Our Care Notebook

PERINATAL QUALITY COLLABORATIVE VERMONT

VCHIP
VERMONT CHILD HEALTH IMPROVEMENT PROGRAM
The University of Vermont | LARNER COLLEGE OF MEDICINE

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PERINATAL QUALITY COLLABORATIVE VERMONT
VERMONT CHILD HEALTH IMPROVEMENT PROGRAM

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This Care Notebook was made for families affected by opioid-use disorder to provide information and resources as you navigate pregnancy and the birth of your baby. Healthcare providers and advocates partnered with families in recovery to create this booklet with support of the Vermont Child Health Improvement Program (VCHIP) and funding from the Vermont Department of Health.

While reading this notebook, we encourage you to write down any questions that you may have about your care and the care of your baby to bring to your pregnancy provider.

You are not alone! We have included links to stories from other parents affected by opioid-use disorder who wanted to share their journey with you, which can be found on our website.

We hope you will find the information useful, and we encourage you to give us any suggestions for improvement of this booklet.

In partnership,

The VCHIP Improving Care for Opioid-Exposed Newborns (ICON) Team

DEDICATIONS

To the families who are living the experience and are striving to improve their lives and the health of their children.

In remembrance of Dr. Anne Johnston throughout this notebook you will see pictures of hearts that were made by Dr. Johnston and her team at the Neonatal Medical-Developmental Follow-up Clinic and given to parents. Dr. Johnston was a passionate advocate for families affected by opioid-use disorder and the founder of this project.

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During Pregnancy

Talking to Your Providers About Substance Use

❖ Obstetricians, midwifes, and family practitioners all provide care to pregnant people. Some providers can also provide treatment for substance use disorders. All providers can help you access local Hubs or Spokes to initiate Medications for Opioid Use Disorder (MOUD), also known as Medications for Addiction Treatment (MAT) or help you access treatment for alcohol or cannabis use disorder.

❖ No matter who provides your pregnancy care, we all want the best for you and your unborn baby. Please talk to us about any substances you may be using so we can have a conversation about any risks and steps you can take to have a healthy pregnancy.

❖ We ask about substance use at every visit for every pregnant person to provide the best care and keep the conversation open about your current use and goals for decreasing or stopping use.

❖ If you are receiving pregnancy and substance use disorder care from different providers, please consider signing releases so we can share relevant information to provide the best care for you and your baby.

One More Conversation **Can** Make The Difference

One More Conversation is a campaign by the Vermont Department of Health to give pregnant people information, questions to ask, and courage to reach out to health care providers and continue the conversation.

Substance Use in Pregnancy | Vermont Department of Health (healthvermont.gov)

https://www.healthvermont.gov/family/pregnancy/substance-use-pregnancy

Treatment of Opioid-Use Disorder During Pregnancy

- When you are using opioids including heroin or pain medications (such as OxyContin, Percocet, Vicodin, etc.) regularly and are sick when you don't use them, chemical changes have happened in your brain that makes it extremely difficult to stop without help.
- When a pregnant person goes into withdrawal, the baby also experiences withdrawal, which can be dangerous.
- If you become pregnant and are using opioids, there are prescription medications available that can help you and your baby have a healthy pregnancy.
- Medications for Opioid-Use Disorder (MOUD) also known as Medications for Addiction Treatment (MAT) include Methadone, Buprenorphine (Subutex), and Buprenorphine-Naloxone (Suboxone). This is the preferred treatments for pregnant people with opioid-use disorder.
- MOUD/MAT help you and your baby. These medicines prevent withdrawal symptoms, decrease your cravings to use, and are safe to use during pregnancy and breastfeeding.
- Many babies will have some symptoms after birth that improve with supportive care. Less than 25% of babies born to mothers receiving MOUD/MAT will need medications (such as methadone or morphine) to treat withdrawal.
- The dose of MOUD/MAT does not predict an infant’s need for treatment. It is important you continue an effective dose during pregnancy as decreasing it may not change the baby’s need for treatment and may lead to withdrawal symptoms for you.
- If your baby needs medicine for withdrawal symptoms, it does not mean your baby was born “addicted”. The baby just needs the medicine (often just one or a few doses), to help them manage their symptoms until they resolve on their own.

During Pregnancy

Tobacco Use in Pregnancy

The birth of your baby is exciting and represents a new beginning for everyone. It can provide a wonderful opportunity to consider making positive changes.

❖ What are the risks of smoking for my baby?

Smoking and vaping tobacco products during pregnancy may lead to:

- Premature birth
- Low birth weight
- Nicotine withdrawal symptoms
- Increased the need for treatment for Neonatal Abstinence Syndrome

Babies exposed to secondhand tobacco smoke are at an increased risk of having:

- Pneumonia
- Ear infections
- Asthma and other breathing problems
- Sudden infant death syndrome

❖ Quitting is hard, will cutting back help?

If you can quit using tobacco products, this is the healthiest choice for you and your baby. However, decreasing the number of cigarettes to less than six a day or reducing the amount of vaping before birth, can decrease the withdrawal symptoms that your baby may have.

❖ What resources are available to help me quit?

802 QUITS YOU CAN QUIT. WE CAN HELP.

Call: 1-800-Quit Now (1-800-784-8669) for Vermont State quit line

Vermont: https://802quits.org/

New York: https://www.nysmokefree.com/

❖ Where can I get more information?

Vermont Department of Health One More Conversation: Tobacco Fact Sheet
adap_1MC_TobaccoFactSheet.pdf (healthvermont.gov)

Cannabis Use in Pregnancy

Though challenging, reducing or stopping cannabis use during your pregnancy is a great step you can take to provide a safe and healthy beginning to your baby's life.

❖ What are the risks of using cannabis for my baby?

