Compassionate Whole Person and Racially Equitable Caring for Birthing Parents with Substance Use Disorder

Ms. Masitsa Muhanji, a proud woman in recovery
Vania Rudolf, MD, MPH, DFASAM
Addiction Recovery Services
Chair, National Women’s Addiction Group, American Society of Addiction Medicine
Member, Board of Directors, Washington Society of Addiction Medicine
You may be filmed or photographed.

Please be aware that we are recording this presentation to be used in Seattle Children’s marketing materials, publications, website and/or social media channels. By participating in this event, you give Seattle Children’s permission to capture and publish photographic and video images of yourself.
Disclosure Statement

• I/We do not have any conflict of interest, nor will I/we be discussing any off-label product use.

• This class has no commercial support or sponsorship, nor is it co-sponsored
Objectives

• Review substance use disorder in pregnant and parenting women.
• Discuss stigma, trauma-informed care and opportunities for non-judgmental equitable care for birthing parents with opioid use disorder.
• Discuss ways to promote compassionate care for birthing parents, babies exposed to opioids and nursing/provider support.
• Summarize care of moms and infants using the COMPASSION model and Eat Sleep Console Method.
• Apply compassionate care that facilitate empathic relationships and collaboration with birthing parents with opioid use disorder.
Myth # 1: Addiction Just Happens
Opioid Pandemic and Women/Birthing Parents

◆ 1999 – 2015: Prescription opioid OD increased 471% women vs 218% men
◆ 1999 – 2015: 850% increase in synthetic opioid-related deaths in women
◆ 1999 to 2010, 400% prescription opioid OD deaths among women increased from 1,287 to 6,631
◆ 2000 - 2009 the use of opioids during pregnancy increased from 1.19 to 5.63 per 1,000 hospital births

In 2016, the number of women of childbearing age (15–44) who reported:

• Past-month heroin use
  • 141,000 in 2016
  • 0.1% increase from 2015
  • Of those, approximately 2,000 women were pregnant

• Past-month use of opioids (including heroin or pain reliever misuse)
  • 1,090,000 in 2016
  • 1.49% increase from 2015
Stigma and Racism Pandemic

Discrimination and Prejudice
Mark of disgrace or infamy with SUD
Negative attitudes, perceptions
Punishment

Racial disparities:

- 2007-2016, the pregnancy-related mortality ratios 2-3 times higher for black and American Indian/Alaska Native (AI/AN) women than for white, Hispanic, and Asian/Pacific Islander women.
- Among women with a college degree or higher, the pregnancy-related mortality ratio over 5 times higher for black women compared to white, Asian/Pacific Islander, and Hispanic women.
- College educated black women are more likely to experience a pregnancy-related death than white, Asian/Pacific Islander, and Hispanic women without a high school diploma.
- Social determinants of health also have an impact on racial and ethnic maternal health disparities.
Stigma - Fear, Discrimination, Barriers to Care

**Fear:** being judged, harming baby, losing custody of their children, legal repercussions/ incarceration

**Discrimination:** pregnant women with SUD are the most likely group to be discriminated against and treated harshly for their substance use

**Barriers to care:** shame, lack of resources, bias, funds/insurance, sober support, transportation, childcare, criminalization, punishment
• **1 in 5** birthing parents will experience mental health or substance use problem during pregnancy and postpartum.

• **75%** of birthing parents who screen at-risk for postpartum depression receive no treatment.

• **90%** of birthing parents who screen at-risk for substance use receive no formal treatment.

• **50%** maternal mortality deaths related to suicide and overdose.

• 2006-2012, the rate of infant and maternal hospitalizations related to substance use increased from **5.1 to 8.7 per 1,000** infant hospitalizations and from **13.4 to 17.9 per 1,000** maternal hospitalizations, resulting in a total cost of **$944 million in 2012**.

• Neonatal Opioid Withdrawal Syndrome rates: fivefold increase, from **2.8 per 1000 births in 2004** to **14.1 per 1000 births in 2014**.

• Sharp increase in health care spending due to increase in hospital length of stay (**$1.5-2.0 billion 2012-14**).

• The cost of NOT TREATING maternal mental health and substance use conditions is **$32,000 per birthing parent-infant pair totaling $14.2 billion nationally**
Truth #1: Addiction Does Not Just Happen

- Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual’s life experiences.

