, Tweaker
- "Those" people
- Crack baby

**✓ Use**

People-first language that confers respect, such as:

- Do not use dehumanizing terms for people who use various substances – that contributes to the othering, stigmatizing, and discrimination of people who have needs. *Instead say: person who uses injection drugs/crack cocaine/synthetic cannabinoids, if in fact it’s necessary to specify.*
- Don’t use “othering” language that draws false distinctions among people. *Instead: use inclusive language and describe the group or individual using people –first language.*
- This label is not scientifically supported and leads to damaging stereotyping. Poverty - not drugs - was found to pose a much higher danger to children’s outcomes. *Instead say: prenatal exposure to a controlled substance.*


https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Created by ACOG District II in 2018
Neonatal Abstinence Syndrome (NAS)

Provide education regarding neonatal abstinence syndrome (NAS) and newborn care.

• Infants born to women who used opioids during pregnancy should be monitored by a pediatric care provider for neonatal abstinence syndrome (NAS), a drug withdrawal syndrome that opioid-exposed neonates may experience shortly after birth.
  • Engage patients early on in care and offer a consultation with MFM or pediatrics in their third trimester
  • Ensure awareness of the signs and symptoms of NAS
  • Include interventions to decrease NAS severity (eg, maternal-infant bonding and breastfeeding, and smoking cessation)
NYS Neonatal Abstinence Syndrome Rate

New York State neonatal abstinence syndrome (NAS) crude rate per 1,000 newborn discharges (any diagnosis)

Source: https://www.health.ny.gov/statistics/opioid/

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Created by ACOG District II in 2018
New York State NAS by county

New York State neonatal abstinence syndrome crude rate per 1,000 newborn discharges (any diagnosis)

Crude hospital discharge rate
Counties are shaded based on quartile distribution
(* Fewer than 10 events in the numerator, therefore the rate is unstable)

Definition: Newborn with withdrawal syndrome or affected by narcotics via placenta or breast milk.

Source: 2012-2014 SPARCS Data as of September 2016
~ The SPARCS data do not include visits/discharges by people who sought care from hospitals outside of NYS, which may lower numbers and rates for some counties, care from hospitals especially those which border other states.

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

29
NAS: Signs to Watch For

- Increased muscle tone “tightness”
- Poor eating or vomiting. Often, babies look like they want to eat, but they are not able to suck and swallow at the same time
- High pitched or long periods of crying or fussiness
- Trouble sleeping. Without enough sleep, they are not able to eat properly.
- Tremors or shaking
- Diarrhea. This may cause the baby to lose weight.
- Fever or sweating
- Frequent yawning or sneezing
- Difficulty breathing because of a stuffy nose, fast breathing, or forgetting to breathe
- Breakdown of skin on face or knees because of rubbing on the linen
- Possible seizures

*Use a modified NAS scoring system (e.g., Finnegan’s)

Source: Catholic Health Women Care NAS Pamphlet
https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Created by ACOG District II in 2018
Plan of Safe Care

Develop a network of providers (eg, social workers, case managers, legal services if available) to assist patients and families in the development of a “plan of safe care” for mom and baby (see appendix, slide 76 for plan of safe care resources).

- Develop patient-specific care plans to enhance communication among treating providers that detail prenatal, labor and delivery, postpartum, and newborn care as well as a plan of safe care after hospital discharge.
  - Representatives from all disciplines who interact with the patient should be engaged in development of the plan, including obstetrics, pediatrics, neonatology, patient advocates, behavioral health, social worker/case managers, anesthesiology, and addiction.
  - Identify a case manager to oversee transition of the patient.
  - Hold regular meetings to review cases and coordinate care management.
Plan of Safe Care

Understand “Plan of Safe Care” requirements.

- Child Abuse Prevention and Treatment Act (CAPTA) *(see appendix, slide 83 for resources)*
- Talk with mom to ensure she has thought about safe care for herself and her baby after delivery
  - Ensure access and referral to support in the community for breastfeeding, postpartum care (including depression screening and family planning), and social services following release from health care providers
- Address the health and substance use disorder treatment needs of the baby and family
- Ensure mom has a plan for continuity of care post-delivery – a safe house to care for her baby, MAT, crib, car seat, etc.
READINESS
(Every Outpatient Clinical Setting/Health System)
Professional Education

Provide staff-wide (clinical and non-clinical staff) education on SUDs.

• Recognize that pregnancy is a great window of opportunity to identify and treat women with OUD and improve maternal and infant outcomes

• What is OUD and who is affected (universal terminology and definitions for common language)?

• Offer strategies to engage the patient and how to overcome barriers

• What medications are appropriate during pregnancy?

• Medication-assisted treatment (MAT): methadone vs. buprenorphine (ie, Subutex/Suboxone) regimens – and accept patients who are NOT willing to take the treatment
  o Interactions with other medications may synergize opioids
Professional Education

• Ensure providers and the obstetric team are educated on safe opioid prescribing practices
• Harm reduction interventions/programs (eg, naloxone distribution and syringe exchanges) for patients
• Appropriate levels of treatment maintained throughout the delivery
• Collaborate with the pediatric provider in the solution and in developing a newborn management plan
• Identify community resources with which to partner (eg, agencies that treat SUD, domestic violence shelters, WIC, home visiting agencies, etc.)

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Created by ACOG District II in 2018
Practice Approach

Practices should **clearly define** the approach to screening and testing pregnant patients for opioid use based on what best aligns with their resources, expertise, and capacity.

• An important first step all practices should initiate is mapping of local resources such as identifying available treatment centers for pregnant women and locating buprenorphine prescribing providers.
  – Educate **ALL** staff on the practice approach and why you are screening, explain the reasons (eg, identify patients early on for care, next steps, NICU stay, etc.)
  – Explain to staff why withdrawing a mom while pregnant is not optimal
**Practice Approach Algorithm**

What is our philosophy of caring for and treating pregnant patients with OUD?

Following a positive screen or disclosure of probable OUD

Patient readiness to engage in treatment (if not ready initially, provide relevant, non-judgmental educational materials and/or schedule another appointment in a short interval to develop trust)

Full range of patient care offered at practice (prenatal care and MAT)

Prenatal care only referred out co-managed for MAT

Refer patient out for all needed services (patient discharged)

**Signs of acute withdrawal?**

Go to ER, consider in-patient stabilization or referral to experienced addiction provider

Patient linked to mental health, chemical dependency and social (eg, housing, transportation, WIC etc.) services.

- Referral to experienced MAT provider (office-based buprenorphine or opioid treatment program (OTP))
- Patient consents to coordinate treatment plans
Practice Education: Patient Encounters

• Ensure office staff are knowledgeable about patient education, MAT, available opioid treatment programs and the potential impact on the fetus (see appendix, slide 72 for resources)
  • This may include coordinating a meet and greet with a pediatrician and ensuring an appointment is scheduled prior to delivery, connecting the patient to community-based services (eg, mental health services).

• Discuss the importance of trauma-informed care and an environment of open communication (see appendix, slide 78 for trauma-informed care resource)
Trauma-Informed Care

Provide training regarding trauma-informed care to your staff.

*It is important that the staff who use motivational interviewing, recognize trauma-informed care as an element in the tapestry of a woman’s life.*

- Understand the neurobiology of trauma
- Recognize the signs and symptoms of trauma in patients and families
- Screen for physical and sexual violence (eg, use ACES screening 10 question as a guide (*see appendix, slide 78 for example*)
- Coordinate care with behavioral health/psychiatric care teams
- Prevent re-traumatization
- Seek someone in the community to educate your staff on trauma-informed care, read articles and books, and recognize cues to help where staff need to go with questions.
  - Attend trainings provided by crisis centers/universities

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Created by ACOG District II in 2018
Becoming a MAT Provider

Buprenorphine Waiver Training:

- **To prescribe or dispense buprenorphine, physicians must** qualify **and apply for a waiver under the Drug Addiction Treatment Act of 2000 (DATA 2000).**

  - **Physicians:** The DATA 2000 specifies training is necessary for physicians to obtain a waiver to engage in office-based treatment of opioid use disorders using drugs approved by the FDA on Schedules III, IV, and V.

  - **Nurse Practitioners and Physician Assistants:** In July 2016, President Obama signed the Comprehensive Addiction and Recovery Act (CARA) into law. CARA authorizes qualified NPs and PAs to become waivered to prescribe buprenorphine in office-based settings for patients with Opioid Use Disorder (OUD) for a five-year period expiring in October 2021. ASAM, AANP, and AAPA are authorized by statute to provide this training.

  *For alternatives to becoming a licensed treatment provider, go to www.buprenorphine.samhsa.gov. Click on "Data Physician Locator" under the "General" category. This will bring you to a listing of qualified physicians, which you can search by city, county or zip code.*
# Methadone vs. Buprenorphine in Pregnancy

<table>
<thead>
<tr>
<th>Methadone</th>
<th>Buprenorphine</th>
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</thead>
<tbody>
<tr>
<td>• May have better treatment retention</td>
<td>• May have less severe NAS</td>
</tr>
<tr>
<td>• No risk of precipitating withdrawal (with initiation of therapy)</td>
<td>• Fewer drug interactions</td>
</tr>
<tr>
<td>• Treatment initiation may be easier</td>
<td>• Ability to be treated on an outpatient basis and does not require daily visits</td>
</tr>
<tr>
<td></td>
<td>• Reduced risk of overdose during induction</td>
</tr>
</tbody>
</table>
Develop pain control protocols that account for increased pain sensitivity and avoidance of mixed agonist-antagonist opioid analgesics.

- Educate providers on strategies to avoid or minimize the use of opioids for pain management, highlighting alternative pain therapies such as nonpharmacological, and non-opioid pharmacologic treatments.
  - Confirm dose of methadone or buprenorphine with women’s health care provider and with ISTOP/PMP.
- Ensure awareness of dosage needs throughout the phases of pregnancy including addressing pain medication with patients and appropriate hospital staff at delivery.
  - If the patient is in prolonged labor, she may need to use her maintenance therapy medications during labor.
Establish Care Coordination

Establish specific prenatal, intrapartum and postpartum clinical pathways for women with OUD that incorporate care coordination among multiple providers (see appendix, slides 80-82).

- Help women’s health care providers obtain resources to become buprenorphine trained.
- Ensure pediatricians in the community are equipped with patient education about NAS and provide education about OUD.
- Educate emergency medicine physicians about the unique care plans for OUD in pregnant women and create protocols/processes for caring for this population when presenting to the ED (eg, care management/coordination through the development of algorithms/visual aids).
- Every hospital should standardize their discharge education and dosing for opioids (7 day supply limit).

Identify provider champions who can promote education and encourage other providers and systems to become engaged.

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Created by ACOG District II in 2018
Establish Care Coordination

Ensure that OUD treatment programs meet patient and family resource needs (eg, wrap-around services such as housing, child care, transportation and home visitation).

- Identify a facilitator to train new staff, determine gaps in services, and bring teams together through hospital-based quality improvement programs.

- Seek out community health worker networks in your region.
Know federal (Child Abuse Prevention Treatment Act – CAPTA), state and county reporting guidelines for substance-exposed infants.  
(see appendix, slide 83 CAPTA notification)  
- Know what the delivering hospital policy is regarding testing, contacting Child Protective Services (CPS), and the expected length of stay  
- Know state, legal and regulatory requirements for SUD care  
For example:  
- Pregnant women have priority (SABG Block Grant Requirements)  
- Treatment providers must ensure timely access to treatment services for pregnant women  
- Providers of treatment services must establish a policy to offer admission preference to substance abusers who inject drugs intravenously or are pregnant
RECOGNITION
(Every Provider/Clinical Setting)
Recognition

- Assess ALL
- SBIRT
- Polysubstance use
- Co-morbidities
- Psychiatric disorders
- Intimate Partner Violence (IPV)
- Smoking
- Readiness to change
Screen and evaluate all pregnant women with OUD for commonly occurring co-morbidities including psychiatric disorders, and physical and sexual violence. Ensure the ability to screen for infectious disease (eg, HIV, hepatitis and sexually transmitted infections (STIs)).

Ensure screening for polysubstance use among women with OUD. Provide resources and interventions for smoking cessation.

- ALL women seen in the office, in-patient or emergency/urgent care should be screened for drug, alcohol and all forms of nicotine use utilizing a selected SBIRT tool (refer back to slide 16-17 screening vs. testing as well as appendix, slides 65-68 for specific screening tools)
OUD Screening Tools

Utilize validated screening tools to identify drug and alcohol use.

- Routine screening should rely on validated screening tools, such as questionnaires like the 4Ps, Audit-C, NIDA Quick Screen, and CRAFFT (for women 26 years or younger)
  - All practices should use a screening tool that is non-judgmental, open-ended and implemented by their practice (see appendix, slides 65-68)
  - Patients may be more receptive to provider questioning while others may prefer a self-assessment on paper.
  - Screening is recommended at the first encounter. Elements can be added to the EMR under the flowsheet and flagged as a reminder to ask about substance use again in the third trimester.
  - In hospital screening – H&P should document what screening tool was used and that it was performed with the patient alone (away from family). Training should emphasize documentation that is non-judgmental not allowing for statements like “non-contributory”.

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Created by ACOG District II in 2018
Brief Intervention

• Patients who screen positive for OUD in pregnancy should receive a brief intervention. This intervention should use principles of motivational interviewing to affect behavioral change (see appendix, slide 75)

• Effective brief intervention includes 3 steps:
  1. **Offer feedback**
  2. **Listen and understand** the patient’s motivation (eg, “I hear that you use x to deal with stress of life at home”)
  3. **Explore other options** to address patient’s motivation for substance use (eg, “Are there other ways to deal with stress in a more healthy way?”)

