



Recovery Friendly Pediatric Practices

NH Experience

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Objectives

1. Gain insight into New Hampshire's landscape for serving children impacted by parental SUD
2. Understand why system re-design is needed within current healthcare and community systems in order to address the root causes of adverse childhood experiences and other factors that impact health and wellness
3. Highlight key factors critical for building sustainable clinic and community partnerships



NH Landscape



- ❑ Perinatal opioid use disorders affect a substantial proportion of pregnancies in New Hampshire, with rates ranging from 5-14% of pregnancies based on geographic location and population served.
- ❑ Rates of neonatal abstinence syndrome (NAS) in NH hospitals have increased nearly 10 fold over the past 15 years.
- ❑ In 2015, 7.5% of women delivering at Dartmouth Hitchcock were in treatment for opioid use disorders at the time of admission, and 10% of infants were monitored for neonatal opioid withdrawal syndrome.



Case # 1

Sarah, 32 years old and with an opioid use disorder, **unintentionally becomes pregnant**. Due to the effects of opioids on her body, she typically has widely spaced menses and was **unaware of pregnancy until ~ 20 weeks gestation**.

At first prenatal visit, she discloses **IV drug use in past year** with symptoms of withdrawal. She denies current use, claiming she went to rehab 3 months ago, and **declines referral to treatment**.



Through pregnancy, she has **sporadic prenatal care, misses many scheduled visits, and is difficult to contact.** However, she has made all well-child visits for her 6-year old who is attending school regularly. She reports that her mother cares for her child when she uses.

At 32 weeks, she is observed for 48 hours for preterm contractions/bleeding. Her **urine test is positive for heroin.**



She is initiated on buprenorphine and referred to a community-based buprenorphine program.

In the remainder of her pregnancy, urine tests are positive for buprenorphine and marijuana. Her provider discusses the possibility of a report to DCYF after her baby delivers due to her substance use in pregnancy. **She reacts emotionally, saying “that’s the reason I didn’t want to tell you guys I needed help. You’re going to take my baby away after she’s born...”**



The Opportunity: Upstream ACE Prevention

- Implement a systematic, integrated approach to interrupt this intergenerational cycle of addiction
- Promote family healing, prevent lifelong morbidity
- Decrease the associated financial and social impact on New Hampshire communities and the state's healthcare system

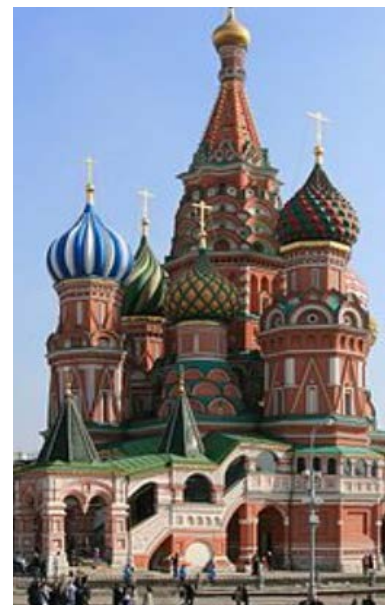
All beautiful, interesting, and well-designed for their specific task.
But do they make a good system together?



Grass Roots
Organizations



Academic Medical
Center



Non-profits



Families

What Do We Get With Our Current System?

- ~25% of children living in homes with income <200% of Federal Poverty Level
- ~14/1,000 children under age 9 in out-of-home placement (NH MCH ACES report)
- ~18% of NH Adults report having 3+ Adverse Childhood Experiences
- 18+% of GDP spent on health care (rising toward 25%)

The NH Approach

- Engagement
- Relationships/Partnerships
- Communication
- Community Collaboration
- Standardized Process Improvement



Steps We Took

- Community stakeholder analysis
- Secure foundation funding
- Gauge pediatric practice interest
- Deploy standardized process improvement framework
 - Individualize the approach
- Identify and begin PDSA cycles
- Collect data
- Analysis results
- Build capacity and scale
 - Assessment and evaluation

