



HHS Public Access

Author manuscript

J Addict Med. Author manuscript; available in PMC 2025 January 01.

Published in final edited form as:

J Addict Med. 2024 ; 18(1): 48–54. doi:10.1097/ADM.0000000000001243.

Priorities for well child care of families affected by parental opioid use disorder

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Abstract

Background and Objectives: Parenting women in treatment for opioid use disorder (OUD) report a lack of family centeredness and anticipatory guidance within well child care (WCC), and WCC utilization is low among affected children. We explore priorities for WCC visit content to inform primary care recommendations for this population.

Methods: Qualitative study of parenting women from one urban, academic OUD treatment program, and pediatric primary care clinicians from a nearby affiliated pediatric practice. Eligible parent participant had a child 2 years old and were English speaking. Semi-structured interviews elicited perspectives on WCC, with questions and prompts related to visit content. Inductive thematic analysis was led by 2 investigators using open coding procedures.

Results: Among 30 parent participants, the majority were white (83%) and unmarried (90%). Approximately 60% reported their child received pharmacotherapy for neonatal opioid withdrawal syndrome (NOWS). Of 13 participating clinicians, 9 were attending pediatricians. Five themes emerged from parental and clinician interviews: 1) improving knowledge and confidence related to child development, behavior, and nutrition, 2) mitigating safety concerns, 3) addressing complex health and subspecialty needs through care coordination, 4) acknowledging parental health and wellbeing in the pediatric encounter, and 5) supporting health education and care related to NOWS. Parents and clinicians expressed difficulty comprehensively addressing such issues due to time constraints, social determinants of health, and significant informational needs.

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Conflict of Interest Disclosures: None

Adherence to preprint policy: We attest that this manuscript is an original contribution not previously published (except as an abstract) and is not be under consideration for publication elsewhere.

Conclusion: Parenting women in treatment for OUD and pediatric clinicians share multiple priorities for anticipatory guidance within WCC visits and barriers to addressing them comprehensively.

Keywords

opioid use disorder; pediatric; neonatal opioid withdrawal syndrome; qualitative; maternal

INTRODUCTION

Opioid use disorder (OUD) during pregnancy is a major U.S. public health issue, with neonatal opioid withdrawal syndrome (NOWS) currently estimated to affect one birth every 15 minutes.^{1,2} Research on hospital care of newborns has focused on screening for prenatal opioid exposure, NOWS treatment, and discharge planning. Many of these studies have demonstrated that consistent, clear, and family-centered information communicated by the newborn care team is important for parent-reported healthcare experiences.^{3,4} After hospital discharge, pediatric primary care also plays a critical role in the continuum of health services for these families.^{5,6}

For parents with OUD and their children, risks to child health and development may include ongoing substance use, poverty, parental trauma, social isolation, and stigmatization. Regularly scheduled preventative visits to the pediatrician – or well child care (WCC) – present an understudied opportunity to improve their healthcare.⁶⁻⁹ The American Academy of Pediatrics (AAP) promotes anticipatory guidance, screenings, and referral to community-based resources during WCC visits, with more recent recommendations for a dyadic approach for families affected by OUD.^{7,8} However, parents with OUD have reported pediatric experiences that lack enhanced anticipatory guidance and key aspects of family centeredness including open communication, personalized care, and respect.^{9,10} Children with prenatal opioid exposure attend fewer WCC visits, despite frequent clinical concerns and higher acute care utilization.¹¹⁻¹³ Given a lack of specific WCC guidelines for these families, research is needed to inform visit content and implementation of WCC for these families that is accessible and effective.

This study evaluated priorities for WCC visit content from the perspective of parenting women in treatment for OUD and pediatric primary care clinicians. Findings will inform a tailored, modular curriculum of WCC that is integrated into OUD treatment to increase the effectiveness and perceived value of pediatric care.

