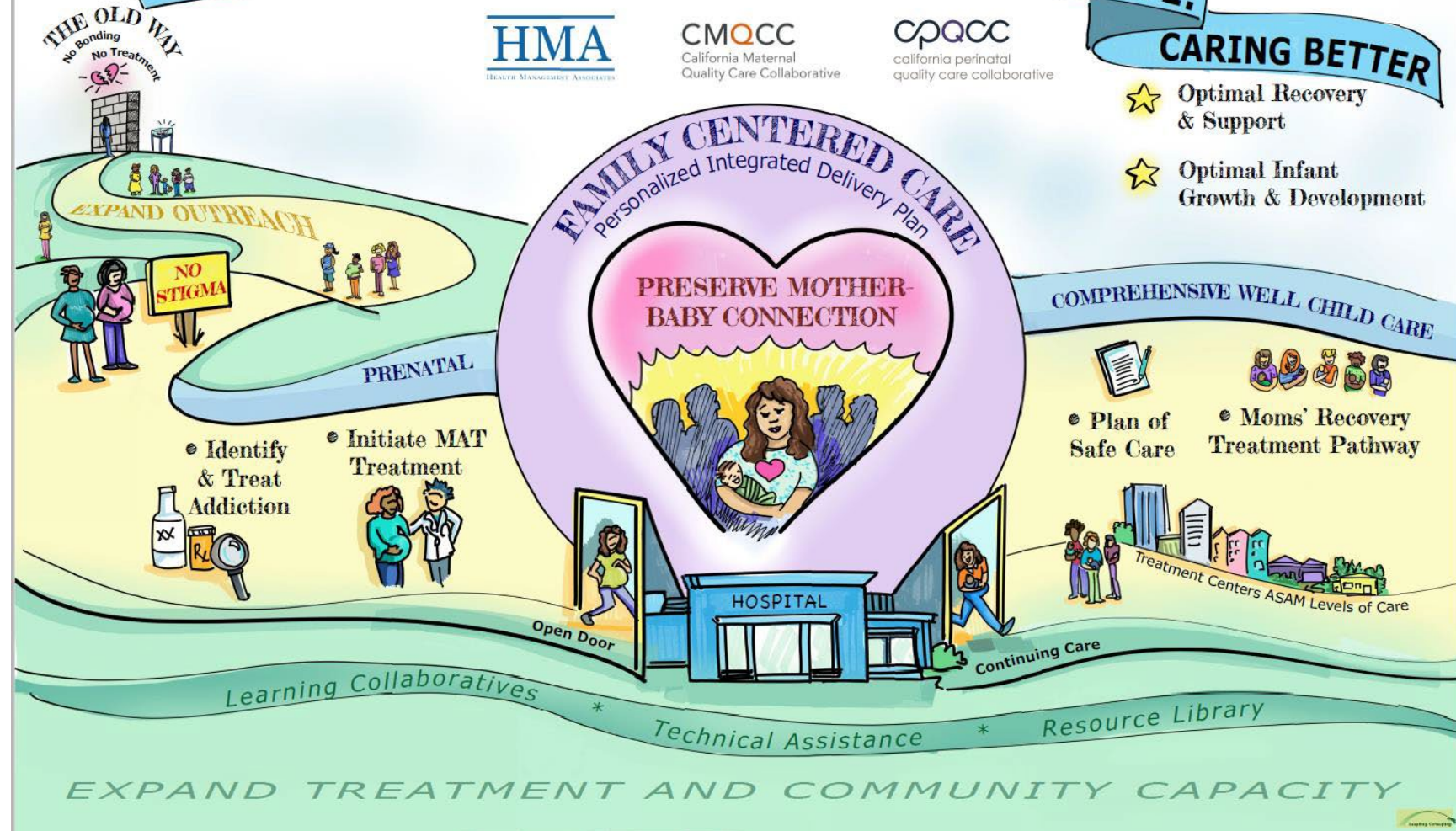




EDUCATION REGARDING SUBSTANCE USE DISORDER

Presentation by Lorena Watson, FNP

MOTHER & BABY SUBSTANCE EXPOSURE INITIATIVE:



EDUCATE STAFF ABOUT OPIOID USE DISORDER

- Treatment of substance use disorder (SUD) is often eclipsed with misperception that SUD is a personal weakness or willful choice.
- Whether or not these misconceptions are consciously employed, they can have a dramatic impact on patient outcomes and adherence to treatment during recovery.