- People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.

- Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.

→ It is unethical and cruel to punish women for the chronic illness of substance use disorder

Adopted by the ASAM Board of Directors September 15, 2019
Myth #2 Addiction is a Choice

*Strong relationship between:*
- Trauma
- Adverse childhood experiences
- Genetics
- Chronic medical conditions
- Opioid prescriptions
- Lack of social support

*And*
*High-risk behaviors and addiction*
What is Trauma

- Trauma is an event that is extremely upsetting and at least temporarily overwhelms internal resources.
  - Single event or multiple over time (complex, prolonged)
  - Experiences that are shocking, overwhelming such as abuse, neglect, violence, disaster, etc.

- Chronic trauma interferes with neurobiological development and the capacity to integrate sensory, emotional and cognitive information into a cohesive whole.

→ Poor physical and mental health, obsessive behaviors, substance use, social dysfunction
Adverse Childhood Experiences

• “A comprehensive assessment of children's health should include a careful history of their past exposure to adverse conditions and maltreatment. Interventions aimed at reducing these exposures may result in better child health”

http://www.cdc.gov/ace/index.htm

Truth #2 Addiction is not a choice

Individuals > 4 ACES; certain experiences are major risk factors for the leading causes of illness and death as well as poor quality of life

- 2-4 fold increase in poor health, tobacco smoking and sexually transmitted disease

- 4-12 fold risk for alcohol and other substance use disorders, depression, suicide attempt, high risk behaviors

- Strong relationship between ACE, violence, trauma and addiction
Trauma approach:

“You’re not bad, you’re not sick. You’re injured.”

Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization.” (SAMHSA)

A strength-based approach and a cultural shift to appreciate/respond to each person’s set of circumstances and needs – “meeting where they are”, when and where they need it.
Trauma-informed Care (TIC)

*Changing the conversation from “what is wrong?” to “what happened?”*

Examples:

“What is wrong with this woman... how could she use drugs during pregnancy?”

→“I wonder what happened to this woman to affect her life this way and the impact it has had on her health and pregnancy?”

“How can she use heroin and call herself a mother?”

→“I can appreciate the vulnerability and the courage she has to reach out for help and talk about her use.”
Provider bias — words matter

**Terminology to use**
- Substance use disorder
- A person with substance use disorder, drug use
- Person in recovery
- Positive drug screen
- A woman with SUD
- A baby/infant born to a mother with SUD

**Terminology to avoid**
- Drug abuse
- Drug addict, druggie, junkie, crackhead
- Clean, sober
- Dirty urine
- An addict mother, these moms
- These babies
Trauma-Informed communication

*Compassionate rapport-building: listen, respect, support/validate, give space/time, assist*

- **Awareness**: Appreciate the role of trauma
- **Safety**: Place priority on physical and emotional safety
- **Trustworthiness**: Optimizing trustworthiness and maintaining boundaries
- **Choice**: Respect autonomy
- **Collaboration/Empowerment**: Inspiring empowerment and skill-building

*Motivational Interviewing:*

A mindful patient-centered approach to elicit behavior changes via emphasizing autonomy with compassionate presence, listening, openness

- **OARS+I** (Open-ended questions, Affirmations, Reflections, Summaries, Asking permission to provide Information)
Challenging Conversations, Internal Bias and Opportunities

• Recognize trauma as part of “escalating” or “difficult” behaviors
• Recognize judgment, shame and traumatic childbirth
  • Black, indigenous and other birthing parents of color can experience higher rates of disrespect and mistreatment in birth -> negative encounters
• Offer comforting and positive regard
• Embrace a whole person trauma-informed approach

*Nursing magic power: courage and kindness!
• Evaluate your role as a provider
• Reflect on your role as a healer and what you bring to the interaction
• Internal bias towards substance use and vulnerability: past experience, race, religion, secondary trauma
Challenging Conversations and Opportunities

4 ways to de-escalate with positive reward/communication

• Cultivate genuine compassion. Extend empathy toward the birthing parent, appreciate their life situation. Validate, respect feelings.

• Ask for permission, Pay attention and be inquisitive. Ask open questions to effectively engage in a therapeutic conversation.