Stakeholder Assessment Needs

TOPIC	STAFF	CHILD	PARENT/CAREGIVER	SYSTEM
How is opioid-linked family disruption showing up in our work	<ul style="list-style-type: none"> • It is everywhere • Provider burnout • Most of the population • Missed follow-up 	<ul style="list-style-type: none"> • State & law enforcement • Lack of attachment • Poor nutrition 	<ul style="list-style-type: none"> • DV • Lack of TX options • Generational 	<ul style="list-style-type: none"> • Wait lists • Stigma • Insurance barriers • Need for process improvement • Care is divided
How are you intersecting with health, NH, and family service organizations to improve care?	<ul style="list-style-type: none"> • Collaboration, referrals into the community • Outreach efforts, health edu 	<ul style="list-style-type: none"> • TLC Family resource center 	<ul style="list-style-type: none"> • Mobile Van • FRC's 	
What frustrates you most about our existing systems of care?	<ul style="list-style-type: none"> • Lack of community resources, follow-up, staff training, disconnect between teams 	<ul style="list-style-type: none"> • Lack of child care 	<ul style="list-style-type: none"> • Parents aren't always transparent • Lack of supports/follow-up • Lack of parenting skills 	<ul style="list-style-type: none"> • Lack of communication • SUD is not isolated • Stigma • 2 states that are segregated
How are our organizations serving this population? (adaptations and innovations)	<ul style="list-style-type: none"> • Always looking for more partnership • MCH advocacy • Engage early • Community events 	<ul style="list-style-type: none"> • In home services (volunteers) 	<ul style="list-style-type: none"> • In home services 	<ul style="list-style-type: none"> • Community partnerships are building • Improved communication systems



Relationships and Partnerships

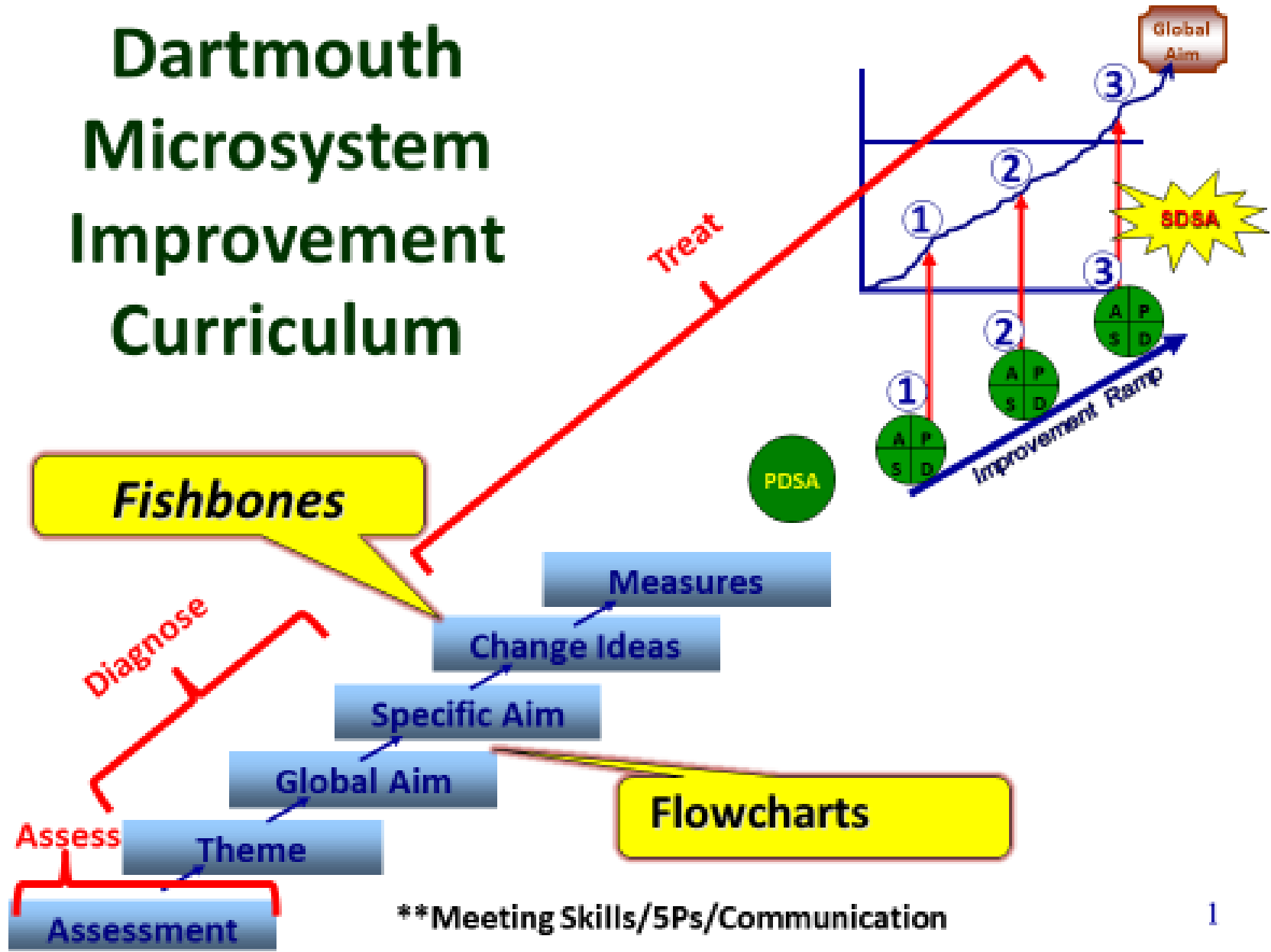
Many stakeholders reported:

