



Provincial Council for Maternal and Child Health Maternal-Newborn Advisory Committee

Neonatal Abstinence Syndrome Work Group

Terms of Reference

Background / Context

Building a brighter future for children begins by ensuring a good start to life with access to appropriate levels of care for mothers and newborns in Ontario. We require an integrated and coordinated provincial system of maternal and neonatal services capable of delivering timely, equitable, accessible, high quality, evidence-based, family-centred care in an efficient and effective manner.

The Issue

Demand for maternal-newborn services is expected to increase. This growing demand places increasing pressure on the already stressed specialized maternal and newborn care system. Many Level III Obstetrical Units and Neonatal Intensive Care Units (NICUs) are operating at levels that do not allow for accommodation of surges resulting in high risk pregnant women and the most fragile neonates being transferred out-of-region or out-of-country for care.

In June, 2008 the Maternal-Newborn Advisory Committee (M-NAC) was convened by the Provincial Council for Children's Health (now PCMCH) and the MOHLTC to address system issues related to maternal-newborn care in Ontario. M-NAC has initiated several work groups to address a number of system issues that affect access to tertiary services including: Fetal Fibronectin Testing; remote screening for retinopathy of prematurity; infection prevention and control policies for maternal-newborn units; access to maternal-newborn services; and transport services for mothers, newborns and children.

During the deliberations of the Access to Care Work Group, members raised the issue of the growing incidence and challenge in management of newborns with Neonatal Abstinence Syndrome. Neonatal Abstinence Syndrome (Code P961) is a classification for neonatal withdrawal symptoms from maternal use of drugs of addiction.

The CIHI data for neonates with NAS (primary or secondary diagnosis) for six fiscal years shows:

Ontario: Neonatal Abstinence Syndrome

Year	Number of infants with NAS as Most Responsible Dx.	Average length of stay	Beds per day utilized across the province	Top 3 LHINs re: # of Cases
2003- 04	106	12.9	3.7	HNHB - 22 NE - 13 CE - 11
2004-05	124	12.8	4.4	TC - 14 HNHB - 13 SE, Champlain, NSM - 11
2005-06	167	14.2	6.5	HNHB - 27 NW - 23 CE, NE - 17
2006-07	167	15.8	7.2	NW - 29 HNHB - 24 CE - 19
2007-08	229	15.0	9.4	HNHB - 45 NW - 40 CE - 20
2008-09	258	15.3	10.8	NW - 57 HNHB - 40 CE - 24

Year	Number of infants With NAS as a Dx. (not just most responsible)	Average length of stay	Beds per day utilized across the province	Top 3 LHINs re: # of Cases
2003-04	171	11.9	5.6	HNHB - 38 TC - 17 CE, NE - 16
2004-05	199	13.9	7.6	HNHB - 32 TC - 22 CE - 19
2005-06	265	13.0	9.5	HNHB - 47 NW - 33 CE - 27
2006-07	249	15.4	10.5	NW, HNHB - 35 CE - 33
2007-08	358	14.5	14.2	HNHB - 67 NW - 58 SW - 36
2008-09	380	14.6	15.2	NW - 77 HNHB - 57 SW - 38

The length of stay and the management of these infants vary significantly. Some infants are managed exclusively in hospital, some are sent home with parents and some receive care from foster parents.

Work Group Purpose:

To assemble experts in the clinical care and social support of pregnant women, families and infants, where the infant may be at risk of NAS, for the purpose of developing recommendations regarding both harm reduction and the optimal management of NAS.

Objectives:

- To describe the scope and epidemiology of the province's substance-exposed infants in general and those exhibiting Neonatal Abstinence Syndrome specifically
- To track multiple substance use/abuse
- To complete an environmental scan of resources and practices regarding NAS in Ontario
- To identify effective, evidence-based social and medical interventions that support pregnant and postpartum women and their families when the women are using substances that can result in NAS
- To recommend strategies to formalize linkages between methadone clinics, health care providers and child protection agencies
- To recommend strategies to improve education and promote harm reduction that may lead to a decrease in the incidence of Neonatal Abstinence Syndrome
- To review best practices in the clinical management of NAS in both hospital and non-hospital settings
- To recommend clinical guidelines for the management of infants with NAS including the most appropriate site of care
- To identify gaps in resources and enhance strategies to provide equitable care throughout the province.

Membership

The Work Group membership will be multidisciplinary and represent the following areas of expertise:

- Addiction medicine clinicians who work with pregnant women
- Child Protection representative
- Public Health Nurse
- Family physicians providing antenatal, postnatal and newborn care
- Foster parent with expertise in caring for babies with NAS
- Motherisk
- Neonatal Nurse Practitioner
- Neonatologists
- Obstetrician
- Paediatricians
- Social worker who works with pregnant women who use addictive drugs

Reporting Relationship

The NAS Work Group will report to the Maternal-Newborn Advisory Committee.

June 8, 2010

Frequency of Meetings

To be determined

Timeframe

May 2010 to January 2011

Decision-Making Process

Members share accountability for decisions. There should be open and direct communication based on honesty, respect and transparency, to ensure that all perspectives are heard. Decisions should be evidence or most-promising practice-based. Decisions will be made by consensus whenever possible.