METHODS

This was a qualitative study of parenting women in treatment for OUD and pediatric primary care clinicians. Parents were from an urban, university-affiliated substance use disorder treatment center for pregnant and parenting women that includes a licensed outpatient opioid treatment program and a residential treatment program. This treatment center provides comprehensive services to approximately 250 women annually, including individual and group psychotherapy, pharmacotherapy (e.g., methadone, buprenorphine) for OUD, life skills, and childcare services. Parents at this center were eligible for this study if they

were: 1) receiving OUD treatment, 2) parenting a child 2 years of age, and 3) English speaking. Child legal guardianship was not required for study participation. Clinicians were recruited from a nearby university-affiliated pediatric practice comprised of 14 primary care attendings, 33 resident physicians, and 6 nurses/nurse practitioners, all of whom were all eligible and invited to participate. The practice (approximately 24,000 primary care visits annually) predominately serves Medicaid-insured patients, with WCC visits typically scheduled for 15 minutes.

Procedures and Data Sources

Study procedures and materials were approved by relevant Institutional Review Boards, including a waiver of written informed consent. Parent recruitment was conducted by two study team members (VS, HS) using convenience sampling to identify potential participants. Parents were telephoned by research personnel to determine eligibility and ascertain study interest. A target sample size of 30 parents was planned to achieve thematic saturation based on prior studies.¹⁴ Parental data were collected October 2020 to January 2021 through a brief telephone survey followed by a 30-minute, semi-structured interview conducted by one of two interviewers (VS, MG). Survey items asked participants to report demographics and answer specific questions about their child's healthcare experience. Parents were compensated \$50 for their time. Clinicians were recruited with an email containing a brief study description and study contact information. We set an initial target sample size of 15 clinicians, with plans to collect additional data if thematic saturation was not achieved.¹⁵ Clinician data were collected January to March 2021 through a brief telephone survey followed by 30-minute semi-structured telephone interview conducted by one interviewer (VS). Survey items asked participants to report demographics, OUD training or education, and confidence with working with families impacted by OUD. No monetary compensation was provided. All interviews were audio recorded and transcribed verbatim by Rev, a web-based, HIPAA compliant speech to text transcription service (<https://www.rev.com>; Austin, TX). Identifying information was removed.

Interview guides with open-ended questions were developed using the Consolidated Framework for Advancing Implementation Research (CFIR) Guidelines.¹⁶ CFIR contains domains to guide the assessment of potential barriers and facilitators to implementation of an intervention (in this context, a tailored, modular curriculum of WCC integrated into OUD treatment). Table 1 depicts some of the interview prompts that were used and their mapping to CFIR domains. Although the full interview guide (available upon request) explored multiple logistical considerations, including the perceived acceptability of a group WCC visit format, we have reported results of identified barriers and facilitators elsewhere. Here we focus on participant responses to the questions about clinical content of pediatric visits, to inform WCC curriculum planning for the intervention. Of note, although the term NOWS is preferred by some researchers and clinicians, we used the less-specific term Neonatal Abstinence Syndrome (NAS) during the interviews and for data collection purposes as this was more familiar to participants in our sample.¹⁷ Also, because our study focused on pregnant and parenting women in treatment for OUD and their relationship as a mother to their child, the terms 'mother' and 'maternal' were used during the interviews, and for consistency will be used for the remainder of this report.¹⁸

Data Analyses

Descriptive statistics were used for survey data. For interview data, thematic analyses were conducted using an inductive approach, relying on the participant's subjectively reported experiences and perceptions.¹⁹ Transcript coding and analysis was led by 2 qualitative researchers [ES, MG] using Dedoose V 8.0.35 and open coding procedures. Four maternal interview transcripts and four clinician interview transcripts were coded independently to establish acceptable inter-coder reliability (pooled Cohen's Kappa coefficient $K=.87$ and $K=.85$, respectively), after which remaining transcripts were divided among the two primary coders.

Transcript excerpts coded as "Priorities for WCC Content" were organized into emergent key themes and are reported here. Thematic saturation was determined when no new themes were identified.^{19,20} Findings were presented to two maternal participants and two clinician participants to validate thematic analyses. Debrief sessions were also held with the entire research team to present findings and further validate or challenge data interpretations. Results are reported in accordance with Consolidated Criteria for Reporting Qualitative Research Guidelines.²¹

RESULTS

Participant Characteristics

Although 31 mothers were interviewed, one participant transcript was excluded from analyses as their responses did not pertain to WCC. Of the 30 mothers whose responses were included for analysis, the majority self-reported as white (83%), non-Hispanic (90%), and unmarried (90%, Table 2). Most reported wanting more time with their child's physician (57%) and more information from their pediatrician on child development and behavior (73%), NAS (67%), and parental stress, physical or mental health (57%).