Using THC containing cannabis products during pregnancy may lead to infants having:

- Lower birth weight
- Decreased muscle tone
- Delays in motor development

During breastfeeding THC from smoking, vaping, or eating cannabis can be found in breast milk within 20 minutes of use and is present for up to 6 days. Infants exposed to THC via breastfeeding may have:

- Sleepiness
- Difficulties breastfeeding or sucking

Babies exposed to secondhand cannabis smoke are at an increased risk of having:

- Respiratory infections and breathing problems
- Sudden infant death syndrome

❖ What about cannabis use for morning sickness?

As THC is associated with risks for your baby, talk to your pregnancy provider about other treatment options for nausea and vomiting, anxiety or sleep difficulties that may be safer than cannabis use.

❖ What resources are available to help me quit cannabis?

Vermont Help link
Telephone: 802-656-LINK
Website: Vermont Helplink for Alcohol & drug support center (vthelplink.org)

❖ Where can I get more information?

Vermont Department of Health Let's Talk Cannabis- Cannabis, Pregnancy and Breastfeeding
Cannabis, Pregnancy and Breastfeeding | Vermont Department of Health (healthvermont.gov)

Vermont Department of Health One More Conversation: Cannabis Fact Sheet
adap_1MC_CannabisFactSheet.pdf (healthvermont.gov)

Hepatitis C in Pregnancy

❖ What is hepatitis C?

Hepatitis C is a virus that attacks the liver. In the United States, there are more than 4 million people who have ever had hepatitis C virus infection.

❖ How does a newborn get hepatitis C?

About 4 in 100 pregnant people who are infected with hepatitis C virus will pass it to their baby during delivery. The risk is related to how much of the virus a person has (viral load) and whether they also are infected with HIV.

❖ When are babies tested for hepatitis C?

If a pregnant person has hepatitis C, their baby will have a blood test at 12-18 months of age to determine whether the infection was passed to the baby.

❖ Can I breast feed if I have hepatitis C?

Yes, it is safe to breast-feed, but if your nipples are bleeding you should express your milk and discard it until they are healed.

❖ Can my baby go to daycare?

Yes, your baby can go to daycare. You do not need to tell the daycare providers or other caregivers that your baby has been exposed to hepatitis C.

❖ Can my baby give hepatitis C to someone else?

This is very unlikely. Kissing, hugging, sneezing, coughing, sharing food or water, or casual contact do not pass along hepatitis C. Children infected with hepatitis C should not be excluded from school, play, or any other childhood activity based on their infection status.

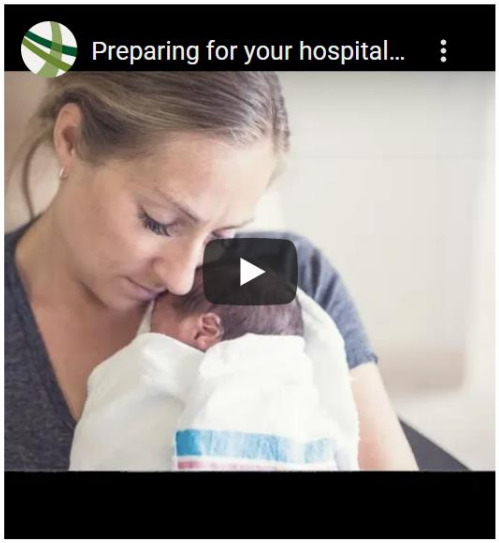
❖ What if my baby does test positive for hepatitis C?

Your baby will be referred to a specialist so that they can monitor them as they grow. Many babies will clear their hepatitis C infection, and treatment is available after age 3 if it does not clear on its own.

Preparing for Your Time in the Hospital

- ❖ While your baby is in the hospital, you will care for your infant as much as possible. It is helpful to have a support person with you to help care for your baby in your room (partner, other family member, or friend).
- ❖ Bring enough clothes and personal items with you to last for 4 days or more.
- ❖ Plan to have someone watch your other children and/or pets while you are away.
- ❖ Sometimes it is hard to talk to your family about why your baby might need to stay in the hospital. If this is true for you, discuss it with your pregnancy provider.

This video may provide answers to some of your questions:



Additional information is also available on our website:
[Improving Care for Opioid-exposed Newborns (ICON) | College of Medicine | University of Vermont (uvm.edu)]

Breastfeeding Questions

❖ Can I breastfeed?

YES! Individuals being treated for opioid dependency/addiction with methadone or buprenorphine can breastfeed. In fact, they are encouraged to do so!

❖ Why breastfeed?

For most newborns, breast milk is the only food needed for the first six months of life. There are many health benefits for both the birthing parent and baby.

❖ For infants:

- Fewer ear infections, lung infections, and gastrointestinal infections
- Decreased risk of sudden infant death syndrome (SIDS)
- Reduced chance of developing obesity, diabetes, and asthma

❖ For birthing parents:

- Bonding time with your baby
- Less post-partum bleeding
- Decreased risk of diabetes, high blood pressure, and certain types of cancer
- Lowered risk of post-partum depression

❖ Will my baby be harmed by methadone or buprenorphine that is passed through my breast milk?

No, the amount of methadone or buprenorphine passed through breast milk is very small and causes no harm to your baby.

❖ In what situations should I NOT breastfeed my infant?

People infected with human immunodeficiency virus (HIV) should not breastfeed. Individuals who are using cocaine, heroin, or non-prescribed substances should also not breastfeed.

❖ Can I breastfeed if I am infected with hepatitis C virus?

YES! Individuals who are infected with hepatitis C virus may breast feed. But if your nipples are cracked or bleeding you should use a breast pump to express breast milk from that affected breast and discard the milk until your nipples have healed. If only one breast is cracked and bleeding, you may still breast feed from the other breast.