• Offer reflective listening. Listen carefully to understand (not to respond)

• Speak respectfully – soft voice, kind and welcoming approach. Find a common goal, give choices, set limits, use humor, positively re-direct.
De-escalating Positively with Listening

Three Main Listening Skills:

**Attending:** Giving your physical (and mental) attention to the birthing parent.

**Following:** Making sure you are engaged by using eye contact.

**Reflecting:** Paraphrasing and reflecting, using the feelings of the birthing parent. (empathy)

*Listen when you are “listening.”* Try to establish rapport and common goals with a team-shared approach.

- No other activities when listening. Multi-tasking is not good/acceptable when you are listening.
- Be empathetic and respectful! Validate -- “I can appreciate.....” “I understand why...”
- Listen to what the parent is really saying. Re-state the message. Clarify the message. Repeat the message.
COVID, Pandemics and Health Equity Opportunities

*Harry Potter and the Magic Wand; 4 areas of growth:*

- Provider Wellness
- Provider Support/Education
- **Access to no wrong door whole person care:**
  - Trauma-informed, compassionate, patient-centered care
  - Racially equitable and evidence-based treatment
  - Foster birthing parent’s individual values, autonomy and gender identity
- **Innovative value-based framework** to support birthing parents, children, families, patients and the community
ARS Team Wellness and Huddles

• “Berry Wednesday”- fresh berries for staff every Wednesday
• “Walk the Talk” – 15-20 minutes interdisciplinary walks
• Team huddles: daily reflections, humor
• Practice gratitude and mindfulness
• Staff appreciation for nurses, counselors, medical providers; potlucks
• Antiracism/Black Lives Matter quarterly workshops (since Jan 2019)
• Dedicated vacation and family time; flexibility in work schedule
• Setting healthy boundaries to separate work and personal life
# ARS Wellness Qualitative Survey Data (January 2019 - March 2020)

<table>
<thead>
<tr>
<th>ARS Wellness Survey Data (January 2019 - March 2020)</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel comfortable to talk about burnout at my workplace</td>
<td>40%</td>
<td>60%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>MD (Jan 2019)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MD (Mar 2020)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel comfortable to talk about compassion fatigue at my workplace</td>
<td>40%</td>
<td>60%</td>
<td>25%</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>MD (Jan 2019)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MD (Mar 2020)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel comfortable to talk about secondary trauma at my workplace</td>
<td>50%</td>
<td>50%</td>
<td>20%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>MD (Jan 2019)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MD (Mar 2020)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel I am at increased risk to experience burnout at my workplace</td>
<td>25%</td>
<td>20%</td>
<td>60%</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>MD (Jan 2019)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MD (Mar 2020)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel I am at increased risk to experience compassion fatigue at my workplace</td>
<td>25%</td>
<td>20%</td>
<td>20%</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>MD (Jan 2019)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MD (Mar 2020)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## ARS Wellness Survey Data (January 2019 - March 2020)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree or Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel that my wellness and quality of life suffer if I feel tired and overworked at my workplace</td>
<td>20%</td>
<td>25%</td>
<td>25%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>I want to change things at my workplace to improve wellness, compassion, fatigue and secondary trauma</td>
<td>20%</td>
<td>25%</td>
<td>25%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>I feel that we have been improving things at my workplace to promote wellness, compassion, fatigue and secondary trauma</td>
<td>20%</td>
<td>25%</td>
<td>25%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>I am willing to participate in regular sessions to address and improve wellness, compassion, fatigue and secondary trauma</td>
<td>20%</td>
<td>25%</td>
<td>25%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>I feel that we have been improving things at my workplace to improve trauma-influenced care and secondary trauma</td>
<td>80%</td>
<td>20%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have the skills and the knowledge to address burnout</td>
<td>40%</td>
<td>40%</td>
<td>20%</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>25%</td>
<td>25%</td>
<td></td>
<td>50%</td>
<td></td>
</tr>
</tbody>
</table>
Provider Support and Education

*Provider attitudes tool* (stigma, compassion, knowledge, comfort level of care, referral to treatment); Swedish, 2016.

Outreach lead by Swedish and Addiction Recovery Team:

- **High risk OB conference**, “Embracing Challenges and Compassion in the Care of Chemically Dependent Patients March 18\textsuperscript{th}, 2016. Attendees 114.
- **Washington Mental Health and Opioid Use Disorder Summit**, Jan 22\textsuperscript{nd}-23\textsuperscript{rd} 2020. Attendees 167.
- **National Women and Addiction Summit**, Jan 24\textsuperscript{th}-25\textsuperscript{th} 2020. Attendees 335.

