



Progeny Newsletter

February 2022

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Opioid Withdrawal in Infants

On January 31, 2022, the U.S. Department of Health and Human Services [announced](#) a new standard clinical definition for opioid withdrawal in newborns.¹ This announcement came on the heels of a [Morbidity & Mortality Weekly Report](#) published by the CDC on January 14, 2022.² This report highlights a follow-up study of six states that have mandatory reporting laws for neonatal abstinence syndrome (NAS): Arizona, Florida, Georgia, Kentucky, Tennessee and Virginia. In 2018, an [evaluation](#) of these states from 2013 to 2017 found that mandatory reporting helped quantify the incidence of NAS and helped to guide the development of state programs and services for families.³ The aim of this recent follow-up study was to examine longer-term surveillance of NAS and program development that occurred in these same six states after mandatory reporting laws were enacted. Investigators found continued advantages in determining NAS incidence and community exposure patterns, which in turn guided the development of state programs. However, states reported persistent challenges and infrastructural gaps that limited their capacity for longer-term surveillance. None of the six states report follow-up of infants or families beyond the initial case report.

One challenge for data collection identified by the states was the lack of a standard clinical definition for diagnosis of opioid withdrawal in neonates. Over time this has resulted in inconsistencies in diagnosing NAS and led to multiple challenges in medical coding, public health surveillance, program development, etc. The **new standard clinical definition for opioid withdrawal** is published in the [Journal of Pediatrics](#)⁴. It includes prenatal exposure in addition to specific evidence-based clinical signs such as excessive crying, fragmented sleep, tremors, increased muscle tone, and gastrointestinal dysfunction. The presence of any 2 of the 5 clinical signs qualifies in the new definition. The definition can be applied to infants in the context of NAS or neonatal opioid withdrawal syndrome (NOWS), the terminologies used to describe withdrawal due to prenatal substance exposure. Providing a consistent way to diagnose withdrawal in infants will lead to better infant care. Other potential benefits include improved medical coding practices and data collection, improved surveillance and better programs/resources for families, better research to guide program development, and better treatments for mothers and infants. The new definition also includes bioethical principles that aim to reduce stigma and protect mothers and infants, so families get the care they need without fear of reprisal.

Currently, there are no mandatory reporting laws related to NAS/NOWS in Iowa. We don't anticipate that this new definition for opioid withdrawal will have any immediate impact on our screening practices for infants at the bedside. Most Iowa birthing hospitals use the Modified Finnegan Scoring System^{5,6} to quantify the severity of NAS and guide treatment decisions. Some hospitals have adopted the Eat, Sleep, Console (ESC)⁷ method for screening and treatment of NAS. Regardless of the method for screening and the plan for pharmacologic treatment, all birthing hospitals should incorporate non-pharmacologic interventions into the plan of care for infants with NAS or NOWS. This non-pharmacologic bundle of care can include rooming-in with parents, extended skin-to-skin contact with the mother, decreased environmental stimulation (quiet and dimly lit room), gentle handling, non-nutritive sucking (pacifiers), swaddling, rocking, supine positioning, and breast milk feedings unless they are otherwise contraindicated. Specific guidelines for breastfeeding



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(Factsheet #11, p. 89) are available in a comprehensive resource from the Substance Abuse and Mental Health Services Administration (SAMHSA, 2018), [Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants](#).⁸

Services for Iowa Mothers with Substance Use Disorder (SUD)

In recent years, the Iowa Department of Public Health has focused on identifying the clinical and supportive care needs of mothers struggling with SUD and their infants. Currently, there are four residential SUD treatment centers in Iowa for pregnant/parenting women that are funded by IDPH: 1. ASAC Heart of Iowa (Cedar Rapids); 2. Jackson Recovery (Sioux City); 3. House of Mercy (Des Moines); and 4. Heartland Family Services (Council Bluffs). Depending on their income, women in treatment may not have to pay for services or they pay on a sliding fee scale. The department also collaborates on the **Iowa Children and Family Collaborative**. This group is led by [Iowa Children's Justice](#) and operates on the premise of three guiding concerns: the health and well-being of children who have been exposed to substances and their families; the success of the care providers; and the responsible allocation and oversight of resources, so as to enhance the quality of life for mothers, children, and families. [Iowa Children's Justice](#) has been successful at writing grants to fund this work. Collaborative members include the following organizations and programs in Iowa: DHS, Juvenile Court, Department of Education, Domestic Violence Prevention, [Early Childhood Iowa](#), [Child Health Specialty Clinics](#), UnityPoint Health System, [Blank Children's Hospital](#), [Mid-Iowa Family Therapy Clinic](#), [Iowa Association of Infant and Early Childhood Mental Health](#), [Center for Alcohol and Drug Services](#), and [Child Protection Centers](#).