During Pregnancy

Breastfeeding Resources

"My baby needed methadone treatment for withdrawal symptoms. Breastfeeding was one of the most important decisions I made regarding his health and treatment plan."

Websites and videos:

FIRSTDROPLETS

Videos to support the successful initiation of breastfeeding.

Droplet (firstdroplets.com) https://firstdroplets.com/

STANFORD HOSPITAL NEWBORN NURSERY

Videos on latch, hand expression, maximizing pumping

Breastfeeding | Newborn Nursery | Stanford Medicine

https://med.stanford.edu/newborns/professional-education/breastfeeding.html

KELLYMOM

Information about many aspects of breastfeeding and parenting.

Many online articles and videos. A great place to get your questions answered.

KellyMom.com Breastfeeding and Parenting https://kellymom.com/

BIOLOGICAL NURTURING

Laid Back breastfeeding video

Biological Nurturing Scenario on Vimeo

THERAPEUTIC BREAST MASSAGE & HAND EXPRESSION VIDEO

Therapeutic breast massage is a light massage technique that mothers can use to help relieve breast swelling and engorgement.

The Basics of Breast Massage and Hand Expression on Vimeo

GLOBAL HEALTH MEDIA PROJECT

Short videos on breastfeeding positioning and latch.

English Language Videos - Global Health Media Project

https://globalhealthmedia.org/language/english/?_sft_topic=breastfeeding

INFANT RISK CENTER

Information on medications, substances, and supplements while breastfeeding.

InfantRisk Center

https://www.infantrisk.com

Pain Relief During Labor and After Delivery

❖ Can I get the same pain medications for labor pain?

Pregnant people with a history of opioid-use disorder or treatment with MOUD/MAT are offered the same methods of pain relief during labor including epidurals. You are entitled to choose your method of pain relief unless there is a medical reason that it cannot be done. Some individuals will need adjustment to get the right level of medication to make them comfortable.

❖ What can I do on my own to manage my pain?

- Change body positions
- Use relaxation or breathing exercises
- Take a shower or bath
- Have someone massage your lower back
- Put heat or cold on your lower back
- Listen to music
- Take a walk

❖ What if I want medicine to help with my pain?

A common way to manage labor pain is through an epidural. The epidural is a small plastic tube put into your back by an anesthesiologist. When you have an epidural, the amount of pain relief can be adjusted as your labor progresses. The goal of pain relief with an epidural is to make you more comfortable without being completely numb. This means that you will still feel the pressure that goes along with contractions but should not have sharp pain.

❖ What if I need a cesarean section?

If you have an epidural in place, the anesthesiologist gives more medication through the epidural to make you completely numb. If you do not have an epidural, then a spinal anesthetic is used. Rarely, when there is an emergency, a general anesthetic is given which means you will be asleep for the delivery of your baby.

❖ What are the risks of epidurals?

Some of the common side-effects of epidurals are low blood pressure and itching. The risks that go along with an epidural are bleeding and infection (rare), nerve damage (rare), headache (1%), the epidural doesn't work well and may need to be re-done (20%).

Pain Relief During Labor and After Delivery (continued)

❖ Will I be able to have pain medicine after the baby is born?

The amount and type of pain medication given after delivery will be determined by how much pain you have and whether you delivered vaginally or by C-section. Ibuprofen and Tylenol alone generally can manage the pain from a vaginal delivery. More complicated deliveries and C-sections may require stronger medication. Pain medication is adjustable to individual needs. If you have pain, please let your nurse know to help develop a plan for optimal pain relief.

❖ Will any of these medications affect breastfeeding my baby?

None of the medications given routinely in labor will impact breastfeeding. A very long or complicated labor can cause a slow start to breastfeeding. The hospital staff is very committed to helping you breast-feed successfully. Be prepared to be patient as your baby figures the food system out.

Neonatal Abstinence Syndrome (NAS)

❖ What is NAS?

Neonatal Abstinence Syndrome (NAS) also known as Neonatal Opioid Withdrawal Syndrome (NOWS), is a group of signs and symptoms a baby can experience after birth related to opioids taken during pregnancy (methadone, buprenorphine, pain medicines, heroin, fentanyl).

❖ How long does my baby need to stay in the hospital to monitor for NAS?

Your baby will stay in the hospital for at least 96 hours. Most babies show signs of withdrawal related to opioids 2-3 days after birth, but some may not show signs until day 4. During your time in the hospital, we will be here to help and support you, but you will be your baby's primary caregiver. Try and identify a support person to come to the hospital to so you can have breaks.

❖ What are the symptoms of NAS?

- Tremors, jitteriness, or shaking of arms and legs
- Tight muscles in arms and legs
- Fussiness, hard to console or calm down
- Problems eating or sleeping
- Need for sucking when not hungry
- Loose or watery stools (poops)
- Losing too much or not gaining enough weight

❖ How will my baby be monitored for signs of NAS?

Your care team with work with you to watch for signs of NAS. Every few hours, ideally after a feed, we will review with you your baby's behaviors listed below:

- How well your baby eats
- How well your baby sleeps
- How well your baby consoles (calms)
- What kinds of things calm your baby (holding, skin to skin contact, swaddling, sucking)

❖ Will I be able to breastfeed my baby?

It is safe to breastfeed if you are in a program receiving a stable dose of MOUD/MAT. There are rare situations when it is not safe to breastfeed, including recent use of non-prescribed medications or substances. Breastfeeding can decrease signs of NAS. Breastfeeding can be challenging but nurses and lactation specialists are available to help you.

Neonatal Abstinence Syndrome (continued)

❖ How can I best help my baby?