*Pre/post intervention on provider attitudes:* improved 13% stigma (p < .001) and 14% compassion (p < .001). Providers demonstrated increased 31% knowledge (p < .001), improved 24% comfort level of care (p < .001), and 17% attitude scores (p < .001)
Provider Support and Education

Trauma-informed care (TIC) and provider wellness tool

Addiction Medicine Fellowship presentations at Swedish, WA and National Perinatal Collaborative Meetings

Treatment for Opioid Use Disorder (TOUD) course, 9/26/2020, Swedish Medical Center:
  • Multidisciplinary provider education/buprenorphine training for family medicine, internal medicine, hospitalist, ICU, mid-level providers: attendees 56, now buprenorphine trained

WA Provider Forum on Compassionate, trauma-informed care for OUD, fentanyl/overdose prevention and mental health 11/30/2020, lead by ARS team

Policy on Eat Sleep Console, COMPASSOION model and substance use disorder in birthing parents, ARS team/12/3/20

WA Perinatal Collaborative, policy and guidelines development
Myth #3 “All I need is detox. I don’t want my baby born addicted”

- Pregnant women who are physically dependent on opioids should receive treatment using methadone or buprenorphine rather than withdrawal management or psychosocial treatment alone.

- A medical examination and psychosocial assessment are recommended when evaluating pregnant women for opioid use disorder. However, completion of all assessments should not delay or preclude initiating pharmacotherapy for opioid use disorder.

- For pregnant women with an opioid use disorder, opioid agonist pharmacotherapy is the recommended therapy and is preferable to medically supervised withdrawal because withdrawal is associated with high relapse rates, ranging from 59% to more than 90%, and poorer outcomes.
Screening for Substance Use

4 P's (plus smoking): Parents, Partner, Past, Pregnancy, Smoking

NIDA Quick Screen

• In the past year how many times have you drunk >4 alcoholic drinks per day?
• Used tobacco?
• Taken illegal drugs or prescription drugs for nonmedical reasons?

Single Question Screen

• “In the last year, have you ever drunk or used drugs more than you meant to?”
• “Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?

Truth #3 Evidence-based treatment
No Wrong Door Whole Person Care

**Opioid detoxification not recommended** because:

- Decreased neonatal birth weight
- Decreased prenatal care, poorer obstetrical outcomes
- Illicit drug relapse
- Resumption of high-risk behaviors (IVDU, prostitution, criminal activity)

Relapse poses grave risks, including communicable disease transmission, accidental overdose because of loss of tolerance, obstetric complications, and lack of prenatal care.

*Medication for Opioid Use Disorder (MOUD) with methadone or buprenorphine - standard of care*

*Reported success rates 63-82%*

*FYI same success rates of other chronic disease like asthma and DM*
Opioid Use and Withdrawal in Pregnancy

Methadone and buprenorphine =
the evidence-based standard of care

Choice of therapy: complex, individualized

• patient preference
• availability
• recovery and treatment history
• current, past substance use disorder (SUD) severity
• intensity of treatment needed
• social, sober support and home environment
Medication Assisted Treatment

**Methadone**
- Full opioid agonist
- T1/2 = 36-48 hours
- Dosed at certified opioid treatment program

**Buprenorphine**
- Partial opioid agonist
- T1/2: 36 hours
- Physicians & PA and ARNP
- Suboxone tablet or film: buprenorphine with naloxone
Methadone and Buprenorphine

Methadone

• **Pros:**
  - Office based treatment
  - Less stigma
  - Less overdose risk
  - Induction faster

• **Cons:**
  - Withdrawal to start
  - Risk of precipitated withdrawal
  - Higher diversion risk
  - Lower retention
  - More challenging pain management

Buprenorphine

**Pros:**
- Office based treatment
- Less stigma
- Less overdose risk
- Induction faster

**Cons:**
- Withdrawal to start
- Risk of precipitated withdrawal
- Higher diversion risk
- Lower retention
- More challenging pain management
Breastfeeding

