NICHQ National Institute for Children's Health Quality

Insights

Improving Maternal and Child Health in the Face of the Opioid Epidemic

"In Illinois, opioid use among pregnant women is rising, and opioid overdose is now the leading cause of maternal death," says Ann Borders, MD, MSc, MPH, who leads the Illinois Perinatal Quality Collaborative's (PQC) opioid initiative.

The statistics Borders describes reflect an ongoing national epidemic. According to the CDC, in a 15-year period, opioid use disorder (OUD) more than quadrupled among pregnant women and, in just one year, overdose deaths among women rose by 20 percent. In addition to overdose and maternal death, opioid use during pregnancy can cause other serious complication for both moms and babies, including preterm birth, low birthweight, and feeding problems.

These are frightening statistics. But the good news is that there are solutions to help ensure these numbers change. Solutions that start by recognizing that this is a treatable chronic disease and that comprehensive care for the mother-baby dyad can improve both short and long-term health outcomes.

"No matter where a mother is—a private medical office, a labor and delivery hospital room, a triage center—her providers need to recognize that this is an urgent obstetric issue, it can happen to anyone, and there are key steps they can take to keep mom and baby healthy," says Borders.

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Both Massachusetts and Illinois are participating in the Centers for Disease Control and Prevention funded, National Network of Perinatal Quality Collaboratives, an initiative of 48 state and multistate PQCs working to improve health outcomes for moms and babies. As the national coordinating center, NICHQ enhances the coordination and communication of PQCs across the nation, advises state PQCs that are in early stages of developing their collaboratives, and provides quality improvement technical assistance.

What are these steps and how can hospitals and states help more health professionals practice them? Below, both Borders and Munish Gupta, MD, MMSc, one of the leads of the Massachusetts PQC Opioid Exposed Newborn Project, offer advice and describe strategies for supporting the dyad at every stage of the pregnancy journey, beginning prenatally, and continuing through the postpartum period.

Help mothers access care early

“Our goal is to get these women into care for OUD early and then keep them in care for the long-term,” says Borders. “That’s how we’re going to address this issue of opioid misuse and women dying from overdose.”

Helping mothers access treatment prenatally connects them with support and resources, improves the health of their pregnancy, and is the first step to ensuring they continue to receive care during the postpartum period. In Illinois, Borders and her collaborative are reaching out to hospital teams and obstetric providers across the state and preparing them to treat and support pregnant women using opioids. All obstetric providers are learning how to implement a universal validated screening tool to screen all pregnant women for OUD, provide a brief intervention and counseling about the risks of OUD and the benefits of treatment, and then refer mothers to treatment and connect them to resources in their area. Since pregnant women with OUD need close follow up and support from their obstetric care team during pregnancy, delivery, and the postpartum period, providers are also asked to incorporate an OUD clinical care checklist to help track the needed care elements across these time periods.

Accomplishing this requires significant outreach and education to obstetric providers, explains Borders. “It’s about changing culture so that all providers understand that this is a chronic disease and there are things they can do prenatally to help. There should be the same level of protocol for a mother who presents with OUD as a mother who presents with hypertension.”

To support this culture shift, the Illinois PQC created care packets that hospitals can send to all obstetric providers affiliated with their hospitals. The packets include a personalized letter; instructions for screening, brief intervention, and referral to treatment (known as SBIRT); information on OUD protocols; a clinical care checklist (so that providers can confirm they have followed recommended care protocols); and a map of all resources in their area. Since individual attention helps with uptake, Borders suggests that hospitals identify obstetric provider and nurse champions who can visit providers and nurse managers in-person at every outpatient site and share the packet with them directly.

Bias and stigma are also major barriers to quality care and culture change. Helping health professionals understand that opioid misuse is a chronic condition can mitigate negative judgement and improve care. That’s why Borders recommends sharing the American College of

Obstetricians' statement about OUD, which characterizes it as a chronic, relapsing brain disease, and connecting providers with resources that address stigma, such as trainings on how word-choice can increase bias, SBIRT training, and the CDC's module on addressing and assessing OUD.

Improving care for mom and baby after birth: two steps healthcare professionals can take

Along with improving prenatal interventions, health professionals can improve outcomes for moms and babies by taking two critical steps post-delivery, explains Gupta.

First, he says, engage families in the care of their opioid exposed newborn after delivery. Evidence demonstrates that family-centered non-pharmacological care improves outcomes—keeping mother and baby together after birth (known as rooming-in), breastfeeding, and direct skin-to-skin contact between mom and baby are all protective factors for both moms and babies. Moreover, giving mothers an opportunity to care for their newborn in a safe hospital environment sets them up for success once they go home.

The Eat Sleep Console approach to treating babies born with neonatal abstinence syndrome prioritizes family-centered non-pharmacological care, and many Massachusetts hospitals are testing it with success. Learn more about the approach here.

"In many Massachusetts hospitals, there's a big effort underway to care for these newborns in their mothers' rooms or a setting where mothers can stay with their infants, instead of keeping babies separated in an intensive care setting," says Gupta. "Even hospitals struggling with the space for rooming-in are finding ways to support it in the ICU. We know this shift is possible because we're making progress."

Second, says Gupta, make sure families receive the support they need once discharged.

"We know the postpartum period is particularly high-risk for these moms and babies," says Gupta. "That's why we need to do more to ensure coordinated discharge planning. We don't have great data on outcomes for these families after hospital discharge, but we do know there are higher rates of relapse and other complications in the first three to six months after birth. It makes sense that improving our discharge process could help to reduce these risks, with steps like a warm hand-off to pediatricians and follow-up and referrals to programs like early intervention and early Head Start. These services are optimally suited to provide families with comprehensive family-centered care post-discharge."

To better support families after they leave the hospital, several hospitals in the Massachusetts PQC are also testing innovative solutions, such as developing comprehensive clinics for babies born with neonatal abstinence syndrome. These clinics, while still in the early phases, connect families with social services, developmental care, and primary care all in one place so that families can more easily access the supports they need.

Looking to learn more about the opioid epidemic and its effect on children's health? Here, one mother shares a story that illustrates the prevalence and adverse effects of opioid misuse among vulnerable communities.