- Be with your baby as much as possible: One of the best things you can do is to keep your baby with you in your room as much as possible. Being close to your baby helps you learn your baby's cues and respond quickly to your baby's needs. Your baby will feel safest and most comfortable when close to you.
- Skin to skin: When you are awake, spend as much time "skin to skin" with your baby as you can. This helps your baby eat and sleep better and will help calm your baby. It can also help decrease other symptoms of NAS. It also helps your milk supply when breastfeeding.
- Swaddle / Cuddle: Hold your baby or swaddle your baby in a light blanket. Just being close to someone, or "tucked" in a swaddle, helps your baby feel safe and comfortable.
- A calm room: Keep your room calm and quiet with the lights low. Loud noises and bright lights may upset your baby.
- Feed at early hunger cues: Feed your baby whenever your baby is hungry and until content, at least every 3 hours. Early signs of hunger include lip licking or smacking, hand or finger sucking, and moving the head quickly side to side.
- Sucking: If your baby still wants to suck after a good feeding, offer a finger or pacifier to suck on. This can be very comforting for your baby. Always make sure your baby is not hungry first!

❖ If my baby does NOT need medicine, when can we go home?

Your baby's care team will help decide when it is safe for your baby to go home. We will need to watch your baby for at least 4 days (96 hours) in the hospital to make sure there are no significant signs of NAS. You will be ready to go home when your baby is easy to console (calm down), sleeping well, and feeding well with appropriate weight. Your baby should also be able to maintain a healthy temperature, heart rate & breathing.

❖ What if my baby needs medication for withdrawal?

Infants may need medication if they have symptoms of withdrawal that affect their ability to eat, sleep or console. Some babies only need 1 or a few doses medicine to treat NAS symptoms and others need to continue for longer. It may take a few days to find the right dose of medication for your baby.

At UVM Medical Center: Infants are treated with methadone and may be monitored the neonatal intensive care unit (NICU) for a period of time after treatment.

At other Vermont hospitals: Infants are treated with morphine and may be monitored in the nursery or while rooming in with their caregivers.

❖ What about cuddlers?

Cuddlers are a group of volunteers who have been specifically trained to hold and comfort babies under nurse supervision. Cuddlers are also trained in confidentiality. They may be available at the hospital to help hold the baby so you can rest or take a break.

Eat, Sleep, Console (ESC) Care Tool

The ESC care tool is a family centered approach to monitor for neonatal abstinence syndrome/ neonatal opioid withdrawal syndrome (NAS/NOWS) due to opioid use during pregnancy.

❖ Principles of ESC:

- To manage symptoms of opioid withdrawal through non-pharmacologic treatment provided by parents or caregivers.
- To reserve medication for those infants who are unable to eat, sleep, or console due to opioid withdrawal symptoms despite maximal non-pharmacologic treatment.

❖ Non-pharmacologic treatment: parents/caregivers are the best therapy for their baby!

- Rooming-in with the baby as much as possible
- Skin-to-skin when caregivers are awake
- Swaddle/Cuddle infant
- Calm room: lights low, volume quiet
- Rhythmic movement
- Encourage breastfeeding
- Feed at early hunger cues
- Sucking: offer finger or pacifier if infant still needs to suck after a feed
- Limit visitors: no more than 1-2 at a time

❖ What is monitored on the ESC care tool?

Eating: Does the infant have poor eating due to opioid withdrawal symptoms (NAS/NOWS)?
Mark yes if infant:

- takes more than 10min to coordinate feeding
- cannot sustain breastfeeding for 10min or take an age-appropriate volume bottle feeding

Sleeping: Did the infant sleep less than 1 hour after feeding due to opioid withdrawal symptoms (NAS/NOWS)?
Mark yes if: Poor sleep is related to opioid withdrawal symptoms (fussiness, restlessness, increased startle, or tremors).

Consoling: Is the infant unable to be consoled within 10 minutes due to opioid withdrawal symptoms (NAS/NOWS)?
Mark yes if infant is unable to console within 10 minutes due to opioid withdrawal symptoms despite consoling support.

❖ How does the ESC Care Tool compare to other tools?

- ESC focuses on the infant's overall functioning rather than scoring each symptom of NAS.
- Infant assessments are reported as yes/no on the ESC care tool instead of a numerical score.
- Infants are still monitored for clinical signs of withdrawal, but treatment decisions will be made based on the infant's ability to eat, sleep and console rather than their "score".
- Full team huddles will be called when symptoms of NAS impair eating, sleeping, or consoling despite maximizing non-pharmacologic interventions to consider medication treatment.
- Infants are assessed every 3-4 hours after feeds for a minimum of 96 hours.

EAT, SLEEP, CONSOLE (ESC) CARE TOOL

ESC 3rd edition 02.24.20

- **Review ESC behaviors**, **signs of withdrawal present,** and **Non-Pharm Care Interventions (NPIs)** with parent(s)/caregiver **every 2-4 hours** (using **Newborn Care Diary**), ***clustering care with infant's wakings and feedings.*** With each assessment, **maintain NPIs** that parents/caregivers are implementing well **("M"),** *and* **educate ("E") / coach parents** in ways that **other NPIs can be increased further** (**"I"**).
- If **Yes** for any **ESC** item *or* **3** for **Consoling Support Needed:** Perform a **Formal Parent/Caregiver Huddle** to ***formally* review NPIs that can be optimized further to help with infant's current ESC difficulties** and **continue to monitor infant closely.**
- If **2nd Yes in a row** for **any single ESC** item **(*or* 2nd "3"** for **Consoling Support Needed)** despite **maximal non-pharm care** *OR* ***other significant concerns*** are present *(e.g., seizures, apnea)***:** Perform a **Full Care Team Huddle w**ith **parent/caregiver**, **infant RN** *and* **physician or associate provider** to 1) **consider all potential etiologies** for symptoms, 2) **re-assess if NPIs** are **maximized** to fullest extent possible in infant's clinical setting, and 3) **determine if Neonatal Opioid Withdrawal Syndrome (NOWS)/Neonatal Abstinence Syndrome (NAS) medication treatment is needed. Continue** to **maximize all NPIs and monitor infant closely.**