Newborns ingest minimal amount of mom’s maintenance medication - less than 1% of the morphine given to treat neonatal withdrawal
Truth #3 Access to Treatment

Compassionate longitudinal and comprehensive racially-equitable care (perinatal care + 4th trimester, mental health, SUD treatment, SI/overdose prevention, peer support)

- Longitudinal framework -> Center of Excellence; innovative value-based model
  - Perinatal Bundle (perinatal, mental health and SUD services)
  - Evidence-based treatment
  - Optimizing postpartum support resources for birthing parents, baby, family
  - Self care and advocacy
  - Tobacco cessation
  - Long Acting Reversible Contraception
  - Overdose/SI prevention
  - Maternal mortality education and prevention, warm hand-off and follow up care

- Postpartum CUPW at ARS, amazing!

- Perinatal Addiction Consultation Service (PACS), established 2016: addiction service (stabilization, treatment, discharge coordination) and support for patients, providers, nurses: 40 visits (2016); 152 visits (2017); 340 visits (2018); >400 visits (2019); >600 visits (2020), ongoing PACS presence embraces “no wrong door and whole person care”, removes barriers

- Peer to Peer Support Line
- E-Consult Support for providers and patients
Neonatal Opioid Withdrawal Syndrome (NOWS)
Neonatal Abstinence Syndrome (NAS)

NOWS/NAS rates: fivefold increase, from 2.8 per 1000 births in 2004 to 14.1 per 1000 births in 2014 (TNA Winkleman, AAAP 2018)

Sharp increase in health care spending due to increase in hospital length of stay ($1.5-$2.0 billion 2012-14)

- Occurs secondary to in-utero opioid exposure
- Methadone, buprenorphine, oxycodone, heroin, fentanyl
- Opioid withdrawal:
  - Altered sleep, increased muscle tone, tremors, irritability, poor feeding, vomiting, diarrhea, sweating, tachypnea, fever
- Protecting Our Infants Act -> focus on maternal opioid use and NOWS
- Treatment recommendations limited to hospital settings
- Average length of stay for infants treated for NOWS/NAS from 2009 to 2012 was 23 days
- AAP recommends all opiate exposed infants to be monitored in hospital for 4-7 days for signs of withdrawal that may require pharmacologic treatment, currently guidelines require 4 days (96 hours) monitoring
Finnegan Scoring 1974

Withdrawal symptoms assigned points based on perceived severity

- Escalation of consecutive scores are an indication to begin and titrate medication
- Typical medication used is morphine, methadone, fentanyl, clonidine
- The rationale for using a score based approach for medication initiation and titration is not scientifically validated
- Scoring system does not focus on how those symptoms affect the infant’s ability to function, subjective based on provider comfort
- Not stressing the importance of non-pharmacologic methods
- Increased use of opiates in babies, overtreating with scheduled doses
- Prolonged length of NICU stay
- Staff fatigue, secondary trauma
- Concern for shift to shift variation in Finnegan scoring and patient assessment
Eat, Sleep, Console (ESC)

- Yale New Haven Children’s Hospital
- Developed based on observation of infants with NAS
- Focus on noninvasive functional assessment of infants with NAS
- Stresses the importance of non-pharmacologic approach
- 12% of infants needed morphine vs 62% if traditionally scored
- Average length of stay of 5.9 days
Eat, Sleep, Console (ESC)

1. “Does the Infant Have Poor Eating Due to NAS- Yes/No?”

   Eating well:
   • Eating well: breast or bottle feeding 8-12 times per day
   • Encouraged to feed whenever infant showing hunger cues; until content

   Poor feeding due to NOWS/NAS:
   • Infant unable to coordinate feeding within 10 minutes of showing hunger
   • Infant unable to sustain feeding for at least 10 minutes at breast or with 10 ml by alternate feeding method
   • Not poor eating if due to prematurity, transitional sleepiness/spittiness in first 24 hours, inability to latch, etc.

2. “Did the Infant Sleep Less Than 1 Hour After Feeding Due to NAS- Yes/No?”

   • Sleep <1 hour may be normal in the first few hours after birth, especially during cluster feeding; consider sleeping pattern for gestational and postnatal age
   • **Sleep <1 hour due to NOWS/NAS:**
     • NOWS: Unable to sleep for at least 1 hour after feeding; fussiness, restlessness, increased startle, tremors (2nd day)
     • Symptoms in the 1st day likely due to nicotine, SSRI withdrawal, cluster feeding, etc.