**Note:** providing written handouts to ALL women can reach those who are afraid to disclose use, but who may be at risk and need treatment


https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Created by ACOG District II in 2018
Referral to Treatment

Match treatment response to each woman’s stage of recovery and/or readiness to change.

- Work with behavioral health/case managers in-office (if available) to assist with the intervention component of SBIRT
- Make referrals as needed that facilitate access to treatment and related services for women who need these services
  - Make connections with treatment providers to build relationships
  - Communicate with MAT providers at least once a month
- Ensure support for women’s health care providers starting buprenorphine waiver training or newly trained (see appendix, slide 87 for resources)
READINESS
(Every Inpatient Clinical Setting/Health System)

Understanding Your Hospital Approach/Philosophy
Regional Perinatal Center (RPC) & Hospital Education

• Engage community resources - ensure that all agencies are involved in the community – create resource guides, etc.

• All hospital teams should be trained in trauma-informed care, substance use disorders, opioid use disorder, safe care plan, etc. (see appendix for examples).

• Facilitate discussions with childbirth educator, obstetric provider (ob-gyn or licensed midwife), pediatric provider or neonatologist, anesthesiologist, and social worker to establish a plan and clarity of approach to care.

• Understand the hospital policy/approach for evaluating newborns for substance exposure at the time of delivery.

• The ob-gyn provider should know the basic discharge criteria for the at risk newborn.

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Created by ACOG District II in 2018
Hospital Approach

- Ensure all health care providers involved in the care of the woman have an understanding of the federal reporting requirements of CAPTA/CARA. Provide education where needed.

- Nursing
- Social Worker
- Women’s Health Care Provider including ob-gyn, midwife, hospitalist, resident, medical and nursing students

- Anesthesiologists
- Neonatologists
- Behavioral Health Specialists
- Emergency Department
Pain Management: General

Develop pain control protocols that account for increased pain sensitivity and avoidance of mixed agonist-antagonist opioid analgesics.

• Each hospital is encouraged to develop guidelines for management of patients with OUD.

• Patients with OUD may experience more pain (increased sensitivity) and require higher doses of opioids (tolerance).

• As appropriate, maximize non-pharmacologic therapies (eg, PT) and non-opioid pharmacologic treatments (eg, NSAIDS). Avoid mixed agonist-antagonists.

• Share ‘withdrawal” order set for pregnancy patients (include anesthesia, pharmacy, OBs, and neonatologists/pediatricians) (see slide 79 for sample order set)
Pain Management

Medical Care

Evaluation and management avoiding bias from patient’s history of OUD and/or pregnancy.

1. Women with OUD are as (or more) susceptible to medical conditions
2. Pregnancy may alter the presentation of common medical conditions
3. Pregnancy is not a contraindication to appropriate evaluation or opioid pain management

Medication-assisted treatment (MAT)
Assess engagement in treatment
Tx: Yes. Verify MAT dose/frequency. Avoid changes unless medically necessary and in consult with MAT provider.
Tx: No. Assess willingness to engage in treatment and refer

Prenatal care
Assess for prenatal care
PNC: Yes. Update provider
PNC: No. Refer for prenatal care

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

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Pain Management: Intrapartum

- Intrapartum analgesia needs are the same as for any other woman
  - It should not be assumed that MAT is sufficient for intrapartum analgesia
- Methadone or buprenorphine should be continued throughout labor
  - Buprenorphine should not be temporarily stopped in anticipation of delivery
  - MAT should not be used/adjusted for intrapartum analgesia
- IV access may be more difficult
- Neuraxial anesthesia is safe
  - The incidence of hypotension may be increased in the presence of some co-morbid health conditions (eg, liver disease)
- Avoid mixed agonist-antagonists
Reassure the patient that their pain will be addressed. Medications for MAT should not be assumed to cover postpartum pain or adjusted/interrupted for pain management.

- **Vaginal delivery**: Non-opioid analgesics are often adequate
- **Cesarean delivery**: Patients often experience more pain and require higher than average opioid doses
- It is **impossible** to predict a patient’s pain level or opioid need
- Maximize nonpharmacological (eg, heat) and non-opioid pain management (eg, TAB block, Toradol); double concentration patient-controlled analgesia (PCA)
  - Consider scheduled, rather than PRN, medications
- Avoid agonist/antagonists and full antagonists.

Breastfeeding should be encouraged for women who are on a stable dose of methadone or buprenorphine, interested, and have no other contraindications.
Withdrawal/Overdose

Assess severity of symptoms using a Clinical Opiate Withdrawal Scale (COWS) (see appendix, slide 84)

Symptomatic management

Consult Addiction Medicine

Naloxone for respiratory depression/maternal overdose

Antihistamines, alpha agonists, benzodiazepines, and opioid replacement

Can continue prescribed methadone or buprenorphine but cannot initiate treatment without waiver approval

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Treatment Services

Identify local SUD treatment facilities that provide women-centered care.
Ensure that drug and alcohol counseling and/or behavioral health services are provided.

- Create better engagement and communication among providers within the continuum of care and across service areas, including the justice system, as needed
- Educate all providers of the importance of universal screening and have resources available for those screening positive (see appendix, slides 85-86 for NYS OASAS Treatment Services; OASAS live dashboard https://findaddictiontreatment.ny.gov or call HOPEline 877.846.7369)
- Contact local counties for a list of Substance Use Disorder Treatment Referral/Provider Directory (provide name of the contact by County)
- Use of the Medicaid Cab program to schedule (five day advance notice) visits even if it brings patients two hours away from RPC and ensure Medicaid cab companies are involved in the solution
Conclusion

• 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.
• It is vital to use language that helps reduce stigma, accurately reflects science, promotes evidence-based treatment, and demonstrates respect for patients.
• Specific prenatal, intrapartum and postpartum clinical pathways for women with OUD that incorporate care coordination among multiple providers should be established.
• Various resources exist, including those listed in the attached appendix.
# ACOG District II Opioid Use Disorder in Pregnancy

## Task Force & Key Partners

<table>
<thead>
<tr>
<th>Person/Title</th>
<th>Institution/Program</th>
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<tbody>
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<td>Dede Hill</td>
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<td>Maria Morris-Groves, MSEd</td>
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<td>Neil Seligman, MD, MS, FACOG</td>
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<td>Maggie Taylor, PhD</td>
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<td>Darlene Walker, RN, FNP</td>
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<tr>
<td>Bridget Walsh</td>
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<tr>
<td>Ellie Ward</td>
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- **Alliance for Innovation on Maternal Health (AIM)**
- **HANYS’ Statewide Opioid Addiction Prevention and Management Collaborative**
- **NYSDOH AIDS Institute, Office of Drug User Health**
- **NYSDOH’s New York State Perinatal Quality Collaborative (NYSPQC)**
- **NYS Office of Alcoholism and Substance Abuse Services (OASAS)**

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Created by ACOG District II in 2018
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For questions on this project:

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The resources provided in this section are for informational purposes only. The exclusion of a resource, program or website does not reflect the quality of that resource, program or website. Note: websites and URLs are subject to change without advance notice.
Resources: Screening Tools

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 drank any alcohol or used other drugs?
Scoring: Any “yes” should trigger further questions

CRAFFT – Substance Abuse Screen for Adolescents & Young Adults
C Have you ever ridden in a CAR driven by someone (including self) 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 our drug use?
T Have you ever gotten in TROUBLE while you were using alcohol or drugs?
Scoring: Two or more positive items indicates the need for further assessment

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Created by ACOG District II in 2018
**STEP 1 – Ask the NIDA *Quick Screen* Question**

**Instructions:** Using the sample language below, introduce yourself to your patient, then ask about **past year** drug use, using the NIDA *Quick Screen*. For **each** substance, **mark in the appropriate column**. For example, if the patient has used cocaine monthly in the past year, put a mark in the “Monthly” column in the “illegal drug” row.

**Introduction (Please read to patient)**

*Hi, I’m __________, nice to meet you. If it’s okay with you, I’d like to ask you a few questions that will help me give you better medical care. The questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances we’ll talk about are prescribed by a doctor (like pain medications). But I will only record those if you have taken them for reasons or in doses other than prescribed. I’ll also ask you about illicit or illegal drug use—but only to better diagnose and treat you.*
**Resources: Screening Tools**

### Quick Screen Question:

*In the past year, how often have you used the following substances?*

- Alcohol
  - For men, 5 or more drinks a day
  - For women, 4 or more drinks a day
- Prescription Drugs for Non-Medical Reasons
- Illegal Drugs
  - If the patient says “NO” for all drugs, in the Quick Screen Question, the patient is not using drugs. The questionnaire can be completed.
  - If patient says “Yes” to one or more days of heavy use, please see NIAAA website “How to Help Patients Who Use Drugs” [http://pubs.niaaa.nih.gov/publications/Practitioner/behavioral/counseling/behavioral/counseling.html](http://pubs.niaaa.nih.gov/publications/Practitioner/behavioral/counseling/behavioral/counseling.html) for information to advise, assess, assist, and arrange help for patients with substance use disorders.
  - If patient says “Yes” to use of tobacco: Any current active tobacco users should be referred to the “Tobacco Use and Dependence Treatment” section of the NIDA-Modified ASSIST.
  - If the patient says “Yes” to use of illegal drugs or prescription drugs for non-medical reasons, proceed to Question 1 of the NIDA-Modified ASSIST.

### STEP 2 – Ask about any lifetime drug use (Question 1)

**Instructions:** Now ask the patient about any *lifetime* drug use. This form may be completed by your patient or any health care professional in your office. Screening personnel should offer to read the questions aloud in a private setting and complete the form for the patient. To preserve confidentiality, a protective sheet should be placed on top of the questionnaire so it will not be seen by other patients after it is completed.

<table>
<thead>
<tr>
<th>Q1. In your <strong>LIFETIME</strong>, which of the following substances have you ever used?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Cannabis (marijuana, pot, grass, hash, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Cocaine (coke, crack, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)</td>
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</tr>
<tr>
<td>d. Methamphetamine (speed, crystal meth, ice, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)</td>
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<td></td>
</tr>
<tr>
<td>f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Xanax, Librium, Rohypnol, GHB, etc.)</td>
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<tr>
<td>g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)</td>
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</tr>
<tr>
<td>h. Street opioids (heroin, methadone, etc.)</td>
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<td></td>
</tr>
<tr>
<td>i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)</td>
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<td></td>
</tr>
</tbody>
</table>
  - Please record nonmedical use only: Non-medical use refers to using a substance either not prescribed to the patient or used in ways or amounts not prescribed by their doctor.
| j. Other – specify: | | |

*Source: [https://www.drugabuse.gov/sites/default/files/files/QuickScreen_Updated_2013%281%29.pdf](https://www.drugabuse.gov/sites/default/files/files/QuickScreen_Updated_2013%281%29.pdf)*

*Created by ACOG District II in 2018*
Resources: Screening Tools

Exhibit 2-2. SBIRT Process

- Screening
  - No or Low Risk → No Further Intervention
  - Moderate Risk → Brief Intervention
  - Moderate to High Risk → Brief Treatment (onsite or via referral)
  - Severe Risk, Dependence → Referral to Specialty Treatment

Source: https://www.integration.samhsa.gov/sbirt/TAF33.pdf
https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Created by ACOG District II in 2018
# Resources: Reimbursement for SBIRT

<table>
<thead>
<tr>
<th>Payer</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial Insurance, Medicaid</td>
<td>99408</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30min</td>
</tr>
<tr>
<td>Commercial Insurance, Medicaid</td>
<td>99409</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30min</td>
</tr>
<tr>
<td>Medicare</td>
<td>G0396</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30min</td>
</tr>
<tr>
<td>Medicare</td>
<td>G0397</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30min</td>
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Source: [https://www.integration.samhsa.gov/sbirt/Reimbursement_for_SBIRT.pdf](https://www.integration.samhsa.gov/sbirt/Reimbursement_for_SBIRT.pdf)

Created by ACOG District II in 2018
## Resources: Reimbursement for SBIRT

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<thead>
<tr>
<th>Program</th>
<th>Code</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Medicare</td>
<td>G0443</td>
<td>Prevention: Up to four, 15 minute, brief face-to-face behavioral counseling interventions per year for individuals, including pregnant women, who screen positive for alcohol misuse; No coinsurance; no deductible for patient <a href="http://www.cms.hhs.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=249">Link</a></td>
</tr>
<tr>
<td>Medicaid</td>
<td>H0049</td>
<td>Alcohol and/or drug screening (code not widely used)</td>
</tr>
<tr>
<td>Medicaid</td>
<td>H0050</td>
<td>Alcohol and/or drug service, brief intervention, per 15 min (code not widely used)</td>
</tr>
</tbody>
</table>

Source: [https://www.integration.samhsa.gov/sbirt/Reimbursement_for_SBIRT.pdf](https://www.integration.samhsa.gov/sbirt/Reimbursement_for_SBIRT.pdf)

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

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Resources: Patient Education

Risks of continued SUD in Pregnancy:

Benefits of Medication-assisted treatment (MAT) in pregnancy with methadone and buprenorphine:
https://store.samhsa.gov/shin/content//SMA14-4124/SMA14-4124.pdf

Safety of the newborn, developing a plan of safe care for mother and newborn:
https://www.guttmacher.org/state-policy/explore/substance-use-during-pregnancy

Neonatal Abstinence Syndrome: What You Need to Know:

Breast feeding - ABM Clinical Protocol #21: Guidelines for Breastfeeding and the Drug-Dependent Woman
Are you taking any of these prescription painkillers?

These are prescription painkillers called opioids and some of their brand names. If you take an opioid during pregnancy, it can cause serious problems for your baby.