For more information, contact Penny Smith, RNC-NIC, BSN, penny-smith@uiowa.edu or Stephanie Trusty RN, BSN, stephanie.trusty@idph.iowa.gov.

References

1. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Health (OASH). HHS Press Release January 31, 2022: HHS Announces A Standard Clinical Definition for Opioid Withdrawal in Infants.
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3. Jilani SM, Frey MT, Pepin D, et al. Evaluation of state-mandated reporting of neonatal abstinence syndrome—six states, 2013–2017. MMWR Morb Mortal Wkly Rep 2019;68:6–10.
4. Jilani SM, Jones HE, Grossman M, et al. Standardizing the clinical definition of opioid withdrawal in the neonate. J Pediatr 2021;1-7.
5. Finnegan LP, Connaughton JF Jr, Kron RE, Emich JP. Neonatal abstinence syndrome: Assessment and management. Addict Dis 1975;2:141-158.
6. D'Apolito KC. Assessing neonates for neonatal abstinence : Are you reliable? J Perinat Neonatal Nurs 2014;28:220-231.
7. Grossman MR, Lipshaw MJ, Osborn RR, Berk Witt AK. A novel approach to assessing infants with neonatal abstinence syndrome. Hospital Pediatrics 2018;8(1):1-6. DOI: 10.1542/hpeds.2016-0128.
8. Substance Abuse and Mental Health Services Administration. *Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants*. HHS Publication No. (SMA) 18-5054. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018; 1-877-726-4727. Available at: <https://store.samhsa.gov/sites/default/files/d7/priv/sma18-5054.pdf>.



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IMQCC Updates

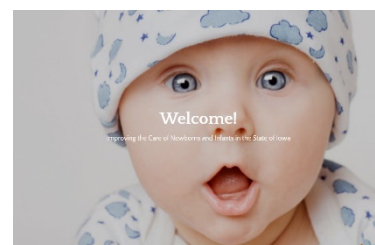
Learning Session 3 will be held March 25 from 9 am to 4:30 pm. The session will be virtual. The agenda is taking shape and will be finalized soon. It should be very informative. We look forward to seeing the teams. The Cesarean Collaborative will conclude collecting data in September 2022. IMQCC has announced that the next [AIM \(Alliance for Innovation on Maternal Health\)](#)



Safety Bundle will [Obstetric Hemorrhage](#). This collaborative will begin in October and conclude in the spring of 2023. All facilities are welcome to participate in the Collaborative. Planning for the Hemorrhage Collaborative will begin with an expert meeting later this spring. We are currently seeking volunteers to participate at the expert meeting. Please contact Nicole Anderson at nicole-anderson@uiowa.edu if you or a colleague are interested in contributing. Facilities that are not currently enrolled in the collaborative and would like more information about AIM and the upcoming collaborative are encouraged to reach out to Dr. Radke, stephanie-radke@uiowa.edu, Nicole Anderson, or Amy Dunbar, amy-brandt@uiowa.edu. Check out the [IMQCC website](#) for updates!

Updates from Iowa Neonatal Quality Collaborative (INQC)

Twenty-one Iowa birthing hospitals are currently engaged in the collaborative. Hospital teams continue to collect data for the **NAS QI project**. At the last INQC meeting on February 17, 2022, Dr. Rosenblum presented retrospective data on 961 NAS patients and prospective data on 304 patients including 43 data fields. We had a brief discussion regarding the barriers hospitals have encountered when implementing Eat, Sleep, Console (ESC) or non-pharmacologic bundles of care. Collaborative work has also begun on the **HIE QI project**. On February 15, 2022, the oversight committee for the Iowa Neonatal Encephalopathy (NE) Registry met for the first time. The committee is led by Dr. Stephanie Lee, neonatologist at UI Stead Family Children's Hospital. It includes representatives from the four cooling centers in Iowa and other stakeholders. The primary aim of the project is to improve neonatal outcomes in the state of Iowa by building a data repository to inform us statewide regarding our screening and management of infants with neonatal encephalopathy. INQC hospitals recently participated in a survey to guide the development of other QI projects in 2022. An overwhelming majority of survey participants chose **Managing the Late Preterm Infant** as the next **QI project** for the collaborative. Recruitment for the subcommittee that will lead this project has begun. Other suggestions for future QI projects include probiotic guidelines and infant driven feedings. Visit the INQC website [HERE](#).



If your hospital is not currently engaged in the collaborative and you would like more information, please contact Penny Smith, RNC-NIC, penny-smith@uiowa.edu or Dennis Rosenblum, MD, dennis.rosenblum@unitypoint.org.

***The Statewide Perinatal Program is funded by the Iowa Department of Public Health.**