- Stigma can be experienced across several domains: self, social, and structural stigma.
- Stigma can come from all staff interactions at all contact points.
- It is not uncommon for health professionals to show unconscious bias whether or not they explicitly report negative attitudes.



PERFORM LANGUAGE AUDITS

Evaluate all materials distributed or posted regarding SUD
to address stigma-perpetuating language

Diagnosis:

Replace “abuse”
“drug habit”
“dependence”

with “Substance use
disorder or opioid
use disorder”

Person-first language:

Replace “Abuse”,
“abuser”, “addict”
“druggie”

With “Person with
SUD” or “person
experiencing” or
“person struggling
with”

Testing and Toxicology:

Replace “clean” and
“dirty” urine toxicology
screens

With “positive”,
“negative”, “consistent
with prescribed
medications”

Maternal and Newborn:

Avoid “crack baby”,
“drug-addicted baby”

With “neonatal
abstinence syndrome
(NAS)” and “in utero
exposure to...”

UNIVERSAL SCREENING

Perinatal Providers **EAST BATON ROUGE PARISH**
☐ INITIAL SCREEN ☐ REPEAT SCREEN *4Ps Plus Screen for Perinatal Substance Abuse and Domestic Violence*

Physician: _____ Case #: _____
 Patient Name: _____ Date: _____
 Date Of Birth: _____ Race: _____ Age: _____
 Address: _____
 Patient's Phone #: _____

		Yes	No	Provide Domestic Violence Assessment	Provide Substance Abuse Prevention/ Education	Provide Tobacco Intervention and/or Substance Abuse Assessment
Parents	Did either of your parents have any problem with drugs or alcohol?	<input type="checkbox"/>	<input type="checkbox"/>			
Partner	Does your partner have any problem with drugs or alcohol?	<input type="checkbox"/>	<input type="checkbox"/>			
	Is your partner's temper ever a problem for you?	<input type="checkbox"/>	<input type="checkbox"/>			
	Have you ever felt out of control or helpless?	<input type="checkbox"/>	<input type="checkbox"/>			
	Does your partner threaten to hurt you or punish you?	<input type="checkbox"/>	<input type="checkbox"/>			
Past	Have you ever drunk beer/wine(wine cooler)/daiquiri/liquor?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
	Have you ever felt down, depressed or hopeless?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
	Have you lost interest in things that used to be fun to you?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Pregnancy	In the month before you knew you were pregnant, how many cigarettes did you smoke?	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Any
	In the month before you knew you were pregnant, how much wine/beer/liquor did you drink?	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Any

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Follow-up Questions to 4Ps Plus

1. Sometimes a woman feels depressed, nervous, or stressed out. When this happens to you, do any of the following help you feel better or to relax?
 a. Talk things over with friends or relatives? ☐ No ☐ Yes
 b. Smoke cigarettes? ☐ No ☐ Yes
 c. Smoke marijuana or pot? ☐ No ☐ Yes
 d. Have a drink of beer, wine or other alcohol? ☐ No ☐ Yes
 e. Take some type of pill or medication? ☐ No ☐ Yes

2. And last month, about how many days a week did you usually drink beer, wine, a daiquiri or liquor?
☐ Did not drink ☐ Every day ☐ 3 to 6 days a week ☐ 1 or 2 days a week ☐ Less than 1 day a week

3a. During the month before you knew you were pregnant, about how many days a week did you usually use marijuana?
☐ Did not use any drug ☐ Every day ☐ 3 to 6 days a week ☐ 1 or 2 days a week ☐ Less than 1 day a week

3b. During the month before you knew you were pregnant, about how many days a week did you usually use any drug such as cocaine, heroin or meth?
☐ Did not use any drug ☐ Every day ☐ 3 to 6 days a week ☐ 1 or 2 days a week ☐ Less than 1 day a week

4a. And last month, about how many days a week did you usually use marijuana?
☐ Did not use any drug ☐ Every day ☐ 3 to 6 days a week ☐ 1 or 2 days a week ☐ Less than 1 day a week