• Buprenorphine (SUBLImat, Buprenex, Butrans, Suboxone, Subsys)
• Codeine
• Fentanyl (Actiq, Duragesic, Sublimaze)
• Hydromorphone (Lorice, Dolantin, Nuvyn, Vixodin)
• Hydrocodone/Dilaudid, Vicod
• Meperidine (Demerol)
• Methadone (Dolophine, Methadone)
• Morphine (Aromorph, Avinza, Duramorph, Roxanol)
• Oxycodone (Opium, Percodan, Percocet, Pristocin)
• Oxymorphone (Oxydox)
• Tramadol (ConClin, Ayport, Ultram)

The illegal benzodiazepines are opioids. Fentanyl and other prescription opioids also are being made and sold illegally.

Your provider may prescribe an opioid for you if you’ve been injured or had surgery. Opioids can be dangerous and addictive. They can cause problems for a baby in the early weeks of pregnancy, even before you know you’re pregnant.

If you take opioids during pregnancy, your baby can be exposed to them in the womb and go through withdrawal after birth. This is called neonatal abstinence syndrome or NAS. Even if you are an opioid-naive like your provider says to, it still may cause NAS in your baby.

If you’re pregnant and using opioids:

• Don’t start or stop taking any opioid until you talk to your health care provider. Getting too stopping certain medications can be harmful to you and your baby. Quitting suddenly (called “cold turkey”) can cause severe problems for your baby, including death.
• Tell your prenatal care provider about any opioids or other medicine you take, even if it’s prescribed by another health care provider.
• If you go to a provider who prescribes you an opioid, make sure she knows you’re pregnant.
• Ask your provider about other kinds of painkillers you can take instead of opioids.

If you’re not pregnant and you’re using opioids:

• Use effective birth control until you’ve stopped taking the opioid.
• Talk to your provider about taking a safer pain medicine.

Watch a video about prescription medicines at: https://www.marchofdimes.org/pregnancy/prescriptionmedicinesforbirthcontrol.aspx

PREGNANCY: Methadone and Buprenorphine

HOW SAFE IS IT TO TAKE METHADONE OR SUPRÉNORPHINE (BUPRENORPHINE) DURING PREGNANCY?

• In the right doses, both methadone and buprenorphine stop withdrawal, reduce craving, and block effects of other opioids.
• Treatment with either methadone or buprenorphine makes it more likely that the baby will grow normally and not come too early.
• Based on many years of research studies, neither medicine has been associated with birth defects.
• Babies born to women who are addicted to heroin or prescription opioids can have symptoms of withdrawal or withdrawal symptoms in the baby (phenobarbital withdrawal syndrome or NAS). These withdrawal symptoms (NAS) also can occur in babies whose mothers take methadone or buprenorphine.
• Talk with your doctor about the benefits versus the risks of medication treatment along with the risks of not taking medication treatment.

IS METHADONE OR SUPRÉNORPHINE A BETTER MEDICATION FOR ME OR MY PREGNANCY?

• A pregnant woman and her doctor should discuss both methadone and buprenorphine. The choice may be limited by which medication is available in your community.
• If a woman is already stable on methadone or buprenorphine and she becomes pregnant, doctors usually advise her to stay on the same medication.

Some women are surprised to learn they got pregnant while using heroin, OxyContin, Percocet or other pain medications that can be abused (known as opioid drugs). You alone, with family and friends, may worry about your drug use and if it could affect your baby.

Some women may want to “detox” as a way to stop using heroin or pain medications. Unfortunately, studies have shown that 9 out of 10 women return to drug use by a month after “detox.” Therefore, doctors treat opioid misuse in pregnant women with either methadone or buprenorphine. These are long-acting opioid medications that are associated with improved outcomes in pregnancy.

HOW CAN I GET STARTED ON METHADONE OR SUPRÉNORPHINE?

• Depending where you live, there may be a special program that offers care to pregnant women who need methadone or buprenorphine. These programs can offer prenatal care and substance use counseling along with your medication.
• Methadone may only be given by specialized clinics while buprenorphine may also be available from your primary care physicians or obstetricians if they have received special training.
• Some women will prefer or benefit from starting these medications while in a residential (inpatient) treatment facility.

WHAT IS THE BEST DOSE OF METHADONE OR SUPRÉNORPHINE DURING AND AFTER PREGNANCY?

There is no “best” dose of either medication in pregnancy. Every woman should take the dose of medication that buprenorphine is the right for her.

• The right dose will prevent withdrawal symptoms without making you too tired.
• The right dose does not depend on how your body processes the medications.
• In pregnancy, you may need to take more of the medication as you get bigger and more active.
• The dose of medication usually needs to increase as pregnancy advances, and the medication may need to be increased more than once a day.
• There is little known about buprenorphine dose changes in pregnancy, but increases may be necessary.
• The dose does not seem to determine how much NAS a baby will have.

After delivery, the methadone or buprenorphine dose may remain the same or may decrease as your body returns to its non-pregnant state. This can take up to a few months after delivery.

Your dose should be reduced if it begins to cause constipation. Be sure to discuss whether you are feeling too sleepy with your doctors, nurses, and counselors. For further information, please see

Sources: https://www.marchofdimes.org/pregnancy/prescription-opioids-during-pregnancy.aspx
https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-In-Pregnancy

Created by ACOG District II in 2018
Resources: Patient Education

Neonatal Abstinence Syndrome

"Too often we underestimate the power of touch, a smile, a kind word, a listening ear, an honest compliment, or the smallest act of caring. All of which have the potential to turn a life around."

—Leo F. Buscaglia

How to Care for a Baby with NAS

Use the Right Words
I was exposed to substances in utero. I am not an addict. And my mother may or may not have a Substance Use Disorder (SUD).

Treat Us as a Dyad
Mothers and babies need each other. Help my mom and me bond. Whenever possible, provide my care alongside her and teach her how to meet my needs.

Support Rooming-In
Babies like me do best in a calm, quiet, dimly-lit room where we can be close to our caregivers.

Promote Kangaroo Care
Skin-to-skin care helps me stabilize and self-regulate. It helps relieve the autonomic symptoms associated with withdrawal and promotes bonding.

Try Non-Pharmacological Care
Help me self-soothe. Swaddle me snugly in a flexed position that reminds me of the womb. Offer me a pacifier to suck on. Protect my sleep by "clustering" my care.

Support Breastfeeding
Breast milk is important to my gastrointestinal health and breast feeding is recommended when moms are HIV-negative and receiving medically-supervised care. Help my mother reach her pumping and breastfeeding goals.

Treat My Symptoms
If I am experiencing withdrawal symptoms that make it hard for me to eat, sleep, and be soothed, create a care plan to help me feel better.

Sources: Catholic Health Women Care
National Perinatal Association

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Created by ACOG District II in 2018
## Resources: Provider Tools – NAS Scoring

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**SUMMARY**

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https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Created by ACOG District II in 2018
Motivational Interviewing: Motivational interviewing is a therapeutic style intended to help clinicians work with clients to address their ambivalence. While conducting a motivational interview, the clinician is directive yet client centered, with a clear goal of eliciting self-motivational statements and behavioral change from the client, and seeking to create client discrepancy to enhance motivation for positive change.
Resources Providers: Plan of Safe Care

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Created by ACOG District II in 2018
Resources: Provider Tools – Perinatal Networks

Perinatal networks can serve as a valuable community resource:

- Knowledge of local programs that a woman can utilize for various medical and social needs.
- May have home visiting programs or can provide a warm connection.
- Serve as a maternal child health resource referral network.
- Referral to community connections and with the employ of Community Health Workers (CHW)
  - CHW’s can help identify other community resources that might come up such as WIC, SNAP, childcare, parenting etc.
- Follow up after a direct referral for more information about support services.
Resources: Provider Tools – Trauma Informed Care

Adverse Childhood Experience (ACE) Questionnaire
Finding your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often …
   Swear at you, insult you, put you down, or humiliate you? 
   or
   Act in a way that made you afraid that you might be physically hurt? 
   Yes No 
   If yes enter 1

2. Did a parent or other adult in the household often …
   Push, grab, slap, or throw something at you? 
   or
   Ever hit you so hard that you had marks or were injured? 
   Yes No 
   If yes enter 1

3. Did an adult or person at least 5 years older than you ever…
   Touch or fondle you or have you touch their body in a sexual way? 
   or
   Try to or actually have oral, anal, or vaginal sex with you? 
   Yes No 
   If yes enter 1

4. Did you often feel that…
   No one in your family loved you or thought you were important or special? 
   or
   Your family didn’t look out for each other, feel close to each other, or support each other? 
   Yes No 
   If yes enter 1

5. Did you often feel that…
   You didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you? 
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it? 
   Yes No 
   If yes enter 1

Source: https://www.ncjfcj.org/sites/default/files/Finding%20Your%20ACE%20Score.pdf
https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Created by ACOG District II in 2018
## Resources: Provider Tools – Withdrawal Order Set

### Withdrawal Order Set

**Source:** Crouse Health Withdrawal Order Set

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

**Created by ACOG District II in 2018**
Resources: Provider Tools – Collaborative Approach

A COLLABORATIVE APPROACH TO THE TREATMENT OF PREGNANT WOMEN WITH OPIOID USE DISORDERS

Practice and Policy Considerations for Child Welfare, Collaborating Medical, and Service Providers

Compared to efforts by individual agencies and systems, collaboration across multiple agencies and systems, coupled with strong leadership and consistent communication, offers a more effective approach, a more efficient way of doing business, and ultimately leads to better outcomes.

https://www.acog.org/AboutACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy
Created by ACOG District II in 2018
Resources: Provider Tools

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Created by ACOG District II in 2018
Resources: Provider

MOMS Care Coordination Model

OB/GYN Labor & Delivery Tree (OB.9-OB.12)

- Check patient history in OARRS
- Substance use screen
- Nicotine withdrawal/smoking cessation (See 5%)  
- Pain/stress management during labor and delivery (See Pain Management Protocols)
- Pain management – postpartum, post-operative, and/or anesthesia consultation (See Pain Management Protocols)
- Newborn care / NAS Screening / Pediatrician or Pediatric Nurse (See Finnegan Scale)
- Lactation consult

OB.10  
Contact care coordination team to ensure care coordination and adequate support for mom and baby

OB.11  
Engage on-call member of care coordination team

OB.12 Inpatient Postpartum Care

- Assess and address immediate care needs
- In case of fetal demise, initiate grief counseling
- Pain management – postpartum and/or post-operative (See Pain Management Protocols)
- Education regarding late onset NAS (See ACOG Committee Opinion S24 and Pediatrics Journal)
- Continuation of nicotine replacement
- Contraceptive and sexually transmitted infection prevention counseling
- Lactation consult
- Child welfare service referral if needed
- Ensure stable housing and safety needs and refer to care coordinator when necessary

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-In-Pregnancy

Created by ACOG District II in 2018
New York State
Child Abuse Prevention and Treatment Act (CAPTA) Requirements
Related to Newborns Prenatally Affected by Substances

Delivery of Newborn

Are there child protection concerns
due to maternal substance use?*

YES

REPORT ACCEPTED BY
STATEWIDE CENTRAL REGISTER

- A newborn or mother has a positive toxicology screen due to
  intrauterine exposure to:
  - illicit substances
  - prescription medication not prescribed to the patient
  - prescription medication not taken as prescribed.
- A newborn has withdrawal symptoms, or is diagnosed with
  neonatal abstinence syndrome (NAS) due to intrauterine
  exposure to:
  - illicit substances
  - prescription medication not prescribed to the patient
  - prescription medication that is not taken as prescribed.
- A newborn has been deemed by a health care provider to have Fetal
  Alcohol Spectrum Disorder (FASD).
LDSS will engage family/caregiver in the development of a Plan of Safe
Care for the affected infant and family/caregiver.

* For all other Child Abuse and Maltreatment concerns follow
Mandated Reporter Protocol.

NO

REPORT NOT ACCEPTED BY
STATEWIDE CENTRAL REGISTER

Hospital staff are required to make a CAPTA notification to OCFS via the
mailbox listed below for any of the following:
- The mother is in treatment for a substance use disorder and is being
  prescribed or administered an addiction medicine by a health care provider.
- The mother is under the care and treatment of health care provider for
  chronic pain and is taking opioids as prescribed.
- The mother is taking benzodiazepines as prescribed by health care provider.

Hospital staff will develop a Plan of Safe Care for the affected infant and
family/caregiver.

