Testimony: House Children and Youth Hearing on NAS

September 2016

Good afternoon Chairwoman Watson, Chairman Conklin and members of the Committee. My name is Ashlee Homer and I am a pediatric acute care registered nurse at Penn State Hershey Medical Center. I am also a member of the Pennsylvania State Nurses Association.

Neonatal abstinence syndrome (also called NAS) happens when a baby is exposed to drugs in the womb before birth. NAS is most often caused when a woman takes opioids during her pregnancy. Subsequently, her baby can experience drug withdrawal after birth.

Taking care of NAS babies requires extra resources. Each baby responds to withdrawal in a different way. Nurses must find the balance between meeting the medical and social needs for each baby and their family while determining how best to provide nursing care for each one individually. Some infants do better

with nearly constant movement while holding them. Others do better in a dark, non-stimulating environment. It is heartbreaking to watch these smallest patients cry inconsolably and feed uncoordinated. This can cause growth delays, tremors and sometimes seizures. The child may also experience very limited to no bonding experiences with its parents.

NAS babies often start their care in a neonatal ICU, which can take resources away from other critically sick newborns. When census in a NICU increases, it is the NAS babies that are moved to another unit to continue their treatment. Once moved, these babies are often cared for by a nurse who has three other patients who also require substantial nursing care.

Last winter, our unit had three NAS babies at the same time. Since the census was high in the NICU, these distressed infants were transferred to us. In assigning nurses, the three NAS babies were divided to spread the workload and heartbreak among the on-duty staff nurses. Each patient was unique and at a different point in their treatment plan.

We had extreme ends of the optimal family environment spectrum represented by these babies. On the extremely positive end, one family went to their appointments every day to continue their own addiction treatment and was very

active in the baby's care and treatment. They demonstrated that they had constructive plans for their new family, which included positive extended family involvement. Since this baby left our unit, we received an update that she was doing great and developing well at home with mom and dad.

This story was additionally distressing knowing the mother and father both battled addiction that started with prescribed opioid pain medications for legitimate injuries sustained in military work. An addiction started; when they were unable to obtain more prescription medications they resorted to illegal substances. Both parents started treatment just prior to discovering the mother was pregnant. They continued their therapy and medication treatment throughout the pregnancy. This addiction scenario may have been prevented if opioids had been prescribed more judicially initially.

On the other end of the spectrum, we cared for a baby whose treatment was extended and complicated. He was with us for approximately two months. During this time, we were very concerned at the lack of family involvement. Foster care placement was considered for this child. Even after these patients complete their treatment, some continue to have ongoing neurological problems.

They all require intensive follow-up appointments to ensure adequate childhood growth and development.

Simply being an NAS baby does not mean the family loses custody of the child. As healthcare providers, we try to keep the family together when it is safe to do so. However, the impact on the family is enormous. Most women expect to go home three days after delivering their new baby. Yet, NAS babies can require one to two weeks of intensive treatment prior to discharge. There are often financial concerns related to the increased length of stay and the cost of care. NICU amounts to thousands of dollars a day to the health insurer, family, the state Medicaid program and taxpayers.

Unfortunately, not every baby is born into an ideal family. These are the babies we want to take home with us to provide a stable and safe environment. As nurses, we do our best to facilitate positive family bonding for these very special little ones. Yet, repeatedly caring for these patients and their families causes increased nurse compassion fatigue and moral distress.

It is my hope for the future that we can decrease the incidence of NAS in our smallest of patients and that opioids are more carefully prescribed and monitored by physicians and providers to achieve the best possible patient outcomes. More

judicious prescribing and monitoring of opioid use will benefit not only these infants but those who care for them.

Thank you for the opportunity to share my experience working with NAS babies and their families.

Respectfully submitted,

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