Perform assessment of ESC behaviors, signs of withdrawal, and NPIs for time period since last ESC assessment *– note date/time:*	
NOWS/NAS RISK ASSESSMENT	
Are signs of withdrawal present? (e.g., hyperactive moro, tremors/jitteriness, increased tone, excessive/disorganized suck) Yes / No	
If Yes, is timing of withdrawal consistent with known opioid exposure? Yes / No / Unsure	
Are co-exposures present that may be contributing to signs of withdrawal? Yes / No / Unsure (please list co-exposures)	
Are NPIs maximized to fullest extent possible in infant's clinical setting? Yes / No / Unsure	
EATING	
Takes > 10 min to coordinate feeding *or* **breastfeeds < 10 min** *or* **feeds < 10 mL** (*or* other age-appropriate duration/volume) **due to NOWS/NAS?** Yes / No	
SLEEPING	
Sleeps < 1 hr due to NOWS/NAS? Yes / No	
CONSOLING	
Takes > 10 min to console (*or* cannot stay consoled for *at least* 10 min) due to NOWS/NAS? Yes / No	
Consoling Support Needed 1 able to console on own within 10 min 2 able to console within (and stay consoled for) 10 min with caregiver support 3 takes > 10 min to console (*or* cannot stay consoled for *at least* 10 min) despite caregiver's best efforts	
CARE PLAN	
Formal Parent/Caregiver Huddle Performed to formally review NPIs to be increased further? Yes / No	
Full Care Team Huddle Performed to formally consider all possible etiologies for symptoms, re-assess if NPIs are maximized to fullest extent possible, and determine if NOWS/NAS medication treatment is needed**?** Yes / No	
Management Decision **a: Continue/Optimize NPIs** **b: Initiate NOWS/NAS Medication Treatment** (e.g., if baby's symptoms & timing of symptoms are consistent with mother's particular opioid *and* NPIs are maximized to fullest extent possible in infant's clinical setting, *OR* other significant NOWS/NAS concerns are present (e.g., seizures, apnea) – please list medication(s) initiated) **c: Continue NOWS/NAS Medication Treatment** **d: Other** (please describe – e.g., Start 2nd Pharmacologic Agent (indicate name); Wean or Discontinue Medication Treatment)	
PARENT/CAREGIVER PRESENCE SINCE LAST ASSESSMENT	
> 3 hours (includes if parent/caregiver present entire time), **2-3 hours**, **1-2 hours**, **< 1 hour**, **0 hours** (no parent/caregiver present)	
NON-PHARM CARE INTERVENTIONS (I = Increase Now, **M** = Maintain, **E** = Educate for Future, **NA** = Not Applicable/Available)	
Rooming-in (i.e., caring for infant in their own room with earlier caregiver response to infant stress or hunger cues)	
Parent/caregiver presence to help calm and care for infant	
Skin-to-skin contact when caregiver fully awake/alert to help organize infant feeding behaviors, calming & sleep	
Holding by parent/caregiver/cuddler to help calm infant & aid in sleep (with caregiver fully awake/alert)	
Safe & effective swaddling (e.g., extremities swaddled in flexed position, blanket snug, no extra blanket around baby's face)	
Optimal feeding (e.g., baby offered feedings when showing hunger cues & fed till content)	
Non-nutritive sucking with infant's hand, pacifier, adult caregiver's washed or gloved finger	
Quiet, low light environment to help limit overstimulation of infant (e.g., tv volume down, quiet "white noise" machine or phone app)	
Rhythmic movement provided by parent/caregiver or infant calming device (e.g., "jiggling" or infant swing in presence of alert adult)	
Additional help/support in room (e.g., other parent, family member, friend, cuddler, staff member, recovery coach, DCYF worker)	
Limiting # of visitors & duration of visit(s) to minimize disruptions in infant's care environment & sleep	
Clustering care & assessments with infant's awake times (e.g., RN & infant provider perform assessment together after infant feedings)	
Safe sleep/fall prevention (e.g., infant sleeps on back, safely swaddled, in own sleep space)	
Parent/caregiver self-care & rest (e.g., identifying another adult to care for infant so parent can rest or take a walk/break)	
Optional Comments: (e.g., staff caring for/consoling baby as parents not available or able to safely care for baby)	

***Special note:** Numbers above are **not** intended as a "score" but instead may indicate/identify a need for increased intervention.*

DEFINITIONS

EATING

- **Takes > 10 min to coordinate feeding** *or* **breastfeeds < 10 min** *or* **feeds < 10 mL** (*or* other age-appropriate duration/volume) **due to NOWS/NAS?:** Baby **unable to coordinate feeding *within* 10 minutes of showing hunger** *OR* **sustain feeding for *at least* 10 minutes at breast** *OR* **with 10 mL by alternate feeding method** (*or other age-appropriate duration/volume)* **due to opioid withdrawal symptoms** (e.g., fussiness, tremors, uncoordinated suck, excessive rooting).
- ***Special Note:* Do not indicate Yes** if poor eating is **clearly due to non-opioid related factors** (e.g., prematurity, transitional sleepiness or spittiness in first 24 hours, inability to latch due to infant/maternal anatomical factors).

SLEEPING

- **Sleeps < 1 hour due to NOWS/NAS:** Baby **unable to sleep for *at least* one hour**, after feeding well, **due to opioid withdrawal symptoms** (e.g., fussiness, restlessness, increased startle, tremors).
- ***Special Note:* Do not indicate Yes** if sleep < 1 hour is **clearly due to non-opioid related factors** (e.g., symptoms in first day likely due to nicotine or SSRI withdrawal, physiologic cluster feeding in first few days of life, interruptions in sleep for routine newborn testing).