Complete CAPTA Notification, scan and send via email to:
ocfs.sm.SafeCareNotifications@ocfs.ny.gov
Clinical Opiate Withdrawal Scale (COWS)

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<th>Patient’s Name: ______________________</th>
<th>Date and Time <em><strong>/</strong></em>/___: ________</th>
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<tbody>
<tr>
<td>Reason for this assessment: __________</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resting Pulse Rate:</th>
<th>GI Upset: over last 1/2 hour</th>
</tr>
</thead>
<tbody>
<tr>
<td>_______ beats/minute</td>
<td>0 no GI symptoms</td>
</tr>
<tr>
<td>Measured after patient is sitting or lying for one minute</td>
<td>1 stomach cramps</td>
</tr>
<tr>
<td>0 pulse rate 80 or below</td>
<td>2 nausea or loose stool</td>
</tr>
<tr>
<td>1 pulse rate 81-100</td>
<td>3 vomiting or diarrhea</td>
</tr>
<tr>
<td>2 pulse rate 101-120</td>
<td>5 multiple episodes of diarrhea or vomiting</td>
</tr>
<tr>
<td>4 pulse rate greater than 120</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sweating: over past 1/2 hour not accounted for by room temperature or patient activity.</th>
<th>Tremor: observation of outstretched hands</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 no report of chills or flushing</td>
<td>0 no tremor</td>
</tr>
<tr>
<td>1 subjective report of chills or flushing</td>
<td>1 tremor can be felt, but not observed</td>
</tr>
<tr>
<td>2 flushed or observable moistness on face</td>
<td>2 slight tremor observable</td>
</tr>
<tr>
<td>3 beads of sweat on brow or face</td>
<td>4 gross tremor or muscle twitching</td>
</tr>
<tr>
<td>4 sweat streaming off face</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Restlessness Observation during assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 able to sit still</td>
</tr>
<tr>
<td>1 reports difficulty sitting still, but is able to do so</td>
</tr>
<tr>
<td>3 frequent shifting or extraneous movements of legs/arms</td>
</tr>
<tr>
<td>5 unable to sit still for more than a few seconds</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Yawning Observation during assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 no yawning</td>
</tr>
<tr>
<td>1 yawning</td>
</tr>
<tr>
<td>2 yawning</td>
</tr>
<tr>
<td>3 yawning</td>
</tr>
<tr>
<td>4 yawning</td>
</tr>
</tbody>
</table>

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy
Resources: Provider Directory

Sources: https://apps.oasas.ny.gov/reports_doc/TreatmentDirectory.pdf
https://oasas.ny.gov/providerDirectory/index.cfm
https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Created by ACOG District II in 2018
## Resources: Provider Directory

### New York State Office of Alcoholism and Substance Abuse Services Provider Directory

#### County Name: Albany

**Program Type - Service:** Crisis Services - Med Sup Withdrawal-Outpatient  
**Provider Name:** St. Peter's Hospital City of Albany

<table>
<thead>
<tr>
<th>Program Address</th>
<th>Contact Phone</th>
<th>Provider NoPRU</th>
</tr>
</thead>
<tbody>
<tr>
<td>315 S Manning Blvd</td>
<td>(518) 225-1039</td>
<td>3300G053187</td>
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</table>

**Program Type - Service:** Crisis Services - Medical Managed Detoxification  
**Provider Name:** St. Peter's Hospital City of Albany

<table>
<thead>
<tr>
<th>Program Address</th>
<th>Contact Phone</th>
<th>Provider NoPRU</th>
</tr>
</thead>
<tbody>
<tr>
<td>315 S Manning Blvd</td>
<td>(518) 225-1039</td>
<td>3300G060227</td>
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**Program Type - Service:** Gambling - Gambling Outpatient  
**Provider Name:** Capital Counseling

<table>
<thead>
<tr>
<th>Program Address</th>
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<th>Provider NoPRU</th>
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</thead>
<tbody>
<tr>
<td>600 Warren St</td>
<td>(518) 464-6531</td>
<td>3631052034</td>
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**Program Type - Service:** Inpatient Treatment Services - Inpatient Rehabilitation  
**Provider Name:** St. Peter's Hospital City of Albany

<table>
<thead>
<tr>
<th>Program Address</th>
<th>Contact Phone</th>
<th>Provider NoPRU</th>
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</thead>
<tbody>
<tr>
<td>3 Mercyview Ln</td>
<td>(518) 452-6740</td>
<td>3300G01039</td>
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</table>

**Program Type - Service:** Methadone Treatment - Medical Maintenance  
**Provider Name:** Whitney M Young Jr Health Center, Inc.

<table>
<thead>
<tr>
<th>Program Address</th>
<th>Contact Phone</th>
<th>Provider NoPRU</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 DeWe St</td>
<td>(518) 464-4771</td>
<td>3520G05011</td>
</tr>
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**Program Type - Service:** Methadone Treatment - Methadone Clinic  
**Provider Name:** PROMESA, Inc.

<table>
<thead>
<tr>
<th>Program Address</th>
<th>Contact Phone</th>
<th>Provider NoPRU</th>
</tr>
</thead>
<tbody>
<tr>
<td>175 Central Ave</td>
<td>(518) 726-5899</td>
<td>30166G2785</td>
</tr>
</tbody>
</table>

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Sources: [https://apps.oasas.ny.gov/reports_doc/TreatmentDirectory.pdf](https://apps.oasas.ny.gov/reports_doc/TreatmentDirectory.pdf)  
https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy  

Created by ACOG District II in 2018
Resources: Medicaid Transportation Services

New York State Medicaid Cab Services
Currently the Department contracts with two Transportation Managers
• Medical Answering Services, LLC • All Counties North of NYC - https://www.medanswering.com (800) 850-5340 (24 hours a day, 7 days a week)
• LogistiCare Solutions, LLC
  ➢ New York City - http://www.nycmedicaidride.net (877) 564-5911 (24 hours a day, 7 days a week)
  ➢ Long Island - https://www.longislandmedicaidride.net (844) 678-1101 (24 hours a day, 7 days a week)

How Do Enrollees Get Transportation

• The medical provider or the enrollee contacts the appropriate transportation manager to request transportation:
  • The Department of Health’s policy requires 3 days notice for non-urgent trips. Every effort is made to assign trips made with less than 3 days notice, as available transportation options decrease as vendors shore up their daily trip rosters.
  • Urgent trips and hospital discharges are not subject to the 3 day window, and are considered priority.

• The transportation manager reviews the enrollee’s information to:
  • Ensure that the enrollee has appropriate Medicaid coverage
  • Assess the appropriateness of the request (i.e., is the request for transportation to a Medicaid-covered service?)
  • Assess the medically necessary mode of transportation
  • Verify enrollee’s address and suggested pick up time
  • Verify destination address, location within the facility, as well as time of appointment

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Created by ACOG District II in 2018
Additional Resources

ACOG Maternal Opioid Bundle

ACOG Maternal Opioid Bundle Resource Listing

Buprenorphine Waiver Training Resources
• https://elearning.asam.org/products/the-asam-buprenorphine-course-acog-march-3-2017
• https://pcssnow.org/clinical-coaching/
• https://pcssnow.org/resources/

Guidance for Treating Pregnant and Parenting Women with OUD and Their Infants
https://store.samhsa.gov/shin/content/SMA18-5054/SMA18-5054.pdf

HANYS Opioid Addiction Prevention & Management Collaborative
https://www.hanys.org/quality/collaboratives_and_learning_networks/opioids/

Medications for OUD
https://store.samhsa.gov/shin/content/SMA18-5063FULLDOC/SMA18-5063FULLDOC.pdf

SBIRT
• http://bigsbirteducation.webs.com/addictionwebinars.htm
• https://www.integration.samhsa.gov/clinical-practice/sbirt#why
• http://www.sbirtoregon.org/

The Alcohol Use Disorders Identification Test (AUDIT)
New York State Opioid Use Disorder in Pregnancy and Neonatal Abstinence Syndrome Initiative (NYS OUD/NAS)
Scope of the Problem

- National and NYS prevalence of pregnant women with OUD increased dramatically in the past decade.
- Between 2010-2016, in NYS the rate of any opioid-related overdose mortality among women of reproductive age increased from 3.9 to 11.6 per 100,000 population.
- The annual rate of NAS increased exponentially mirroring the rise in maternal opiate use.
- Between 2000 and 2013, the U.S has seen a 5-fold increase in the incidence of NAS.
- The rate of NAS in NYS was 5.2 per 1,000 newborn discharges in 2014, more than double the 2005 rate of 1.9 per 1,000 newborn discharges.
NYS OUD/NAS Goals & Key Partners

• Identify and manage women with opioid use disorder during pregnancy. Improve the identification, standardization of therapy and coordination of aftercare of infants with neonatal abstinence syndrome.

• This project is being undertaken as a collaboration of the NYSDOH Perinatal Quality Collaborative (NYSPQC), American College of Obstetricians and Gynecologists (ACOG) District II, Greater New York Hospital Association (GNYHA), Healthcare Association of New York State (HANYS) and other partners as part of the national Alliance for Innovation in Maternal Health (AIM).
State and National Partnerships
NYSDOH Survey of Toxicology Screening Practices in Perinatal Substance Use

• Purpose: To assess policies and practices in use in all NYS birthing hospitals in regard to perinatal toxicology screening.

• The survey was sent to all NYS birthing hospitals on January 23, 2017.

• 100% (124/124) response rate.
Key Findings of NYSDOH Toxicology Survey

• 50% (62/124) of hospitals have a written policy/protocol for toxicology screening of both pregnant women and infants.

• 83% (103/124) of hospitals screen some pregnant women based on specific risk criteria during the birth hospitalization.

• 60% (75/124) of hospitals have a written standardized protocol for infant toxicology screening.
NYS OUD/NAS Project

- Obstetric Focus
  - Obstetric Clinical Advisory Workgroup
  - Pilot Birthing Hospitals (N~15)
    - Statewide Expansion to All Birthing Facilities
- Neonatal Focus
  - Neonatal Clinical Advisory Workgroup
ACOG District II Knowledge, Attitudes and Practices Survey

ACOG DII OUD Task Force developed a knowledge, attitudes, and practices survey disseminated to ob-gyns across NYS, results include:

62% of respondents felt there was not adequate training and resources in their area/region to appropriately manage OUD in pregnancy

Respondents had limited comfort level with managing/treating pregnant women with addiction and withdrawal

There was lack of awareness regarding current state regulatory requirements when receiving a positive drug test

Source: ACOG District II Opioid Use Disorder in Pregnancy White Paper
NYS OUD/NAS Project Development

• Participation in national AIM project, including its advisory work groups

• Selected and invited members to join Clinical Advisory Work Groups for Obstetrics and Pediatrics

• Project materials currently under development:
  • Recruitment & Pre-work Package;
  • Driver Diagrams for OUD and NAS arms;
  • Change Package; and
  • Data strategy, measures, guides, collection forms, etc.

• Series of educational activities, including upcoming webinars and an in-person learning session

• Prepared to launch on September 20, 2018
NYS OUD/NAS Project Timeline

January 2017, Provider KAP Survey Disseminated

April 2017, ACOG OUD Summit held

November 2017, ACOG White Paper w/ Key Recommendations Disseminated

April 2018, Provider Bundle (Toolkit) Part 1 Disseminated

May 2018, NY Becomes AIM State

June 2018, Clinical Advisory Work Groups Selected

September 2018, Project Launch in Pilots Hospitals

January 2017, NYSDOH Survey on Toxicology Screening Practices in Perinatal Substance Use Administered

April 2018, Provider Bundle (Toolkit) Part 1 Disseminated

May 2018, NY Becomes AIM State

August 2018, OUD in Pregnancy Webinar
Opioid Use Disorder (OUD) in Pregnancy: Readiness, Recognition & Prevention

Pregnancy provides an important opportunity to identify and treat women with OUD. Early universal screening, brief intervention, and referral for treatment of pregnant women with OUD improves maternal and infant outcomes. This webinar will provide multi-faceted education and implementation tools to better assist health care providers who care for pregnant women with OUD, encourage better communication and engagement among providers across all services within the continuum of care and enhance patient and family engagement through education and common language.

Tuesday, August 14, 2018; 3:00pm-4:30pm

Faculty:
Leah Kaufman, MD, FACOG, Residency Program Director, Associate Professor and Vice Chair of Obstetrics and Gynecology, SUNY Upstate Medical University
David Garry, DO, FACOG, Department of Obstetrics, Gynecology and Reproductive Medicine, Stony Brook Medicine

Audience: OB/GYNs, Family Medicine, Nurse Midwives, Nurse Practitioners, Nurses, Behavioral Health Providers, Social Workers, all those managing/treating pregnant women with OUD.
Education Progress

- ACOG District II grand rounds are available on OUD in Pregnancy

- Provider education bundle in development
  Phase 2: Response *(to be completed within next few months)*

  **Phase 1 now available!**

- Video vignettes for SBIRT being created

- Continued partnership & collaboration with NYS OASAS to spread educational awareness
NYS OUD/NAS Project Presentations
Where can I find out more?
NYS OUD/NAS Key Partners

• New York State Department of Health (NYSDOH)
  o Marilyn Kacica, MD, MPH, Executive Director, NYSPQC
  o Kristen Lawless, MS, Project Director, NYSPQC
  o Lusine Ghazaryan, MD, DrPH, Project Advisor, NYSPQC

• American College of Obstetricians and Gynecologists (ACOG), District II
  o Christa Christakis, MPP, Executive Director
  o Kelly Gilchrist, Project Manager

• Greater New York Hospital Association (GNYHA)
  o Lorraine Ryan, BSN, MPA, Esq., Senior Vice President, Legal, Regulatory and Professional Affairs
  o Wing Lee, MBBS, MPH, Senior Project Manager

• Healthcare Association of New York State (HANYS)
  o Loretta Willis, RN, BS, CPHQ, CCM, Vice President, Quality and Research Initiatives
  o Kathy Rauch, RN, MSHQS, BSN, CPHQ, Director, Quality and Research Initiatives
Contact

New York State Perinatal Quality Collaborative
Empire State Plaza
Corning Tower, Room 984
Albany, NY 12237

Ph: 518/473-9883
F: 518/474-1420
NYSPQC@health.ny.gov
www.nyspqc.org
# New York State Opioid Use Disorder in Pregnancy and Neonatal Abstinence Syndrome Project