4b. And last month, about how many days a week did you usually use any drug such as cocaine, heroin, or meth?
☐ Did not use any drug ☐ Every day ☐ 3 to 6 days a week ☐ 1 or 2 days a week ☐ Less than 1 day a week

5. And last month, about how many days a week did you usually smoke cigarettes?
☐ Did not smoke ☐ Every day ☐ 3 to 6 days a week ☐ 1 or 2 days a week ☐ Less than 1 day a week

Intervention and Referrals Made: Check all that apply

Referral	Referral Accepted?	
<input type="checkbox"/> Brief Intervention	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Tobacco Cessation	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Substance Abuse Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Other, Specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Date: _____ Signature: _____
 Circle: MD RN MSW LPN NP MA RD BCSAC Other: _____
 Screening Site: _____

Refer for further evaluation

Educate patients about universal screening!!!

Let them know you ask every patient the same questions!

- We created a checklist to include this universal screening at first prenatal visit and once each trimester.
- A standard work flow reduces missed opportunities for screening.

EDUCATE PATIENTS AND FAMILIES ABOUT OPIOID USE DISORDER

Addiction is a chronic, relapsing condition. Pregnancy can motivate women to discontinue drug abuse, but abrupt discontinuation of opioids during pregnancy can have negative effects for both mother and fetus.

Patients and their families may not be aware that medication assisted treatment (MAT) is the standard of care for opioid use disorder during pregnancy.



EDUCATION CONTINUED:

- Patients need to be educated on different types of opioids to understand how they will affect their body.
- Understanding types of opioids opens a discussion about withdrawal symptoms, warning signs to look for, and when to obtain medical help for withdrawal.
- Patients and their families need to fully understand the nature of addiction, potential impact of continued use during pregnancy and recommended treatment for OUD during pregnancy and beyond.

EDUCATE PATIENT ABOUT RESOURCES TO ASSIST WITH MAT

- Creating a list of contacts on one piece of paper for patient.
 - Including office address, phone numbers, behavioral health office, local resources.
 - This proved to be very helpful. We created folders and had all info ready to go (info on MAT, Naloxone, local resources to assist with special needs).

- Schedule extra prenatal appointments with patients.
 - Routine OB visits are every 4 weeks until 28 weeks. MAT patients are seen every 2-3 weeks (or weekly if needed).



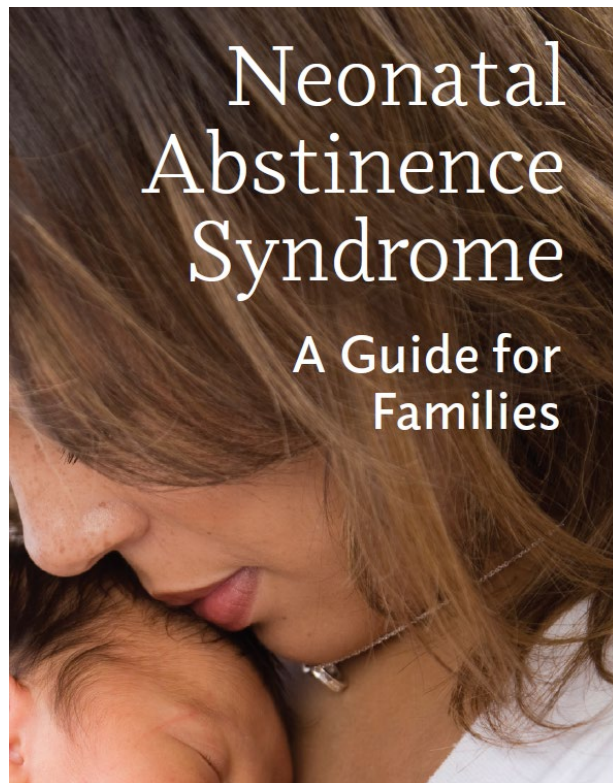
We had a county wide meeting and created a list together!