CONSOLING

- **Takes > 10 min to console (*or* cannot stay consoled for *at least* 10 min) due to NOWS/NAS:** Baby **takes longer than 10 minutes to console** *OR* **cannot stay consoled for *at least* 10 minutes** (**due to opioid withdrawal symptoms) despite** infant caregiver/provider's **best efforts to implement NPIs** (e.g., skin-to-skin contact, non-nutritive sucking when baby not hungry).
- ***Special Note:* Do not indicate Yes** if infant's difficulties consoling are clearly **due to non-opioid related factors** (e.g., caregiver non-responsiveness to infant hunger cues, circumcision pain).

CONSOLING SUPPORT NEEDED

1. **Able to console on own:** Able to console on own without any caregiver support needed.
2. **Able to console within (and stay consoled for) 10 min with caregiver support:** Baby with absence of crying, grimacing, or other signs of distress while being held (or otherwise consoled) by a caregiver.
3. **Takes > 10 min to console (*or* cannot stay consoled for *at least* 10 min) despite caregiver's best efforts:** Baby with presence of crying, grimacing, squirming/tensing, or other signs of distress despite a caregiver's best efforts to implement recommended NPIs (e.g., parent/caregiver presence, skin-to-skin, holding, safe swaddling, optimal feeding, non-nutritive sucking when not hungry).

CARE PLAN

- **Formal Parent/Caregiver Huddle**: **RN bedside huddle** with **parent/caregiver** to ***formally* review NPIs that can be optimized** ("Increased") **further to help with infant's current eating, sleeping, and/or consoling difficulties**. To be performed if infant receives **Yes** for any **ESC** item ***or* 3** for **Consoling Support Needed**.
- **Full Care Team Huddle: Formal huddle** with **parent/caregiver**, **infant RN** *and* **physician or associate provider** to 1) **consider all potential etiologies** for symptoms, 2) **re-assess if NPIs** are **maximized** to fullest extent possible in infant's clinical setting, and 3) **determine if NOWS medication treatment is needed**. To be performed if infant **receives 2nd Yes in a row** for **any single ESC** item **(*or* 2nd "3"** for **Consoling Support Needed)** despite **maximal non-pharm care** *OR* ***other significant concerns*** are present**.**

PARENT/CAREGIVER PRESENCE SINCE LAST ASSESSMENT: Time (in hours) since last assessment that parent (or other caregiver) spent together with infant in own room *or* in Nursery.

OPTIMAL FEEDING:

- **Baby feeding at early hunger cues** and **until content** without any limit placed on duration or volume of feeding. Feedings are encouraged **at least every 3 hours, optimally 8-12 times per day**, to ensure baby does not become too hungry or disorganized with feeding and to optimize nutritional intake. A baby may remain sleeping for more than 3 hours *for therapeutic rest* if feeding difficulties or excessive weight loss are *not* present. If a pacifier is used, it should be introduced only after a baby has been fed or offered a feeding. As infants with NOWS/NAS may have poor feeding, have excessive/watery stools, or be hypermetabolic, **closely follow daily weights** and **provide increased volume and/or caloric density** of feedings, as needed, **for more than expected weight loss** *and/or* **poor weight gain for age.**
- **Breastfeeding:** Baby latching deeply with comfortable latch for mother, and sustained active suckling for baby with only brief pauses noted. **If feeding difficulties present**: a) **assist directly with breastfeeding** to help achieve more optimal latch and position, b) **demonstrate hand expression** and have mother **express colostrum prior to and/or during feedings**, and/or c) have baby feed on a clean or gloved adult finger first to **organize suck prior to latching**. As able based on infant's symptoms, consider withholding pacifiers until babies are breastfeeding well due to the potential to interfere with a good latch/suck. Consider use of nipple shield to facilitate palatal stimulation, or supplementation at the breast (as tolerated by mother), if infant requires assistance to maintain latch/suck.
- **Bottle feeding:** Baby effectively coordinating suck and swallow without gagging or excessive spitting up. **If feeding difficulties are present:** a) **assess need for altered nipple shape/flow rate**, b) instruct parent to **provide chin support during feedings**, *and/or* c) **modify position of bottle and flow of milk** to assist baby with feeding (e.g., modified side-lying position).
- **Consult a feeding specialist** (e.g., lactation, speech therapy, feeding team) when **feeding difficulties are present**.

Adapted from ESC Care Tool 3rd edition 11.14.19

Eating								
Time of Baby's Feeding (start and end times)	Start:_____ Finish:_____	Start:_____ Finish:_____	Start:_____ Finish:_____	Start:_____ Finish:_____	Start:_____ Finish:_____	Start:_____ Finish:_____	Start:_____ Finish:_____	Start:_____ Finish:_____
Breast Feeding (total minutes on each side)	Left: _____ Right:_____	Left: _____ Right:_____	Left: _____ Right:_____	Left: _____ Right:_____	Left: _____ Right:_____	Left: _____ Right:_____	Left: _____ Right:_____	Left: _____ Right:_____
Bottle feeding (total number of milliliters)								
Did your baby feed well?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
If no, describe:								
Sleeping								
Time baby fell asleep								
Time baby woke up								
Did your baby sleep more than an hour?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
If no, please describe:								
Console								
Did your baby console in 10 minutes or less?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
If no, please describe:								
Diapering								
Did your baby pee or poop?	Pee Poop	Pee Poop	Pee Poop	Pee Poop	Pee Poop	Pee Poop	Pee Poop	Pee Poop
Please describe poop	Normal Loose Watery	Normal Loose Watery	Normal Loose Watery	Normal Loose Watery	Normal Loose Watery	Normal Loose Watery	Normal Loose Watery	Normal Loose Watery
Notes:								

Helpful Referrals:

Nurse Home Visiting:

Home visiting programs are available in each county in Vermont.