- Not having recent/on going communication across teams
- Not knowing what their current community resources were
- Identified need for how to share resources with families
- Desire to improve cross-system partnerships to help families



Process Improvement

Dartmouth Microsystem Improvement Curriculum



Global Aim

“We aim to improve the health and well-being of children and families impacted by substance misuse”

Specific Aims

- “We want to increase the number of family support referrals from pediatric practices by conducting outreach activities to pediatric staff to build relationships and provide current program information”
- “We want to increase the number of contacts with CHW in OBGYN to increase the referrals coming from pregnant women to FRC”
- “We aim to improve staff education around SUD topics from 0-75% of the staff having attended at least 1 related professional development topic”

Nitty Gritty

How do we build relationships?

How do we partner?

Strength-based approaches

Individualized experience

Assessment and evaluation



Different Windows, Same House



Results: *themes*

- ❑ Need for staff education (addiction and recovery, trauma informed care)
- ❑ Identified gap between referral to services and engagement in services
- ❑ Identified gap in understanding community resources beyond the clinic walls
- ❑ Need for parenting education
- ❑ Strength-based approaches to clinical encounter
- ❑ Increased opportunities to engage with families (support)

What are families saying?

We need help with things such as transportation and food? Also how can I find child care?

How do I talk to my child about my recovery?

I don't want to feel judged when I come to my child's appointment.

I trust my pediatrician.

“People in Recovery can be great parents too!”