## Learning Session #1

**Thursday, September 20, 2018 – 10:00 AM – 3:15 PM**

Empire State Plaza, Meeting Rooms 4 & 7, Albany, New York

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>10:00 AM</td>
<td>Registration</td>
</tr>
<tr>
<td><strong>10:30 AM</strong></td>
<td>Welcome &amp; Introductions (Meeting Room 4)</td>
</tr>
<tr>
<td>10:30 AM –</td>
<td>Marilyn Kacica, MD, MPH, Executive Director, NYSPQC; Medical Director, Division of Family Health, NYS Department of Health</td>
</tr>
<tr>
<td>10:50 AM</td>
<td>The Cycle of Addiction</td>
</tr>
<tr>
<td>10:50 AM –</td>
<td>Paul Updike, MD, Medical Director for Substance Use Services, Catholic Health Services of Buffalo</td>
</tr>
<tr>
<td>11:00 AM</td>
<td>Review of Toxicology Survey Results</td>
</tr>
<tr>
<td>11:30 AM</td>
<td>Marilyn Kacica, MD, MPH, Executive Director, NYSPQC; Medical Director, Division of Family Health, NYS Department of Health</td>
</tr>
<tr>
<td>11:45 AM</td>
<td>Quality Improvement Overview and the Importance of PDSAs</td>
</tr>
<tr>
<td>11:45 AM –</td>
<td>Jane Taylor, EdD, Improvement Advisor, National Institute for Children’s Health Quality</td>
</tr>
<tr>
<td>12:15 PM</td>
<td>Lunch and Transition to Break-out Rooms</td>
</tr>
<tr>
<td>12:45 PM</td>
<td>Break Out Sessions / Facilitated Discussion</td>
</tr>
<tr>
<td>12:45 PM –</td>
<td>Obstetrics – Pain Management (Meeting Room 7)</td>
</tr>
<tr>
<td>2:00 PM</td>
<td>Leah Kaufman, MD, FACOG, Residency Program Director, Department Vice Chair, SUNY Upstate Medical University</td>
</tr>
<tr>
<td><strong>13:00 AM</strong></td>
<td>Pediatrics – Non-pharmacological Care (Meeting Room 4)</td>
</tr>
<tr>
<td><strong>13:30 AM</strong></td>
<td>Matthew Grossman, MD, Yale University School of Medicine and School of Public Health, Department of Pediatrics</td>
</tr>
<tr>
<td>Time</td>
<td>Event</td>
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<td>-----------</td>
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</tr>
<tr>
<td>2:00 PM</td>
<td>Transition to Plenary Room (Meeting Room 4)</td>
</tr>
<tr>
<td>2:10 PM</td>
<td>Transition to Plenary Room (Meeting Room 4)</td>
</tr>
<tr>
<td>2:10 PM</td>
<td><strong>Caring for Mother and Baby Across the Continuum of Care:</strong></td>
</tr>
<tr>
<td>3:00 PM</td>
<td>Multidisciplinary Team Work</td>
</tr>
<tr>
<td></td>
<td>- Michelle Eastman, MS, NNP-BC, <em>Glens Falls Hospital</em></td>
</tr>
<tr>
<td></td>
<td>- Kathleen Dermady, DNP, CNM, NP, <em>Director of Centering Pregnancy Special Care, SUNY Upstate Perinatal Center</em></td>
</tr>
<tr>
<td>3:00 PM</td>
<td>Wrap-up &amp; Next Steps</td>
</tr>
<tr>
<td>3:15 PM</td>
<td>- Kelly Gilchrist, <em>Manager, Medical Education, ACOG District II</em></td>
</tr>
</tbody>
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This event is supported through funding from the Centers for Disease Control and Prevention and New York State Health Foundation (NYSHealth).
<table>
<thead>
<tr>
<th>PFI</th>
<th>Level</th>
<th>Hospital</th>
<th>County</th>
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<tbody>
<tr>
<td>0001</td>
<td>RPC</td>
<td>Albany Medical Center Hospital</td>
<td>Albany</td>
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<tr>
<td>0866</td>
<td>1</td>
<td>Corning Hospital</td>
<td>Steuben</td>
</tr>
<tr>
<td>0636</td>
<td>RPC</td>
<td>Crouse Hospital</td>
<td>Onondaga</td>
</tr>
<tr>
<td>1005</td>
<td>1</td>
<td>Glens Falls Hospital</td>
<td>Warren</td>
</tr>
<tr>
<td>0925</td>
<td>3</td>
<td>Good Samaritan Hospital Medical Center</td>
<td>Suffolk</td>
</tr>
<tr>
<td>0208</td>
<td>RPC</td>
<td>John R. Oishei Children's Hospital of Buffalo</td>
<td>Erie</td>
</tr>
<tr>
<td>0213</td>
<td>2</td>
<td>Mercy Hospital of Buffalo</td>
<td>Erie</td>
</tr>
<tr>
<td>0583</td>
<td>1</td>
<td>Mount St. Mary's Hospital &amp; Health Center</td>
<td>Niagara</td>
</tr>
<tr>
<td>0541</td>
<td>RPC</td>
<td>North Shore University Hospital</td>
<td>Nassau</td>
</tr>
<tr>
<td>1464</td>
<td>RPC</td>
<td>New York-Presbybterian/Columbia University Medical Center</td>
<td>New York</td>
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<tr>
<td>0218</td>
<td>3</td>
<td>Sisters of Charity Hospital</td>
<td>Erie</td>
</tr>
<tr>
<td>0630</td>
<td>3</td>
<td>St. Joseph's Hospital Health Center</td>
<td>Onondaga</td>
</tr>
<tr>
<td>0413</td>
<td>RPC</td>
<td>Strong Memorial Hospital/University of Rochester Medical Center</td>
<td>Monroe</td>
</tr>
<tr>
<td>0058</td>
<td>3</td>
<td>United Health Services Hospitals, Inc. - Wilson Hospital Division</td>
<td>Broome</td>
</tr>
<tr>
<td>0245</td>
<td>RPC</td>
<td>University Hospital (Stony Brook)</td>
<td>Suffolk</td>
</tr>
<tr>
<td>0628</td>
<td>1</td>
<td>Upstate University Hospital at Community General</td>
<td>Onondaga</td>
</tr>
<tr>
<td>0181</td>
<td>3</td>
<td>Vassar Brothers Hospital</td>
<td>Dutchess</td>
</tr>
</tbody>
</table>
New York State Opioid Use Disorder in Pregnancy / Neonatal Abstinence Syndrome Project
Neonatal Abstinence Syndrome (NAS) Driver Diagram

**Key Drivers**
- Global AIM
  - Improve the care of infants with NAS.
- SMART AIM
  - By February 2020, decrease the average hospital length of stay (ALOS) for newborns with NAS by 10%.

**Provider education**
- Early and accurate identification of newborns with signs of NAS
- Management of newborns using standardized NAS treatment protocol
- Create a Multidisciplinary Coordinated Discharge Plan

**Parent and family education**
- Key Changes*
  - Pharmacologic care
    - Standardize parent and family education regarding mother/dyad health postpartum
    - Provide parent and family education on OUD, NAS and the importance of maternal involvement in infant care
    - Provide lactation education and support to all women
    - Engage parent and family partners in quality improvement initiative to provide unique perspective
  - Non-pharmacologic care
    - Utilize function-based assessments consisting of symptom prioritization for the assessment and management of NAS (Eat, Sleep, Console)
    - Establish and implement standardized protocols for non-pharmacological management including:
      - Low lighting / Quiet environment
      - Encourage kangaroo care / skin-to-skin contact
      - Allow rooming-in as appropriate
      - Encourage / support breastfeeding if appropriate
    - Encourage and facilitate maternal involvement with the newborn
    - Multidisciplinary care coordination
    - Shared decision making approach between caregiver and providers
  - Standardize provider and staff education on OUD and postpartum care
    - Provide staff-wide training on:
      - Opioid Use Disorder
      - Management and treatment of OUD
      - Verbal screening of mother and toxicology testing
      - CPS reporting process
      - Breastfeeding implications
      - Trauma informed care
      - Cultural humility and non-judgmental care
      - Maternal involvement in pediatric management of NAS and infant care postpartum
      - Pharmacological and non-pharmacological care strategies of infants with signs of NAS
    - Encourage providers to partner with parent/family partners in quality improvement initiative to provide unique perspective
  - Collaborate with OB providers to identify mothers whose newborns may be opioid exposed
  - Involve obstetricians in the discussion about OEN
  - Train clinical staff to recognize signs and severity of NAS
  - Provide staff-wide training on:
    - Opioid Use Disorder
    - Management and treatment of OUD
    - Verbal screening of mother and toxicology testing
    - CPS reporting process
    - Breastfeeding implications
    - Trauma informed care
    - Cultural humility and non-judgmental care
    - Maternal involvement in pediatric management of NAS and infant care postpartum
    - Pharmacological and non-pharmacological care strategies of infants with signs of NAS
  - Encourage providers to partner with parent/family partners in quality improvement initiative to provide unique perspective

**Key Changes* Refer to project Change Package for additional detail.
New York State Opioid Use Disorder (OUD) in Pregnancy / Neonatal Abstinence Syndrome (NAS) Project
OUD in Pregnancy Driver Diagram

**Global AIM**
Improve the identification and treatment of pregnant women with opioid use disorder.

**SMART AIM**
By February 2020, increase the percent of pregnant women screened for substance use disorder (SUD) with a verbal screening tool by 20%.

By February 2020, increase the percent of pregnant women with opioid use disorder (OUD) who are referred for treatment by 20%.

**Key Changes**
- Ensure coordination of care among providers during pregnancy, postpartum and the inter-conception period
  - Identify local resources
  - Identify partners to receive referrals
  - Establish protocols for referral
  - Encourage all patients with OUD to enroll in an OUD treatment program and link to resources/services
- Adopt prescribing protocols for pain management for patients with OUD
- Implement evidence based guidelines to reduce opioid over prescribing to pregnant and postpartum women
- Educate providers on the risk of overdose / use of naloxone
- Consider providing at risk patients with OUD naloxone education and a prescription for naloxone
- Engage the multidisciplinary team with mother and identified care partner(s) in discharge planning
  - Refer to follow up and treatment appointments (MAT, etc.)
  - Create a plan for how the home environment will support the mother/baby dyad
  - Engage social work for assessment and link to community based services for the mother/baby dyad including WIC, Early Intervention, transportation assistance, etc.
  - Engage families in safety planning and consider home safety assessment referral
- Ongoing communication between obstetric and pediatric teams

**Key Drivers**

- Standardize patient and staff education on OUD and pregnancy/postpartum care
- Increase the number of providers trained in MAT to treat pregnant and postpartum women with OUD
- Provide staff-wide training on:
  - Opioid Use Disorder
  - Verbal screening and toxicology testing
  - Management and treatment of OUD
  - Stigma
  - Breastfeeding implications
  - Management of acute withdrawal
  - Trauma informed care
  - CPS reporting process
  - Cultural humility and non-judgmental care
  - Prescribing guidelines for pain management / alternative therapies for pain management
  - Maternal involvement in pediatric management of NAS and infant care postpartum
- Encourage providers to partner with parent/family partners in quality improvement initiative to provide unique perspective

**Patient & Family Education**
- Implement universal prenatal screening
  - Select a verbal screening tool
  - Train staff to use verbal screening tool
  - Screen all pregnant women for SUD using a verbal screening tool
- Provide patient education regarding mother and infant health during pregnancy and postpartum
  - Provide patient education on OUD, NAS, naloxone, the importance of maternal involvement in infant care postpartum, and the CPS reporting process
  - Facilitate prenatal consults with pediatrician and lactation specialist for opioid exposed newborns (OEN)
  - Provide lactation education and support to all women, including those on psychotherapy and MAT
- Engage parent/family partners in quality improvement initiative to provide unique perspective

**Provider Education**
- Standardize provider and staff education on OUD and pregnancy/postpartum care
- Increase the number of providers trained in MAT to treat pregnant and postpartum women with OUD
- Provide staff-wide training on:
  - Opioid Use Disorder
  - Verbal screening and toxicology testing
  - Management and treatment of OUD
  - Stigma
  - Breastfeeding implications
  - Management of acute withdrawal
  - Trauma informed care
  - CPS reporting process
  - Cultural humility and non-judgmental care
  - Prescribing guidelines for pain management / alternative therapies for pain management
  - Maternal involvement in pediatric management of NAS and infant care postpartum
- Encourage providers to partner with parent/family partners in quality improvement initiative to provide unique perspective

**Identification of Women with Opioid Use Disorder**
- Encourage providers to partner with parent/family partners in quality improvement initiative to provide unique perspective

**Optimize Medical Care of Pregnant Women with OUD**
- Implement universal prenatal screening
  - Select a verbal screening tool
  - Train staff to use verbal screening tool
  - Screen all pregnant women for SUD using a verbal screening tool

**Create a Multidisciplinary Coordinated Discharge Plan**
- Ongoing communication between obstetric and pediatric teams
District III

Resident Global Exchange Project
November 30, 2018

Linda Kinnane
ACOG
409 12th Street SW
Washington DC  20024

Dear Council of District Chairs:

On behalf of the District III Advisory Council, it is my pleasure to nominate the District III Owen Montgomery Global Exchange Scholarship project for the CDC Service Recognition Award. This project is an initiative of the District III Advisory Council Education Committee, whereby a US Resident visits a Dominican Republic residency program and a Dominican Republic resident visits a US Residency Program. The goal of the program is to promote collaboration with our members in the Dominican Republic and to offer valuable educational opportunities to US and Dominican Republic residents.

Attached is a project summary, timeline and evaluation from our first resident exchange.

Thank you for your consideration of this important award.

Sincerely,

Ann Honebrink, MD, FACOG
Chair, ACOG District III
Introduction: The global health resident exchange program is an initiative of the District III Advisory Council Education Committee, whereby a US Resident visits a Dominican Republic residency program and a Dominican Republic resident visits a US Residency Program.

**Education Committee Meeting October 8, 2017**
Proposal: A US Residency Program host a resident from the DR each year and that we explore the option to send a resident to the DR for an elective.