CREATE A CHECKLIST INDIVIDUALIZED FOR THE PATIENT

- Include the patient in this checklist.
 - Includes overview of coordination of care between clinic and hospital.
 - Neonatal specific follow-up (withdrawal symptoms and ways to help prevent).
 - Postpartum follow-up such as contraception and close monitoring (visits every 1-2 weeks postpartum).
 - Open conversations about risk of relapse after delivery.
- Include a detailed plan on hospital care:
 - Notify them that social worker may come and see patient. **This is not a negative!** Emphasize the positive of having someone else check on them and assess their needs in the hospital.
 - Notify them about pediatrician follow-up and extra appointments after birth.
 - Encourage patient to ask hospital staff if any part of the plan is unclear.

EDUCATION ON NEONATAL ABSTINENCE SYNDROME

- https://static1.squarespace.com/static/5e8f4e2a4eaf8154a7c9c939/t/5f8893c7c0207b1930f52e4b/1602786254066/opqc_nas_parent_guide_092914.pdf



What to Expect When Your Baby Leaves the Hospital

Parent and family support can make a big difference in how fast a baby with NAS gets better. Babies can continue to have mild symptoms of withdrawal for up to 6 months after leaving the hospital.

Once at home, your baby may continue to experience the following:

- Problems feeding
- Slow weight gain
- Crankiness
- Sleep problems
- Sneezing, stuffy nose, and trouble breathing

Asking questions helps you help your baby

If you have any questions or concerns about your baby when you are at home, or if something just does not seem right, talk to your baby's doctor or nurse. It is important to feel comfortable taking care of your baby, and asking questions—any questions helps you help your baby.



PATIENT EDUCATION OVERVIEWS:

- Emphasizing that universal screening for substance use is a standard practice.
- Educate all patients on risks SUD can have on their pregnancy and fetus.
- Educate on MAT. Start patients on MAT, get them established with resources and follow them closely.
- Educate patients on plan of care, in-office and in the hospital setting. No surprises!!
- Provide compassionate, culturally sensitive care.

CMQCC MOTHER AND BABY SUBSTANCE EXPOSURE TOOLKIT

■ <https://nastoolkit.org/>

Where do you work?

Outpatient



The Best Practices in this section apply to staff, administration, and providers who care for expecting and/or postpartum mothers, and newborns, in the outpatient setting.

Labor and Delivery



The Best Practices in this section apply to staff, administration, and providers who provide inpatient care to women who are pregnant, in labor, or immediately postpartum.

Nursery/NICU



The Best Practices in this section apply to staff, administration, and providers who provide inpatient care to newborns in the newborn nursery and Neonatal Intensive Care Unit (NICU).

Click below to see the Best Practices for each topic area

Screening Assessment and Level of Care Determination



Topic areas include: universal screening with a validated verbal screening tool, maternal urine toxicology and the role of explicit/implicit bias, selective newborn biological toxicology testing, and more.

Treatment



Topic areas include: inpatient treatment protocols, pain management and anesthesia, minimizing opioid use, breastfeeding, pharmacologic and nonpharmacologic treatment of newborns with NAS, and more.

Transition of Care



Topic areas include: creating a dyad-centered Plan of Safe Care, implementing a discharge checklist, linking to home visitation programs and other resources, communication with the follow-up newborn provider, and more.

Education



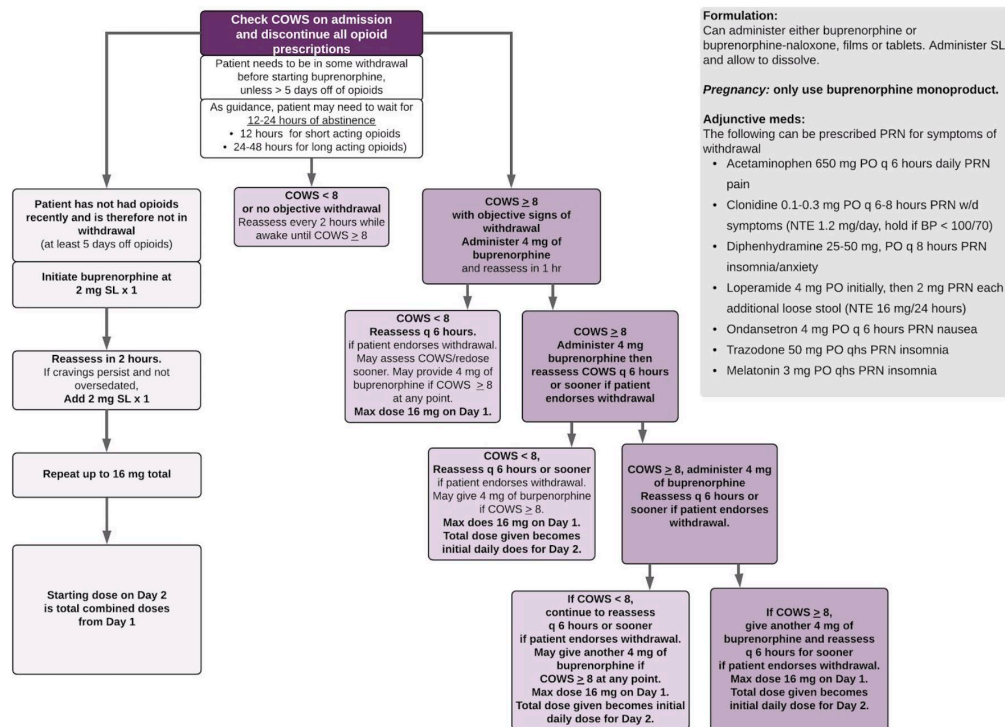
Topic areas include: educating staff about opioid use disorder, Neonatal Abstinence Syndrome, stigma, Trauma-Informed Care, and more.