Strong Families Vermont:

In this program nurse home visitors work with pregnant people and new parents until the child's second birthday. Parents and caregivers enroll in a free, voluntary program that is structured and customized to meet the family's goals.

Learn more about different home visiting services here: Strong Families Home Visiting | Children's Integrated Services Partners (vermont.gov) https://cispartners.vermont.gov/roles/strong-families

Vermont 2-1-1:

Prenatal/Postnatal Home Visitation Programs resource list has contact information for each home visiting program in Vermont.
Website: Vermont 2-1-1 Resource Directory (navigateresources.net)

Children's Integrated Services (CIS): Early intervention

A family-centered program with early intervention services for infants and toddlers who have a delay in their development or a health condition which may lead to a delay in development. All infants exposed to opioids (prescription, MAT/MOUD, or non-prescribed) are eligible for CIS services.

Telephone: Call 2-1-1 and ask for CIS in your county
Website: Early Intervention Directory | Department for Children and Families (vermont.gov) https://dcf.vermont.gov/partners/ei

Getting to Know Your Newborn

Baby Care

Sing, talk, and read to your baby; avoid TV and digital media

Calm your baby by cuddling/holding close or gently rocking

Try to sleep or rest when your baby sleeps.

Keep up routines to help your family adjust to the new baby.

Take help from family and friends

Take your baby's temperature with a rectal thermometer, not by ear or skin.

A fever is a rectal temperature of 100.4F/38.0C or higher.

Tobacco-free spaces keep children healthy.

Avoid smoking or using e-cigarettes. Keep your home and car smoke-free.

Avoid crowds and keep others from touching your baby without clean hands

Call the baby's doctor's office anytime you have questions or concerns

Feeding Your Baby

Feed your baby when hungry. Look for feeding signs such as:

◦ Putting hands to mouth.

◦ Sucking or rooting.

◦ Fussing.

Stop feeding when you see your baby is full.

Your baby might show these signs:

◦ Turning away

◦ Closing mouth

◦ Relaxing arms and hands

Hold the baby so you can look at each other during feedings

Your baby is getting enough to eat if there are at least 5 wet diapers and 3 soft stools per day and the baby is gaining weight appropriately.

Breastfeeding:

▪ Feed your baby on demand. Expect at least 8 to 12 feedings per day.

▪ A lactation consultant can give you information and support on how to breastfeed your baby.

▪ Begin giving your baby vitamin D drops (400 IU a day).

▪ Continue your prenatal vitamin with iron.

▪ Eat a healthy diet; avoid fish high in mercury

Formula Feeding:

◦ Babies typically eat about 2 oz of formula every 2 to 3 hours by the time they are 3-5 days old.

◦ If your baby is still hungry offer more.

◦ Stop a feeding when your baby shows signs that they are not hungry anymore.

Car Safety	
Use a rear-facing-only car safety seat in the back seat of all vehicles. Your baby's safety depends on you. Always wear your lap and shoulder seat belt.	Never drive after drinking alcohol or using drugs. Never text or use a cell phone while driving.
Make sure your baby always stays in the car safety seat during travel. If the baby becomes fussy or needs to feed, stop the vehicle, and take the baby out of the seat.	Never leave your baby in the car alone. Start habits that prevent you from ever forgetting your baby in the car, such as putting your cell phone in the back seat.
Sleep Safety	
Always put your baby to sleep on their back in their own crib, not your bed.	Your baby should sleep in your room until at least age 6 months.
Make sure your baby's crib or sleep surface meets the most recent safety guidelines.	Swaddling should be used only with babies younger than 2 months.
Burn Safety	
Prevent scalds or burns. Don't drink hot liquids while holding your baby.	Prevent tap water burns. Set the water heater so the temperature at the faucets at or below 120°F /49°C.

"Reading to a child at night, responding to their smiles with a smile, returning their vocalizations with one of your own, touching them, holding them - all of these further a child's brain development and further potential even in the earliest months." - T. Berry Brazelton

Adapted from Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 4th edition, 2019, American Academy of Pediatrics.

Infant Development

Help-Me-Grow Vermont:

Developmental specialists can answer questions about child development and provide screening tools to complete and share with the child's medical home.
Telephone: Dial 2-1-1 option 6 or text HMGVT to 898211
Website: Developmental Screening | Help Me Grow (helpmegrowvt.org)
https://www.helpmegrowvt.org/developmental-screening

Centers for Disease Control and Prevention: "Learn the Signs. Act Early."

Source of updated developmental milestones from 2 months to 5 years of age as well as answers to common developmental questions, and connections to local supports. You can also download the free Milestone Tracker App.
Website: "Learn the Signs. Act Early." | CDC
https://www.cdc.gov/ncbddd/actearly/index.html

Important Milestones: Your Baby by Two Months

What most babies do by this age:

Social/Emotional Milestones

- Calms down when spoken to or picked up
- Looks at your face
- Seems happy to see you when you walk up to her
- Smiles when you talk to or smile at her

Language/Communication Milestones

- Makes sounds other than crying
- Reacts to loud sounds

Cognitive Milestones (learning, thinking, problem-solving)

- Watches you as you move
- Looks at a toy for several seconds

Movement/Physical Development Milestones

- Holds head up when on tummy
- Moves both arms and both legs
- Opens hands briefly

Remember: You can always contact your baby's primary care provider for any concerns about your baby's health or development!