The DR Section Vice Chair was charged to submit a proposal at the 2018 IDM: proposal for how elective in DR would work, where the resident would stay, what the curriculum would be, what the language requirements are, what the vaccine requirements are, what budget would be needed, what is the liability coverage.

A member of the Advisory Council was charged with exploring how other programs within the district but made it work for residents visiting the US.

District III Vice Chair and Residency Program Director was charged to submit a proposal at the 2018 IDM: how elective in US would work, where the resident would stay, what the curriculum would be, what the language requirements are, what the vaccine requirements are, what budget would be needed, what is the liability coverage.

**Education Committee Meeting March 2018 IDM**
Proposed official project title – DISTRICT III OWEN MONTGOMERY GLOBAL EXCHANGE SCHOLARSHIP

Proposal: 1-2 US residents per year go to DR for 2-week experience and have 1-2 DR residents per year come to US for 2 week observership

A. Logistics – US resident to DR
   Resident selected for pilot and is going in May 2018 funded by District III for travel and lodging
   a. 3rd or 4th year resident
   b. application process – deadline December 1?
   c. selection committee
   d. timing – ideally travel Feb-May
   e. education – visits at the two teaching hospitals in Santa Domingo
   f. housing – hotel (Drakes Inn) near hospital
   g. point person – DR Section Fellow and JF Officers
   h. vaccines – visit to travel med recommended, typhoid and Hep A recommended
   i. transportation – will be picked up and taken to airport

B. Criteria
   a. knowledge of Spanish language
      i. rotate among sections and programs within the district
b. Liability Insurance – in letter of agreement the US residency program

C. Logistics – DR resident to US
   a. 3rd or 4th year resident
   b. application process - DR Section to develop
   c. selection committee – DR Fellow and JF Officers
   d. timing – ideally travel Feb-May
   e. education – probable observership/simulations on various services
   f. housing – TBD – home stay or hotel
   g. point person – District III Vice Chair/Program Director/JF Chair
   h. vaccines – visit to travel med recommended, PPD, Hep B, Rubella, Flu, Varicella (vaccine or proof of immunity recommended)
   i. transportation – will be picked up and taken to airport
   j. criteria – TBD (knowledge of English language)
   k. Liability Insurance – original hospital to provide; in letter of agreement the US residency program

D. Budget
   • $650 Airfare
   • $700-2800 (home vs hotel)
   • $200 transportation to/from airport and hospital
   • $700 food and incidentals stipend
   
   TOTAL - $4350

$18,000 special project allocation

PILOT: US Resident to Dominican Republic, April 30 – May 10, 2018 Schedule

Resident: Megan Madrigal, MD, PGY4.
Hosting Hospital: Hospital Maternidad Dra. Evangelina Rodriguez Perozo.
OBGYN Teaching Faculty Director: Rocio Caridad, MD, ACOG Fellow.
Resident Supervisor: Agustin Diaz, MD, ACOG JF Chair for DR Section, attending physician at hosting hospital. Mobile phone 1-829-548-4877.
Rotation Supervisor and Emergency Contact in DR: Elisa Fernandez, MD, ACOG Fellow Chair for DR Section. Mobile phone 1-849-201-3111.

Monday April 30th
2:22 pm Arrival at Santo Domingo Airport (SDQ)
       Host hospital pick-up from airport and transport to hotel.
6:00 pm to 8:00 pm Dinner with 3 residents

Tuesday May 1st
7:00 am to 8:30 am Morning Check-Out Rounds and Teaching Session at hosting hospital
8:30 am to 8:45 am Breakfast with residents at hosting Hospital Cafeteria
8:45 am to 9:30 am Hosting Hospital Tour
<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
</table>
| 9:30 am to 4:00 pm | Labor and Delivery                                                        
|                    | Lunch when possible with L&D residents at Hospital Cafeteria           |
| Wednesday May 2nd  |                                                                           |
| 7:00 am to 8:30 am | Morning Check-Out Rounds and Teaching Session at hosting Hospital       |
| 8:30 am to 8:45 am | Breakfast with residents at hosting Hospital Cafeteria                  |
| 8:45 am to 4:00 pm | Labor and Delivery                                                       
|                    | Lunch when possible with L&D residents at hosting Hospital Cafeteria   |
| 6:30 pm to 8:30 pm | Dinner and Conference on Nutrition during Pregnancy at Galerias 360. (JF Chair pick-up and drop-off at hotel). |
| Thursday May 3rd   |                                                                           |
| 7:00 am to 8:30 am | Morning Check-Out Rounds and Teaching Session at hosting Hospital       |
| 8:30 am to 8:45 am | Breakfast with residents at hospital Hospital Cafeteria                 |
| 8:45 am to 4:00 pm | Labor and Delivery                                                       
|                    | Lunch when possible with L&D residents at hosting Hospital Cafeteria   |
| Friday May 4th     |                                                                           |
| 7:00 am to 8:30 am | Morning Check-Out Rounds and Teaching Session at hosting Hospital       |
| 8:30 am to 8:45 am | Breakfast with residents at hosting Hospital Cafeteria                  |
| 9:30 am to 12:00 pm| OB Clinic                                                                 |
| 12:00 pm to 1:00 pm| Lunch at hosting Hospital Cafeteria                                     |
| 1:00 pm to 4:00 pm | Free time                                                                 |
| 4:00 pm to 8:00 am | On call. Check-out with on call team will be on L&D at 4:00 pm         
|                    | Dinner when possible with on call team at hosting Hospital Cafeteria   |
| Saturday May 5th   |                                                                           |
| 8:00 am to 8:30 am | Check-out to incoming on call team at L&D                                |
| Rest of the day    | Free time                                                                 |
| Sunday May 6th     |                                                                           |
| 1:00 pm to 3:00 pm | Lunch with DR Section Officers                                          |
| Monday May 7th     |                                                                           |
| 9:00 am to 1:30 pm | OBGYN clinic at DR Section Chair’s Private Practice                     |
| 1:30 pm to 2:30 pm | Lunch provided at Staff Lounge in OBGYN Clinic                          |
| 2:30 pm to 4:30 pm | Continue OBGYN clinic at DR Section Chair’s Private Practice            |
|                    | Dinner on your own                                                        |
| Tuesday May 8th    |                                                                           |
7:00 am to 9:00 am    Private Hospital Surgical observership day
9:00 am to 1:30 pm    Free time and lunch on your own
1:30 pm to 4:00 pm    GYN clinic at hosting Hospital
Dinner on your own

Wednesday May 9th
7:00 am to 7:30 am    Morning Check-Out Rounds at hosting Hospital
7:30 am to 12:00 pm   GYN Surgery at hosting Hospital OR
12:00 pm to 1:00 pm   Lunch at hosting Hospital Cafeteria
1:30 pm to 4:00 pm    GYN clinic at hosting Hospital
6:00 pm to 7:30 pm    Farewell dinner with DR Section officers and hosting Hospital residents.

Thursday May 10th
Departure from Santo Domingo Airport (SDQ)

US Resident Post Evaluation

Page 1: PREPARATION FOR TRIP
Q1 I received enough information prior to leaving the United States to prepare me for my rotation in the Dominican Republic. (Please elaborate on any issues that you feel could have been better prepared before the trip)
Agree, always

Page 2: EXPERIENCE
Q2 I was allowed to participate as an active member of the team during my experiences at the public hospital/clinic.
Maybe, sometimes., please elaborate.: Sometimes the language barrier, since I am not completely fluent, inhibited my ability to fully function as a part of the team. This more so applied to the clinic and labor setting, the language issues were less prominent in the OR. The residents though were very eager and accommodating to let me participate as much as I could. I think someone more fluent in Spanish could be more hands on, but even without being able to help see clinic or ER patients, or not being able to do some labor flood work (like the IV's, administering meds) because I don't have training in that, it was really interesting and educational to even observe the differences in care provision between the two residencies
Q3 I had adequate supervision during my rotation in the Dominican Republic.
   B. Maybe, sometimes, please elaborate:
   In terms of residents being helpful, 100% of the time. But the supervision question makes me think of attending oversight, which seems to be just different than what programs in the US do, so it's a cultural difference on the definition of "supervision". I never felt unsafe and abandoned, in or outside of work.

Q4 The rotation helped me to better understand the health care system in the Dominican Republic (please expand on what you learned)
   A. Agree, always.

Q5 During my rotation in the Dominican Republic I was able to comply with the guidelines for duty hour restrictions recommended by ACGME.
   A. Agree, always.

Q6 The housing during the rotation met my needs.
   A. Agree, always.
   I appreciate a 2 minute walk to the hospital over fancy accommodations.

Q7 The food during the rotation met my needs.
   A. Agree, always.
   I really appreciated the groceries that Dra. Fernandez brought, that was very helpful, as the rotation kept me quite busy and I usually wasn't feeling up to a run to the grocery store at the end of the day.

Q8 Transportation during my rotation met my needs (ie: airport and hospital transfers).
   A. Agree, always.
   I really appreciated the residents helping to drive me to most of the locations. The taxi service used by the hotel was also good, and I think that phone number (and the cost) could be included in the orientation packet for the next participants. The car service to the airport was very nice.

Q9 During my rotation in the Dominican Republic, I felt safe.
   A. Agree, always.

Q10 Overall, I would recommend this global rotation to my peers.
   A. Agree, always.
Q11 My goals for the trip were met (please elaborate on what those goals were and how they were met).

A. Agree, always.
I really wanted to get exposure to how healthcare was provided in other countries, especially lower resource settings than my own experience. I also found it very interesting to experience how residency can vary in other countries (and also how similar it can be :)). I did want to help provide care, which I did find a little tough 1) due to my language restriction but also 2) I didn't want to steal experiences from residents who were looking to further their own training and education. I also wanted to meet new people and explore a new country, so I loved getting to spend so much time with the residents as well as the planned dinners/conferences/outings. I think having a full 2 weeks would allow for more exploration of the city and the country, which I didn't feel I could do as much given my truncated schedule. It may also be worth considering sending the two residents down at the same time to rotate, as that way they would have someone to go sightsee or travel on the weekends with.

Q12 What I liked best about the rotation/experience was: (list 5)
1. Working with the residents
2. Being the scrub tech for c-sections (since we don't do that!), and operating with the residents
3. Volleyball and dinner with Dr. Albert, felt like a very local experience
4. Working at different hospitals to see the different settings
5. Weekend trip to the beach : )

Q13 What I disliked most about the rotation/experience was: (list 5)
1. That I didn't speak enough Spanish to be more helpful
2. That I didn't have enough time to explore more of Santo Domingo, let alone any surrounding areas
3. Again that my Spanish hindered me from interacting with all the residents, who were all very eager to get to know me and also understand my experience as well

Q14 To improve the rotation in the future I would suggest: (list 5)
1. For people of moderate Spanish speaking ability (like myself) tailor the rotation to be more observational, for example a single day each in OB and Gyn clinic, and the ED, and focus more on L&D/Surgery; like how my rotation was set up
2. Encourage people to be fluent speakers to do the rotation, which could let them be more active in clinic and would recommend more time in the ED, which was a very interesting experience. Also it would allow them to be more interactive with the residents.
3. For a full two week rotation, set aside one weekend for exploring
(TAB 3)

District IV

Georgia – Preventing Maternal Death in Georgia
November 19, 2018

Re: CDC Service Recognition Award – Georgia (District IV ACOG)

Dear Members of the Council of District Chairs:

On behalf of the leaders and members of District IV, it is personally rewarding to have the pleasure of writing a letter of support for the project submitted by the Georgia Section for the CDC Service Recognition Award. The description of the project submitted by Dr. David Byck of Savannah, chronicles the work of the entire section and their advocates including the members of the Georgia Obstetric and Gynecologic Society (GOGS). It is a timely report of the activities in the state of Georgia to secure support and funding from the Georgia legislature for studying and improving the maternal mortality rate. The report details their efforts and success in procuring the “most money any state has ever appropriated for the prevention of maternal death.”

Georgia successfully married two current problems in the state to support their request with the data needed to sway legislative opinion.

• Since 1994, Georgia has seen nearly 40 labor and delivery units close.
• As of April 2018, more the half of the counties in Georgia did not have an OB/GYN.
• The Georgia DPH reported over 100 maternal deaths in 2010.
• Advocacy spurred on the mandate for the Maternal Mortality Review Committee (MMRC).
• The MMRC reported on maternal hemorrhage and circulatory disease as a leading cause of maternal death.
• Georgia became an AIM state in 2017 to gain help in addressing these issues.
• Georgia successfully combined the problems of rural health coverage and maternal death with a strong advocacy program and years of relationship building to secure funding from the legislature. The clear purpose was to secure grants to rural hospitals for maternal hemorrhage bundles.

The Georgia initiative has demonstrated the right way to get the job done when it comes to patient advocacy. Now the hard work starts for Georgia as they utilize these funds and put their skills to the test in demonstrating the success that we hope to see with their planned interventions.

Sincerely,

Wade A. Neiman, MD
ACOG District IV Chair
The high rate of maternal death in the United States has been well-documented in recent years. The U.S. has the worst rate of maternal death among developed countries, and efforts related to understanding the causes of and enacting efforts to prevent maternal death have only just begun in earnest. Unfortunately, the rising cost of health care, unfavorable insurance reimbursement for physicians and hospitals, and the Great Recession have created a perfect storm that is not conducive to hospitals in medically underserved areas to remaining viable. As a result, many have closed, which has resulted in decreased access to critical preventive health services and attendant worsening health outcomes, especially as they related to maternal health care.

Georgia is one state that has been particularly impacted by prolonged high rates of maternal death. Since 1994, Georgia has seen nearly 40 labor and delivery units close. When these facilities shut down, it is usually the case that the OBGyn will leave the area. Accordingly, as of April 2018, more than half of the counties in Georgia do not have an OBGyn.