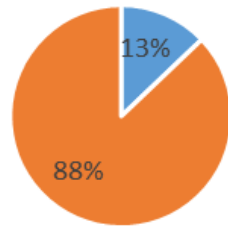
Snapshots of Change





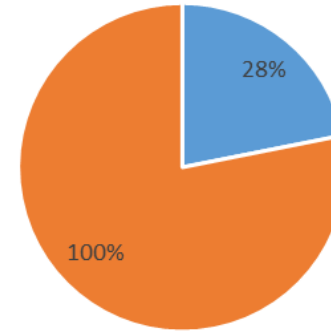
Surveys

STAFF REPORTED: "VERY KNOWLEDGEABLE" IN UNDERSTANDING THE IMPACTS OF STIGMA ON HEALTH



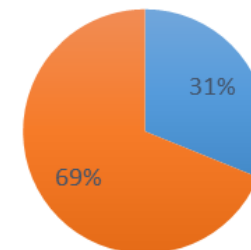
■ Pre ■ Post

STAFF REPORTED: "VERY KNOWLEDGEABLE" IN UNDERSTANDING IMPACTS OF TRAUMA ON BRAIN DEVELOPMENT



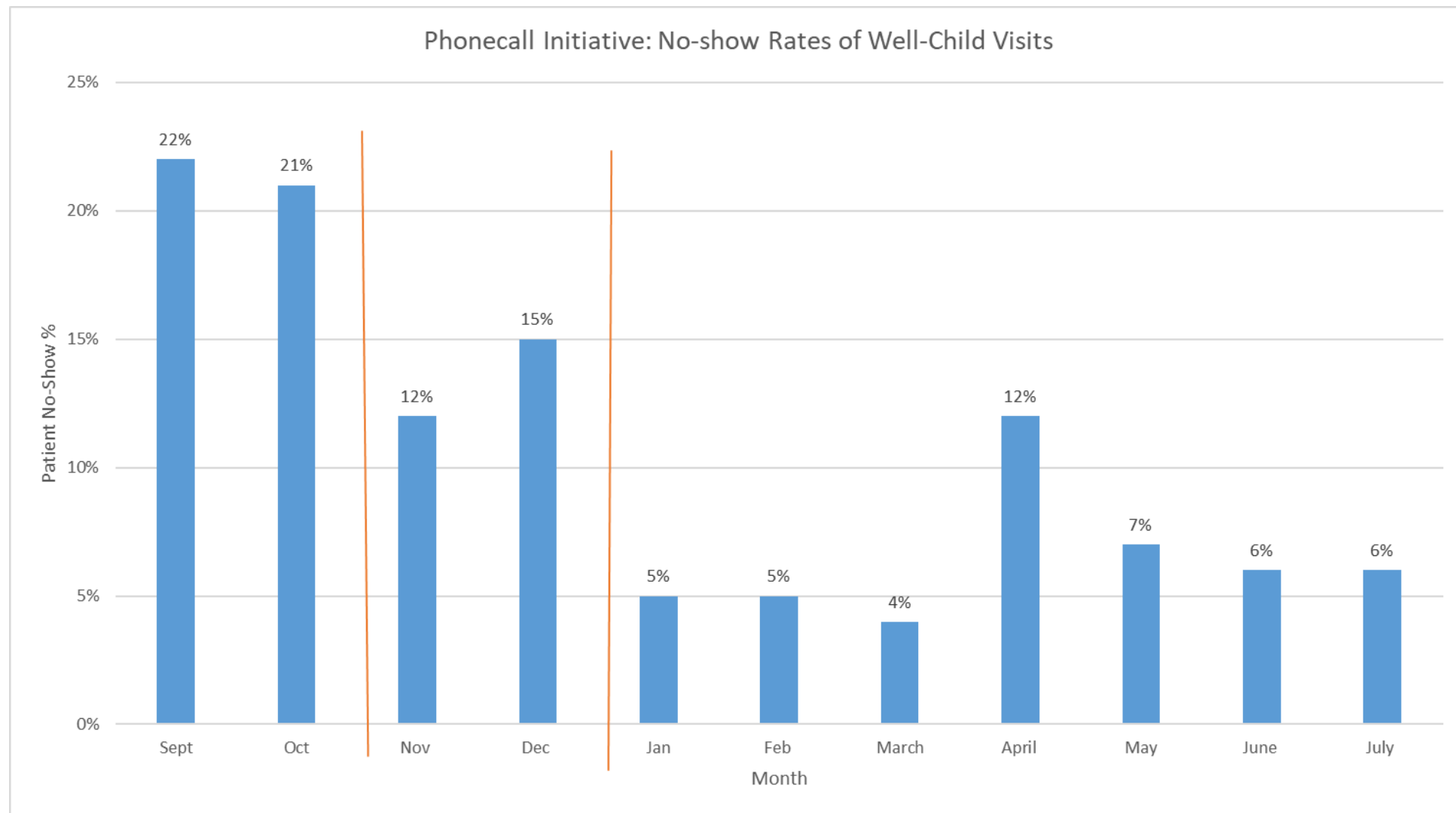
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STAFF REPORTED: "VERY KNOWLEDGEABLE" IN UNDERSTANDING THE TYPES OF TRAUMA THAT CAN IMPACT CHILDREN