3. “Is the Infant Unable to be Consoled Within 10 Minutes due to NAS- Yes/No?”

   • If unable to console within 10 minutes despite caregiver **effectively** providing all the recommended consoling support interventions
Team- Shared and Patient-Centered Culture

- Encompass the last 3-4 hours since the prior assessment
- Engagement/Feedback for all caregivers
- Does not require the infant to be removed from the mother to complete
- **If the baby does not eat, sleep, or console then:**
  - Team huddle to decide next steps
  - Active decision-making, team process
  - Minimize exposure
  - PRN dosing as opposed to scheduled and escalating morphine doses
  - Continue ESC
Zero Separation with COMPASSION-Culture of Nonjudgment and Acceptance

- Normalize care on the postpartum floor
- Birthing parent is the main caregiver, partner, family engagement
- Remove barriers to care by keeping mom, baby and family together
- Empower the parenting engagement with compassionate and welcoming approach
- Medication stabilization, mental health, lactation, breastfeeding, tobacco cessation support
- Education to birthing parents, partner, family members, medication stabilization
- Parent-centered rounding/huddle → rooming-in with baby; skin-to-skin; holding/gentle rocking baby; swaddling/flexed position; breastfeeding, optimal feeding quality; quiet environment; non-nutritive sucking with pacifier
- Teamwork and empowerment, positive regard and joint effort
- First-line treatment for infants is “zero separation” and “mother’s love”
- non-pharm care-> reduces NOWS/NAS scores and need for pharmacologic treatment
Access to Treatment
Zero Separation with COMPASSION

COMPASSION Model:
Community Of Maternal PArenting Support for Substance Impacted WOmen and Newborns - 5- day extended postpartum floor stay for moms/birthing parents and babies, zero separation. Financially CUPW reimbursed by HCA!

A total of 40 women with OUD on methadone (40-250mg/d), 60% homeless
• 20 women/baby couplets with standard postpartum floor discharge Day 1-3
  • 80% babies received morphine and prolonged NICU stay; NICU LOS 18 days
  • 50% babies discharged to foster care
• 20 women/baby couplets with COMPASSION 5-day postpartum floor stay. Zero Separation for birthing parent, baby, family!
  • 80% babies did not receive morphine/NICU admission; NICU LOS 3.2 days
  • 80% babies discharged with mom and follow up treatment
Community Healing with COMPASSION

Support Women/Birthing Parents Across the Lifespan

- **OB Outreach Clinic** – walk-in clinic, evidence-based care for birthing parents and their children
- **Bridge Clinic** – no barrier walk-in clinic for birthing parents and patients of all genders, adolescent/geriatric, families, community support; WA/CDC grant

**Supportive group care model for women/birthing people at the Bridge clinic:**
- Monthly group buprenorphine visits
- Weekly zoom visits for patients with OUD, AUD, TUD, Chronic pain, Eating Disorder
- Transgender group visits
- Postpartum parents/women of all ages/stages (babies welcome)
- Father stabilization, family support

→ Medication for SUD, mental health, parenthood and recovery support

- **Washington Perinatal Collaborative**, partnership with DOH, WSHA, HCA (lead by ARS)
- **March of Dimes (MOD) partnership** - supportive group model for pregnant and parenting people with SUD created by ARS and MOD
Take Home Points for Health Equity Growth Opportunities

Foster “no wrong door”, whole-person care that is trauma-informed, compassionate, racially equitable and evidence-based

- Equity, substance use and mental health wellness
- Support birthing parent’s individual values, autonomy and gender identity
- Trauma-informed communication encourages treatment engagement and breastfeeding
- Methadone or buprenorphine is the standard pharmacotherapy
- Comprehensive longitudinal care that is compassionate and patient-centered helps with challenges
- Center of Excellence, Zero Separation and COMPASSION improve outcomes

Meeting needs of vulnerable and disadvantaged people

Community Effort

Birthing Parent/Woman Empowerment

- Together we can make a difference
- Yes, We Can!
THANK YOU!

Addiction Recovery Services Team
Swedish Medical Center, Seattle, WA
Vania.Rudolf@swedish.org
Yes, we can!