Helpful Resources

Vermont 2-1-1:

Provides confidential help 24/7 for everyday needs and difficult times. Call specialists provide help solve problems and link individuals and families with local, statewide, regional, and national resources.
Telephone: Dial 2-1-1 (local call anywhere in VT) or Toll Free 866-652-4636
Website: Vermont 211 Homepage — VT 211 https://vermont211.org/

Help-Me-Grow Vermont:

Provides parents and caregivers with tips on positive parenting, resilience, and child development. Answers questions about development and provides screening tools to complete and share with the child's medical home.
Telephone: Dial 2-1-1 option 6 or text HMGVT to 898211
Website: Help Me Grow VT https://www.helpmegrowvt.org/

Vermont Family Network:

Provides support to all Vermont children, youth, and families, especially those with disabilities or special health needs.
Telephone: 802-876-5315
Website: Home - Vermont Family Network https://www.vermontfamilynetwork.org/

WIC:

Provides food benefits, nutrition education, breastfeeding support, counseling and programs for pregnant Vermonters, parents, and caregivers with children under 5.
Telephone: 800-464-4343 toll free or 802-863-7200
Website: WIC | Vermont Department of Health (healthvermont.gov)
https://www.healthvermont.gov/family/wic

Department for Children and Families: Economic Services Division

Connects individuals and families with Vermont based benefits and services including ReachUp, 4 Squares, Fuel assistance, and Child Care Assistance.
Benefits service center: 1-800-479-6151 Childcare helpline: 1-800-649-2642
Website: Benefits & Services | Department for Children and Families (vermont.gov)
https://dcf.vermont.gov/benefits

Housing & Shelter: Vermont 2-1-1

Resources for permanent, temporary, and emergency housing throughout VT.
Telephone: Dial 2-1-1 (local call anywhere in VT) or Toll Free 866-652-4636
Website: Vermont 211 Homepage — VT 211 https://vermont211.org/

Helpful Resources (continued)

Child Welfare Training Partnership:

Provides training and parenting support for Kin, Foster, and Adoptive parents including the Resource Parent Curriculum (RPC) and Trauma Informed Parenting Skills (TIPS) for Tuning In courses.
Website: Kin, Foster & Adoptive Families - Vermont Child Welfare Training Partnership (vermontcwtp.org)
https://vermontcwtp.org/kin-foster-adoptive-families/

Intimate Partner Violence resources:

National Domestic Violence Hotline 800-799-7233
Chittenden County: Steps to End Domestic Violence
Telephone: 802-658-1996
Website: Steps to End Domestic Violence (stepsvt.org) https://www.stepsvt.org/

Prevent Child Abuse Vermont:

PCAVT is the Vermont Chapter of Prevent Child Abuse America and the National Circle of Parents and provides resources, training, and support for parents and caregivers around recognizing and preventing abuse.
Telephone: 1-800-CHILDREN (1-800-244-5373) or dial 2-1-1
Website: Prevent Child Abuse Vermont (pcavt.org) https://www.pcavt.org/

Perinatal Mood and Depression Supports:

The #1 complication of childbirth is depression; it affects more than 1 in 7 new moms. It is treatable. Please reach out for support:

- Contact your obstetric office or primary care provider office
- Call Help-Me-Grow at 2-1-1 extension 6

Postpartum support international provides online support groups
HelpLine: 1.800.944.4773 call or text
Website: Postpartum Support International - PSI https://www.postpartum.net/

If you are in crisis or feeling suicidal:

- Contact the Crisis Text Line (text "VT" to 741741),
- Call the National Suicide Prevention Lifeline at 800-273-8255
- Go to the local Emergency Department

Interwoven Opioid Stories

In February 2022, VCHIP's ICON team hosted a pair of storytelling workshops for individuals with a history of opioid use disorder (OUD) during pregnancy and health care professionals who work with parents or families affected by OUD in Vermont. Every storyteller had one united reason to share their story: supporting you and telling you that you are not alone in this!

Whiskey Oriented Ashlee

‘’ I had my first alcohol drink when I was 17. I smoked my first bowl when I was 18. I was given an OC 80 for my 19th birthday by a friend of mine. That’s how it started. It was a social thing at first and then it wasn’t. I remember the day I realized that I was addicted. I was standing in the galley at work and I was dope sick.

Everything was Readily Available- Heidi

‘’ I was actively using Opiates, Cocaine and alcohol for three years before I got pregnant with my son. I was 30.

Everything was readily available to me. Money was no object at that time and I was in a situation where my fiancé had a really good job. We had beautiful home, nice things beautiful cars. I was very well put together.

Sunny Side Up - Jessica

‘’ My father passed away in my early 20s and that’s when I really leaned into Oxycontin. When that became progressively more difficult to find, I transitioned to using dilated and then very quickly heroine. I was addicted when I got pregnant which was really scary for me. I was so afraid that DCF would get involved. For some reason, I found the strength to not use during the last month of my pregnancy.

The Life I never thought I could have- Lindsay

‘’ I got my wisdom teeth out at 17 and got a prescription for 40 Vicodin and that was it. I was addicted pretty quickly. At one point, I was so out of it that I left my baby with my parents for what I thought was 4 days but was really a month

Read the full stories by visiting our website:

Improving Care for Opioid-exposed Newborns (ICON) | College of Medicine | University of Vermont (uvm.edu)
https://www.med.uvm.edu/vchip/icon/icon_parents_with_lived_experience

Read more from providers with experience caring for families affected by opioid use disorder here:

https://www.med.uvm.edu/vchip/icon/icon_community_provider_experiences

My Notes & Thoughts

For more information about the
Improving Care for Opioid-Exposed Newborns (ICON) project, please visit:

Improving Care for Opioid-exposed Newborns (ICON) | College of Medicine | University of Vermont (uvm.edu)