In 2014, the Georgia OBGyn Society (GOGS) became the lead advocate for urging the State of Georgia to devote resources to understanding the causes of maternal death. Through vital records data, the Georgia Department of Public Health reported over 100 maternal deaths in 2010. Due to strong advocacy by GOGS, the General Assembly legislatively mandated the creation of the Maternal Mortality Review Committee (MMRC), administratively housed at the Department of Public Health (DPH), the annual identification and review of maternal deaths, and subsequent report of the causes of death and recommendations for prevention. In January 2018, DPH released its second case report that included 2013 data, and in May 2018, completed its review of 2014 maternal deaths with a tentative report date of December 2018.

The MMRC found that the rate of maternal death was actually not as high as was captured by DPH due to coding errors on the death certificate. However, the rate was still a national leader. In 2012, the MMRC determined there were 86 maternal deaths. In 2013, there were 79. In both of these years, the main causes of death were hemorrhage and disease of the heart and circulatory system. In 2017, Georgia became an Alliance for Innovation On Maternal Health (AIM) state. At the time, AIM was a relatively new national effort to improve the quality of maternal healthcare. Georgia’s standing as an AIM state would allow technical assistance from national experts in strategies to prevent maternal death. However, the funding that was received was nominal in comparison to the need for real prevention.

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In November 2017, members of the DPH Maternal and Child Health Section, Georgia Perinatal Quality Collaborative (GaP-QC) and GOGS met to form a plan for requesting funding from the General Assembly to initiate maternal clinical quality improvement in areas of greatest need in Georgia. AIM had developed a maternal hemorrhage prevention and treatment protocol and stakeholders saw this as the perfect fit for Georgia.

In January 2018, GOGS strongly supported a request by DPH for $2 million for the specific purposes of preventing maternal death. The money would be primarily used in the form of grants to rural hospitals with labor and delivery units to be able to assess and successfully treat maternal hemorrhage. A smaller portion of the funding would be used to support education and evaluation. Previously, Georgia had appropriated $100,000 to DPH to fund the MMRC and production of the case reports. The leap from $100,000 to $2 million was certainly no small feat, but one that must be made if lives were to be saved.

Through an increase in the contract from DPH to GOGS, the Society hired a labor and delivery nurse with a public health background to lead the efforts of maternal quality improvement for the Society, hedging our bets a little that the $2 million would be awarded. This staff person was planned to work in concert with staff from DPH to roll out the maternal hemorrhage bundle with the Gap-QC organization and guidance from its medical director.

Advocacy began in December 2017 with meetings with targeted legislative leaders to let them know this was our request and garner support before the session began. The legislators were familiar with the plight of maternal mortality in Georgia and generally supportive of the idea of preventing maternal death, but $2 million is a lot of money, and we had to be crystal clear about how this money would be used.

The House Appropriations Subcommittee on Health recommended the full $2 million in the FY 2019 state budget. The House Appropriations Committee agreed and the House sent the budget to the Senate for consideration. However, there was some concern that the $2 million might be reduced and portions of that money could be used for other needs. Again, advocacy efforts were repeated in the Senate with multiple visits to Senate leadership offices and letters to Appropriations Committee leaders.

In the end, the Senate agreed with the House, and the $2 million was left fully intact all the way to the Governor’s desk.

Having data to support our request, as well as making a strategic decision to focus the money in rural labor and delivery units, were the key factors in our advocacy. Other success factors were utilizing the expertise of contract lobbyists to obtain the support of specific legislative champions, maintaining consistent messaging throughout the session, utilizing “Dear Chairman” letters from legislators to Appropriations Committee leadership, maintaining distance from other controversial issues, utilizing relationships of OB/Gyns to specific legislators, and appropriate usage of physicians during the legislative day to continue to reinforce our request. Another major reason for why we were successful is due to many years of cultivating strategic legislative relationships, being present at the Capitol, cultivating relationships with state agency staff, and heeding the advice of contract lobbyists.

According to the Alliance for Innovation On Maternal Health, this is the most money any state has ever appropriated for the prevention of maternal death.
District VI

Illinois – Fertility Preservation Bill
November 1, 2018

Council of District Chairs
American College of Obstetricians and Gynecologists
409 12th Street, SW
Washington, DC  20024

re: CDC Service Recognition Award

Dear CDC members,

I hereby strongly recommend the Illinois Section of ACOG for the CDC Service Recognition Award. The Illinois Section under the strong leadership of Dr. Maura Quinlan, the Illinois Section Legislative Chair.

Dr. Quinlan, the Illinois Section past Chair, initiated a weekly educational series for the Northwestern Obstetrics and Gynecology residents three years ago. The passion around advocating for women’s and children’s health spread and as a result, one of the junior residents came up with the idea to introduce legislation in our state legislature to require 3rd party payors to require insurance coverage for fertility preservation related to iatrogenic infertility.

While the idea was initially focused on adolescents with cancer undergoing chemotherapy or radiation, the final bill was more inclusive and covers anyone with infertility related to medical condition or procedures.

The residents worked with Dr. Quinlan, the ISACOG lobbyist, Phil Milsk, the ACOG Government affairs team and state legislator, Robyn Gabel.

The team focused on this bill during the 2017 & 2018 Lobby days in Springfield. The result was that the bill passed both housed in the spring of 2018 and was signed into law by the Governor in August 2018.

Perhaps more importantly, the entire exercise fueled a passion for advocacy in a cohort of young, energetic and enthusiastic Ob – Gyne physicians. We look forward to great things from them in the future.

Please accept this nomination for the CDC Service Recognition Award.

Sincerely,

Denise M Elser, MD
Chair, District VI
American College of Obstetricians and Gynecologists
The Illinois legislative accomplishment in the current session was the passage of the Fertility Preservation Bill. This bill began in the summer of 2016, when the Northwestern residents chose their “Summer Series” focus to be Legislative Advocacy. One session involved discussion of the legislative process with Dr Maura Quinlan who is the legislative chair of the state section of ACOG, Phil Milsk, the ISACOG lobbyist, and legislator Robyn Gabel. Northwestern junior resident Jessica Walter suggested the idea of introducing a bill to require insurance coverage for fertility preservation for iatrogenic infertility.

With the help of ACOG Government Affairs team, we were able to write our first proactive legislation modelled after similar legislation in other states. Ms Gabel introduced the bill in February 2017. Illinois House Bill 2617, specifically outlining that “Health insurance shall provide coverage for medically necessary expenses for standard fertility preservation services when a necessary medical treatment may directly or indirectly cause iatrogenic infertility.” Importantly, this bill also requires Medicaid to cover fertility preservation. Coalition partners joined including the Alliance for Fertility Preservation who added their significant experience. Fertility preservation clinical navigators from the largest children’s hospital in the state came on board and recruited a patient who experienced fertility preservation during chemotherapy as a teen. These individuals added their passion for this issue to ours, and made numerous trips to Springfield to testify in committee hearings and meet with legislators. Our lobby day in 2017 had this bill as a priority.

The bill passed the house in spring 2018, and our lobby day 2018 had this bill as a continued priority. Michelle Brown, a resident from University of Chicago, was able to have a 2 week state advocacy block in spring 2018, and devoted her time to preparing for lobby day and meeting with multiple legislators in their home offices to gather support. Support of the state medical society and the insurance industry was key to the passage of this bill.

The bill passed both houses May 2018, and was signed by the Governor 8/27/2018.

This bill started with the idea of a resident who saw the need as she cared for patients. We added the passion of individuals and groups who care deeply about the issue, utilized the resources of the ACOG government affairs team and our indefatigable lobbyist and state advocacy team to pass legislation for the benefit of both women and men in Illinois.
Current Legislative Session, ends 12/31/2018

1) HB 2617 Fertility Preservation Bill – Our First Proactive Legislation!

This bill would require health insurance (including Medicaid) to provide coverage for medically necessary expenses for standard fertility preservation services when a necessary medical treatment may directly or indirectly cause iatrogenic infertility.

Update: Signed into law at a bill signing ceremony with Governor Rauner 8/27/2018!

2) HB 4165: ACA Protection

This bill would require a joint resolution of the IL General Assembly before the state could apply for any federal waivers to reduce access to Medicaid coverage required under the ACA (such as work restrictions, block grants, etc - the attacks on Medicaid we are seeing in many other states). This would put up a road block to make it much more difficult to strip IL residents on Medicaid of their coverage.

This bill has also passed both houses. Governor Rauner vetoed 8/24/2018 as expected, as the bill did not have veto-proof votes in either chamber.

3) HB 0274: Pharmacists Dispensing Hormonal Contraception

Allows pharmacist dispensation of hormonal contraception to patients under the standing order of an MD (the director of the Illinois Dept of Public health) if patients fill out an appropriate (MEC based) screening questionnaire. ACOG prefers true over-the-counter OCP access in addition to ensuring no-copay contraception. ACOG, however, does support this bill in its current form as it helps to increase access to contraception.
Next legislative session, begins 1/1/2019

1. Pharmacists Dispensing Hormonal contraception (HB 0274 as above)

Will be reintroduced in January, likely more support as more Democrats in both chambers

2. Planning proactive legislation in response to renewed interest in maternal mortality after recent IDPH Maternal Mortality Review Committee Document including:

   1. Maternal levels of care legislation: Would allow IDPA to establish ACOG levels of maternity care, supported by ISMS
   2. Expand Medicaid from 2 months to 1 year post-partum (Gabel to sponsor)
   3. Maintain Title X funding for all qualified providers if federal funding withdrawn
      a. 800,000 women served by Title X in Illinois/year
      b. Prevents 26,000 unintended pregnancies
      c. Saved the state 150 million in 2010
   4. Implement law (PA 100-0208) allowing pharmacists to dispense 17OHP

Lobby Day Successful April 2018

Lobby date set for April 3, 2019

83 @IllinoisACOG Twitter followers

53 members of ISACOG Legislative Interest Group

3 Grand Rounds/resident lectures on ISACOG/legislative advocacy given this academic year
Selection of media reporting of Illinois Fertility Preservation bill

Chicago Tribune editorial written by the resident who initially proposed the bill, 4/20/2017

Daily Herald guest editorial written by resident Michelle Brown, 4/9/2018
https://www.dailyherald.com/discuss/20180409/proposed-law-would-assure-cancer-patients-insurance-for-fertility-preservation

Chicago Tribune article after bill introduction, 4/19/2018

Chicago Tribune article about cost of fertility preservation in response to bill, 5/24/2018

Chicago tribune coverage of bill signing 8/27/2018

Northwestern University announcement including YouTube video of Governor Rauner speaking at the bill signing, 8/27/2018
(TAB 5)

**District IX**

Trifecta for Maternal Mental Health!
CDC Outstanding District Service Award
Dear Dr. Elser and District Chairs;

**Trifecta for Maternal Mental Health!**

District IX is extremely proud of the collaborative efforts made in 2018 to support the improvement of Maternal Mental Health (MMH). Participation with the Institute for Medicaid Innovation, California Task Force on Postpartum Depression, 2020 MOM and legislative efforts for MMH gave District IX (California) a strong step in the right direction concerning the growing awareness and knowledge of these serious issues.

In November 2018 the Institute for Medicaid Innovation (IMI) released its document “Innovation in Maternal Depression and Anxiety: Medicaid Initiatives in California and Nationwide”. This document highlights some pilot programs utilized in and beyond California that have been successful in addressing MMH. It also has set goals and ideas for improvement, such as Medicaid expansion to include the entire year post-partum. District leadership participated on the Technical Expert Panel of this process as well as the California Task Force on Postpartum Depression. The findings from the Task Force were frequently referenced in the IMI document.

Legislative efforts in the state resulted in the passage of 3 bills concerning MMH. While improving funding, education, screening and treatment of MMH disorders seems a logical “easy win”, the behind the scenes negotiations to protect our Fellows as well as provide the best for our patients was complex and required efforts from District leadership and legislative teams as well as outreach to MMH organizations and our State medical society.

The **bills, our positions and explanations:**

- **AB 893**: required the California Department of Public Health to investigate and apply for federal funding opportunities to support MMH.
  
  ACOG IX position: **Support**.

  *This was the easy one!*

- **AB 3032**: Requires hospitals with perinatal units to develop and implement a program to provide education and information to health care professionals and patients about MMH conditions.

  ACOG IX position: **Support**.

  *We requested an early amendment to ensure inclusion of Medical Staff in the process.*

- **AB 2193**: Initial language mandated all OB/Gyn providers screen all perinatal women for MMH and refer to payor provided case management programs. Disciplinary penalties were to be applied by the licensing agency (California Medical Board) for failure to comply. After complex and very sensitive negotiations, subsequent modifications to the language occurred resulting in the final language which requires OB/Gyn providers of perinatal care to verify screening has occurred or provide it.
ACOG-IX position: Oppose (initially)---Neutral (final).

Our initial objection was due to the mandate on medical practice with licensing penalties. The payors very quickly negotiated out of the case management programs which we believed important enough to prevent us from moving to a support position without it. This bill required extensive negotiations with the authors, MMH organizations, and California Medical Association. The public became aware following multiple news publications including NPR painting ACOG-IX as being unsupportive of MMH issues. ACOG-IX had to fight the “bad” public image for not initially supporting this bill which required education of our opponents and the public that we do not support mandates on healthcare, but are very supportive of MMH concerns. We felt strongly that screening and identification of patients in need of treatment without implementation of treatment programs did not properly address our concerns. Ultimately we were able to come to agreement that enabled ACOG-IX to take a neutral position with removal of the mandate/penalty portion. We remained steadfast not to support due to lack of treatment options and the because other, non-OB/Gyn perinatal providers such as Family Medicine, Pediatrics, Emergency Medicine and Midwives were not included in the screening requirement.