<https://cha.com/wp-content/uploads/2019/01/SHOUT-GUIDELINE-inpatient-buprenorphine-4-18-18.pdf>

Quick Guide: Buprenorphine Starts in the Hospital

Quick Guide: Buprenorphine Starts in the Hospital

Appendix B



Appendix B

Testing prior to first dose:

- ☐ Urine toxicology
- ☐ Liver function tests
- ☐ Urine pregnancy test
(PRN childbearing potential)
- ☐ HIV, Hep B, Hep C as indicated
- ☐ DSM 5 criteria for opioid use disorder
- ☐ CURES report
- ☐ **Pregnancy:** non-stress test or fetal heart tones as indicated

Contraindications/cautions:

Call experts as needed, may still start with support

- Allergy to buprenorphine
- Medically unstable, unable to tolerate mild withdrawal
- Methadone in last week
- AST or ALT > 5x upper limit normal
- Surgery in next 48 hours
- Acute severe pain
- Binge alcohol or benzo use

Patients started in the ED:

- If given total dose of <16 mg in ED, continue to follow day 1 algorithm
- If given total dose 16 mg in ED, hold additional doses on day 1, then day 2 start 16 mg qday
- If given total dose > 16 mg in ED, hold additional dosing until return of cravings/withdrawal, then start 16 mg qday
- If patient is experiencing pain may split dose TID

Day 2:

- Administer total daily dose from day 1 as single dose in am, or if patient is experiencing pain may split total daily dose TID
- Repeat COWS in 6 hours, if ≥ 8 administer additional 4 mg

Subsequent days:

- Administer total daily dose from previous day as single dose in am – split TID if ongoing pain
- Increase dose prn cravings/withdrawal/pain
- Decrease dose prn sedation, insomnia, adverse effects
- Typical max dose 24 mg

Discharge prescriptions:

Buprenorphine may only be prescribed on discharge by X licensed provider. Prescribe dose required in hospital as daily dose on discharge.

Example:

- Buprenorphine/naloxone 8 mg/2 mg film, 2 films SL qday, #14, 0 refills
- Naloxone 4 mg/0.1 ml intranasal PRN opioid overdose. Spray 0.1 ml into one nostril, call 911, if no response in 2-3 minutes repeat with second device in additional nostril. #1 pack of 2, 3 refills
- Consider pre-exposure HIV prophylaxis

RESOURCES

- Resources on Buprenorphine hospital quick start :
- <https://cabridge.org/wp-content/uploads/CA-BRIDGE-Blueprint-for-Hospital-OD-Treatment-September-2020.pdf>
- Resources on screening tools, MAT prescribing and free clinical consultations:
- <https://nccc.ucsf.edu/clinical-resources/substance-use-resources/>
- California Maternal Quality Care Collaborative Mother Baby Substance Exposure Toolkit:
- <https://www.cmqcc.org/resources-toolkits/toolkits/mother-baby-substance-exposure-initiative-toolkit>
- 4 P's Screening Tool:
- <https://www.ntiupstream.com/4psabout>