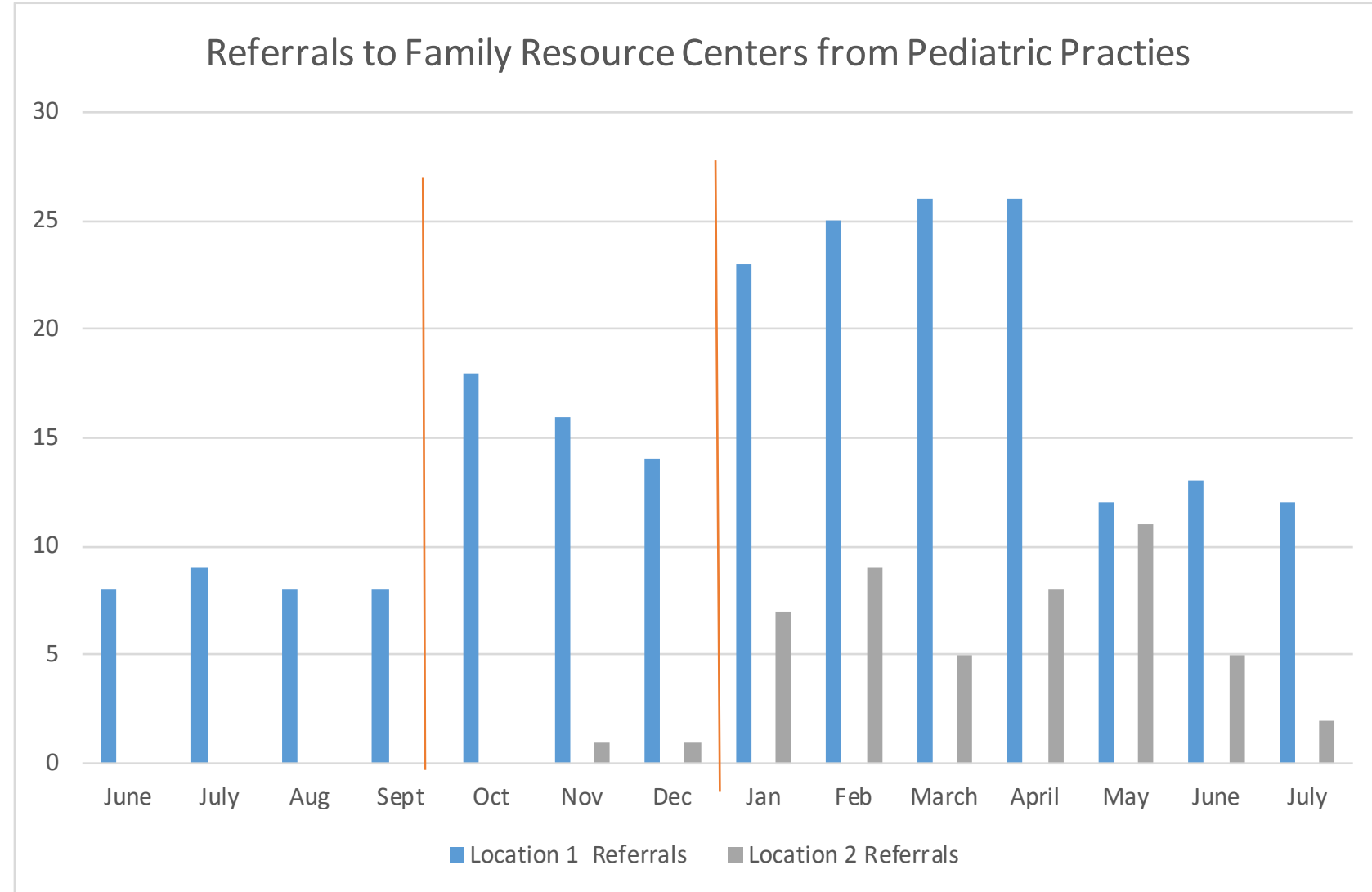


■ PRE ■ POST

Engagement with Families: Improved appointment rates



Improved clinic and community connections: access for families



Recovery Friendly Pediatric Practice

Stigma Reduction



Dyadic Approach



Community Collaborations



Strength-based
Family Centered Care





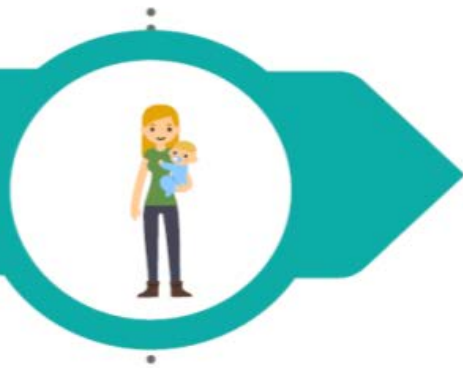
Stigma Reduction



- Staff Education
- Public Awareness
- Resources and Materials
- Recovery Supports
- Non Stigmatizing Language