Moving forward into implementation of the bills, ACOG-IX has plans to work with California Healthcare Foundation to disseminate information and educate our Fellows and other providers on MMH screening and to improve knowledge of treatment options.

Maternal mental health is a vital focus for us as OB/Gyns and is very important to District IX where we deliver 12.5% of the babies in the United States annually. Working in collaboration with MMH groups, legislation and state societies to raise awareness, improve and implement legislation is making strides to improve care for the women we serve.

I respectfully nominate District IX for consideration by the Council of District Chairs for the CDC Service Recognition Award.

Respectfully submitted,

Laura Sirott, MD. District IX Chair
District X

Navy - Process Improvement in Non-delayed Contraception (PINC)
The Armed Force District of the American College of Obstetricians and Gynecologists would like to respectfully submit the Navy’s PINC (Process Improvement in Non-delayed Contraception) clinic for the ACOG Council of District Chairs Service Recognition Award.

The Navy’s PINC clinic was started in 2016 by a team at Naval Medical Center San Diego (NMCSD) as a way to improve operational readiness and access to contraception through offering walk-in/no charge contraceptive services. Contraception has always been provided without charge within our system but published studies have revealed high rates of unintended pregnancy among active duty service women and major factors were thought to be access to care as well as limited use of effective methods of contraception¹.

The premise of the PINC clinic is to provide easy access to high efficacy contraception based on clearly defined evidence-based policies and procedures which can be rolled out as a standardized package to military installations around the world. Everything from formulary needs to staffing requirements is provided. This was designed to be easily translated to military treatment facilities both large and small, stateside and international.

Since opening at NMCSD two years ago, now nine clinics around the world offer these walk-in contraceptive services. The sites in the continental United States include: Camp LeJeune, NC; Cherry Point, NC; Jacksonville, FL; Kearney Mesa, CA; Mayport, FL; and Sewell’s Point, VA. The sites overseas include: Sigonella, Italy; Okinawa, Japan; and Yokosuka, Japan. Hawaii was scheduled to open this spring, but their provider champions were deployed so the plan to open was put on hold until this winter. Guam, as well as Quantico, have start dates of early 2019.

Recent outcomes analysis has revealed that over 50% of those who utilize this service are young, enlisted sailors. Visits to these clinics average about 600 per month. Approximately 23 minutes per patient are spent counseling and providing the desired contraception. Recent usage data has revealed monthly LARC procedures doubled from a baseline of 600 to now over 1200. Of note, Nexplanon insertions remained nearly the same, but it was hormonal IUD usage that increased so dramatically. Although pregnancy data lags, current calculations predict a cost avoidance of $2,283,217 based on a conservative estimate of preventing 225 additional pregnancies per year.

Given the proven ability of the PINC clinic to be adopted for rapid usage at 12 sites worldwide and the initial significant impact of being able to rapidly double hormonal IUD placement provided to our active duty women, the Armed Forces District is proud to nominate the PINC clinic team for the Council of District Chairs Service Recognition Award.

Respectfully submitted,

John O’Boyle, MD

(TAB 7)

**District XII**

Tdap Vaccination Project
Council of District Chairs Service Recognition Award
ACOG District XII
Committee on Healthcare for Underserved Women
Tdap Vaccination Project
November 2018
Dear Ms. Kinnane,

As the Chair of ACOG District XII, I would like to recommend ACOG District XII for the Council of District Chairs (CDC) Service Recognition Award for the Tdap Vaccination Project that was recently completed by our Committee on Health Care for Underserved Women.

In 2016, the committee conducted two surveys regarding Tdap vaccination during pregnancy. One survey was distributed to providers (ACOG District XII members) and the other survey was given to postpartum patients prior to discharge from the hospital. Results from the surveys indicated that providers encountered barriers to offering the vaccination in their office and for patients the results indicated safety concerns as well as lack of understanding regarding the importance of the Tdap vaccination in the third trimester of pregnancy.

As a result, the committee felt it was important to raise awareness to the importance of getting the Tdap vaccination during pregnancy and therefore decided to develop educational materials. The committee created posters and pamphlets that can be posted in their office as well as distributed to patients. In addition, a thumb drive resource was also created for providers that includes copies of the educational materials as well as important educational literature including: ACOGs Committee Opinion Number 718-Update on Immunization and Pregnancy: Tetanus, Diphtheria and Pertussis Vaccination, and two abstracts Barriers for Tdap Vaccination in Pregnancy and Providers Perspectives on Tdap Vaccination in Pregnancy Patients.

The educational materials were distributed to District XII members at the 2018 Annual District Meeting this past August. Also, an order form for the educational materials is available on the acog12.org website, where the materials can also be downloaded for use.

I am proud of this committee and their efforts to bring awareness to this important vaccination for mothers and babies. Included with this letter of recommendation are copies of the educational materials that the committee created. It is my hope that you will strongly consider the ACOG District XII's Committee on Health Care for Underserved Women for the ACOG CDC Service Recognition Award. Please feel free to contact me should you have any questions.

Sincerely,

Guy Benrubi, MD
Chair, District XII
The vaccine against pertussis is not given to babies until 2 months of age. By getting vaccinated during your pregnancy, you can protect your baby. All family members should be vaccinated including parents, siblings, grandparents, and all caregivers.

The American College of Obstetricians and Gynecologists (ACOG), District XII represents over 3,000 members who deliver obstetric and gynecologic health care to the women of Florida. Our commitment to professional excellence, combined with our choice to be a strong public advocate for women, has made ACOG one of the state’s most trusted and credible voices on all aspects of health care for women.

Vaccinations against whooping cough can protect both you and your baby.

www.acog12.org
Protect Your Baby from Whooping Cough

Whooping cough can be a deadly infection for your baby. You can protect your baby by getting vaccinated during pregnancy. The vaccine is safe during pregnancy and cannot give you whooping cough. It also provides protection against diphtheria and tetanus.

What is Whooping Cough?

Whooping cough is a disease caused by pertussis. Symptoms include severe coughing fits, a “whooping sound” when the baby inspires, and vomiting after coughing.

Complications for an infant under 4 months of age include seizures, respiratory failure, pneumonia, difficulty breathing, inability to feed, and death. Infants under 4 months are usually hospitalized. Treatment includes antibiotics and management of symptoms. Vaccination during pregnancy protects your baby from this illness, especially in the critical period following birth. Newborns are at especially high risk of death from this infection.

Vaccination against the bacteria that causes whooping cough protects your baby after birth. Antibodies formed by your body cross the placenta and protect your baby after birth.

It is recommended for pregnant women to receive vaccination against whooping cough during the 3rd trimester. Getting the vaccination after the baby is born does not provide the same protection.

In order to provide the best protection to your baby, you should receive this vaccination during each pregnancy. All people who are in contact with your baby should receive the vaccination. This practice is called “cocooning.”
Protect Your Baby from Whooping Cough

- Vaccination against *whooping cough* during pregnancy helps to protect your baby from whooping cough after your baby is born.

- The *vaccine is safe* and cannot give you whooping cough. *Whooping cough* can be deadly for newborns.

- It is recommended to be vaccinated against *whooping cough* between 27 weeks and 36 weeks of pregnancy.

- Any *family members* or people who will be taking care of your baby should receive the vaccination.

- You need to get the vaccine during each pregnancy! Protect all of your babies.

*Ask your doctor about getting your whooping cough vaccine today!*
ACOG COMMITTEE OPINION

Number 718 • September 2017

(Replaces Committee Opinion Number 586, June 2013)

Committee on Obstetric Practice
Immunization and Emerging Infections Expert Work Group

This Committee Opinion was developed by the Immunization and Emerging Infections Expert Work Group and the Committee on Obstetric Practice, with the assistance of Richard Beigt, MD.

Update on Immunization and Pregnancy: Tetanus, Diphtheria, and Pertussis Vaccination

ABSTRACT: The overwhelming majority of morbidity and mortality attributable to pertussis infection occurs in infants who are 3 months and younger. Infants do not begin their own vaccine series against pertussis until approximately 2 months of age. This leaves a window of significant vulnerability for newborns, many of whom contract serious pertussis infections from family members and caregivers, especially their mothers, or older siblings, or both. In 2013, the Advisory Committee on Immunization Practices published its updated recommendation that a dose of tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis (Tdap) should be administered during each pregnancy, irrespective of the prior history of receiving Tdap. The recommended timing for maternal Tdap vaccination is between 27 weeks and 36 weeks of gestation. To maximize the maternal antibody response and passive antibody transfer and levels in the newborn, vaccination as early as possible in the 27–36-weeks-of-gestation window is recommended. However, the Tdap vaccine may be safely given at any time during pregnancy if needed for wound management, pertussis outbreaks, or other extenuating circumstances. There is no evidence of adverse fetal effects from vaccinating pregnant women with an inactivated virus or bacterial vaccine or toxoid, and a growing body of robust data demonstrate safety of such use. Adolescent and adult family members and caregivers who previously have not received the Tdap vaccine and who have or anticipate having close contact with an infant younger than 12 months should receive a single dose of Tdap to protect against pertussis. Given the rapid evolution of data surrounding this topic, immunization guidelines are likely to change over time, and the American College of Obstetricians and Gynecologists will continue to issue updates accordingly.

Recommendations

The American College of Obstetricians and Gynecologists (ACOG) makes the following recommendations:

- Obstetric care providers should administer the tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis (Tdap) vaccine to all pregnant patients during each pregnancy, as early in the 27–36-weeks-of-gestation window as possible.
- Pregnant women should be counseled that the administration of the Tdap vaccine during each pregnancy is safe and important to make sure that each newborn receives the highest possible protection against pertussis at birth.
- Obstetrician–gynecologists are encouraged to stock and administer the Tdap vaccine in their offices.
- Partners, family members, and infant caregivers should be offered the Tdap vaccine if they have not previously been vaccinated. Ideally, all family members should be vaccinated at least 2 weeks before coming in contact with the newborn.
- If not administered during pregnancy, the Tdap vaccine should be given immediately postpartum if the woman has never received a prior dose of Tdap as an adolescent, adult, or during a previous pregnancy.
- There are certain circumstances in which it is appropriate to administer the Tdap vaccine outside of the 27–36-weeks-of-gestation window. For example, in cases of wound management, a pertussis outbreak, or other extenuating circumstances, the need for protection from infection supercedes the benefit of
INTRODUCTION: The American College of Obstetricians and Gynecologists (the College) and the Centers for Disease Control and Prevention recommend the Tdap vaccination in the 3rd trimester of pregnancy in order to protect newborns from neonatal pertussis. The purpose of this study was to identify barriers to Tdap vaccination in pregnancy.

METHODS: A multisite study was conducted at UF Health and Sacred Heart Hospitals in Florida. This study was performed in conjunction with the College's District XII Committee for Healthcare of Underserved Women. Admitted postpartum patients were offered a survey to complete on day of discharge.

RESULTS: A total of 162 patients completed the survey. Forty-eight patients had private or government-sponsored insurance (TriCare, Medicare, VA) and 114 patients had Medicaid. Of private/gov-insured patients, 62.5% (30) received Tdap in the 3rd trimester compared to 21.9% (25) of patients with Medicaid. Of those who did not receive Tdap in the third trimester, 50% (6) of private/gov-insured patients cited education while 34% (21) of patients with Medicaid cited lack of access. Of patients who did not receive Tdap in the third trimester, 46.5% (53) of the Medicaid patients received it postpartum compared to 37.5% (18) of private/gov-insured patients.

CONCLUSION: Patients with Medicaid insurance are less likely to receive the Tdap vaccine in the 3rd trimester than those with private or other government-sponsored insurances. In patients who did not receive Tdap, those with Medicaid cited lack of access as the primary reason they did not receive the vaccine while those with private/gov-insurance cited education-related reasons. Tdap vaccination rates in pregnancy could be increased by improving both education and access to patients.

Financial Disclosure: The authors did not report any potential conflicts of interest.

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Providers Perspectives on Tdap Vaccination in Pregnancy Patients [8M]

Vidrine, Samantha MD; DeCesare, Julie MD; Roussos-Ross, Dikea MD; Ashby, Mary MD; Floyd, Elizabeth; Peterson, Hanna

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Abstract

INTRODUCTION:The CDC recommends Tdap vaccination during pregnancy to increase infants’ protection against pertussis. The best time to vaccinate is between 27 and 36 weeks gestation in order to maximize the maternal antibody response and transfer to the infant. This project looks at the providers prospective as to why women are not receiving the vaccine.

METHODS:An 8 question survey was sent out to all members of the American College of Obstetricians and Gynecologists District XII. The questions were concerning Tdap vaccination in pregnancy. Responses were received from 139 providers.

RESULTS:According to the survey, 83.4% of obstetricians universally offer Tdap vaccinations in the third trimester in their office. Of the patients who are offered the vaccine, 51-75% of patients accept the vaccine. Concern for vaccination safety was the most common response for why patients decline, followed by lack of understanding of importance. 55.9% of providers answered that they encounter barriers in trying to offer Tdap in their practice, and identified was lack of point of care availability (70.3%) as the most common barrier. Difference in vaccination rates between insure types were noted and 59% answered that Medicaid patients are less likely to receive Tdap in the third trimester due to lack of reimbursement.

CONCLUSION:The most common reasons cited for patients to not receive Tdap vaccination in the third trimester is concern for safety and lack of understanding of importance. More than half of the providers answered that Medicaid patients are less likely to receive the vaccine due to reimbursement and point of care issues.

Financial Disclosure: The authors did not report any potential conflicts of interest.

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