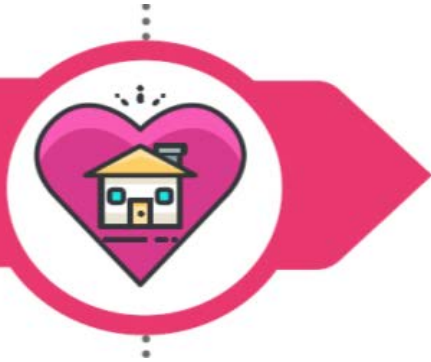
Dyadic Approach



- Maternal Screening and Referrals
- Plans of Safe Care
- Engage Early with Prenatal Team
- Multiparty Consents



Community
Collaborations



- Embedded Family Resource Centers
- Multidisciplinary Staff Collaboration
- Enhanced Communication Pathways
- Access to Resources



- Co-design care
- Compassion fatigue
- Patient & family advisors
- Peer support
- Continuity of care

Redesigned Care





Case # 2

Jill, a 26 year old woman presents to OB clinic for prenatal care in her second trimester. She discloses use of oxycotin, heroin, and street bupinorphine over the past 6 months. The clinic enrolls her in a treatment program for pregnant and parenting women, and a Plan of Safe Care is started including supportive community resources such as a local food shelf and home visiting care. A Community Health Worker/Recovery Coach tells her about a “Recovery Friendly Pediatric Practice” nearby.

She delivers at term and is discharged after 4 days in the newborn nursery. Jill is nervous about her daughter’s pediatric appointment the next day, feels shame, and is worried that her daughter will be taken away from her.

Pediatric Purple Pod



CHaD Children's Hospital at
Dartmouth-Hitchcock

At her first pediatric visit, she is roomed by an MA who tells her **we support recovery**, and is **greeted by the same Community Health Worker she saw before delivery**. Her pediatrician asks her about her **strengths, supports and goals**, and asks her about her recovery program, and if she needs help finding care for herself. She also says she has questions about breastfeeding, so a lactation consultant is able to come into the appointment, and also refers to additional community supports.

She enrolls in WIC and a Family Resource Center: home visiting program during her clinic time. After going home, she received a follow up text, and then a few days later **a phone call asking how she is doing, and what she'd like to discuss at the next visit**.

She **remains in recovery** throughout her first year with frequent visits to clinic, but no ED visits or hospitalizations.

Current Engagement

Valley Regional Pediatric Practice

Evidence informed Staff Education (3 part series)
Embedding of TLC Family Resource Center 2 days/week
Standardized loop-back referral for communication from FRC to Peds Practice
Enrolled in Reach Out and Read

DHMC Lebanon: *Pediatric Purple Pod & Pediatrics*

Evidence informed Staff Education (3 part series)
Embedding of TLC & TFP Family Resource Centers 2 days/week- Pedi, 1 day/week-OBGYN
Standardized loop-back referral for communication from FRC to Peds Practice
Parent education series at Mom's in Recovery
2 m ASQ & Dev Screenings at Mom's in Recovery
Parent education series in newborn nursery
Creation of System of Care Collaboration meeting

Alice Peck Day

Evidence informed Staff Education (3 part series)
Enrolled in Reach Out and Read

Newport Pediatrics

Completed assessment & identified priorities

New London Pediatrics

Meeting to assess interest completed

Evidence & Research Informed Practice

Circle of Security
Medical Home
Reach Out & Read
Home visiting
Strengthening families
HealthySteps

Next Steps

Recovery Friendly Practice Tool kit

- Awareness, advocacy, sustainability

Collective Impact

- Link to other related efforts

Expand to other pediatric practices

- Improve access and collaboration

Funding and Sustainability

- Medicaid & private insurance (bundled model for mother & infant)

Q&A



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