Of the 53 clinicians invited to participate, 13 enrolled and provided interviews that were included in thematic analysis. Most self-reported as female (92%), white (92%), and non-Hispanic (92%; Table 2). Approximately half (54%) reported feeling very confident working with families affected by substance use.

Qualitative Themes

Five themes emerged from the qualitative data from both participant groups, and are outlined below and in Table 3. Thematic saturation was achieved by the 21st interview for mothers, similar to other studies focused on parental perceptions of pediatric healthcare.^{22,23} Clinician interviews revealed consistent priorities for WCC content, resulting in saturation for the five broad themes after only two interviews. However, as described below, clinicians did express some nuanced differences in how content areas should be addressed and the specific challenges in doing so. The maternal and clinician participants who reviewed findings confirmed that these were generally consistent with their experiences. Representative quotes for each theme are included in Table 3.

Improving Knowledge and Confidence Related to Child Development, Behavior, and Nutrition.—Mothers and clinicians identified developmental, behavioral, and nutritional anticipatory guidance as priorities for WCC. This included education about growth, developmental milestones, pediatric immunizations, developmentally appropriate behaviors, behavior management, sleep, teething, and toilet training. Many clinicians perceived that mothers with OUD tend to have more knowledge gaps and lower parenting self-efficacy and often have unrealistic expectations about child development or concerns about behaviors that the clinicians believe to be normal. As one clinician stated, “I find that they’re second guessing their decisions.” Clinicians reported spending substantially more time educating mothers with OUD on what they considered to be basic parenting skills, responding to questions, and providing validation and reassurance. While clinicians tended to perceive this as important and necessary, they expressed that it did not seem possible to meet maternal information needs while also addressing standard WCC content and adhering to clinic visit time constraints. Consistent with this, many mothers reported needing more information about development and behavior. They described that clinic visits felt rushed, that there was not enough time to adequately discuss their questions about development and behavior, and that their concerns were sometimes dismissed.

Participants noted the importance of discussing feeding and nutrition. However, several mothers reported feeling that the information they received from their child’s pediatrician was insufficient, expressing a need for more detailed or tailored education on a variety of topics including breastfeeding challenges, feeding and nutrition for non-breastfed babies, weaning from nighttime feedings, and stages of feeding development with healthy food options for each stage. Clinicians expressed specific challenges in providing anticipatory guidance about these topics, perceiving that mothers with OUD tend to have substantial knowledge gaps regarding feeding and nutrition, and to require additional time during visits to review nutrition guidance, developmentally normal feeding behaviors, and/or common feeding challenges associated with NAS. Several clinicians also discussed the need to assist mothers with problem solving, as recommendations regarding feeding and nutrition may be difficult to carry out within the family’s living environment or social context (e.g., restrictions within a communal living setting, limited access to healthy foods due to poverty).

Mitigating Child Safety Concerns.—Safety education was emphasized as an important priority for WCC content, but mostly by clinician participants in the sample. Multiple clinicians noted spending more time discussing child safety with mothers with OUD due to perceived knowledge gaps and challenges inherent in their living environments, including communal living (e.g., limited space, infection risk). Many clinicians and a couple of mothers noted the importance of education regarding safe infant sleep practices and the need to tailor these discussions to the family’s specific needs and circumstances. Clinicians also discussed the importance of asking about safety outside of the home (e.g., neighborhood, school).

Addressing Complex Health and Subspecialty Needs Through Care Coordination.—Both mothers and clinicians described individualized education about

special healthcare needs (e.g., congenital disorders, preterm birth) as being a priority for WCC visit content for this population. Mothers of children with special healthcare needs generally described the education and support they received as helpful. They noted that their clinicians took time to clearly explain the condition and answer questions, provide education on caring for the condition, and facilitate referrals to specialists (including Early Intervention). However, some clinicians noted that dedicating visit time to a special healthcare need resulted in less time for more general anticipatory guidance. Several clinicians also mentioned the need to follow up on referrals and provide additional support to ensure specialist appointments are made, as they perceived that mothers with OUD often have challenges navigating the healthcare system and attending multiple appointments. As one clinician expressed, “mothers that are in a daily methadone maintenance program already have to manage their own medical care, and then we do require pretty frequent follow-up for these kids.”

Acknowledging Maternal Health and Wellbeing.—Clinicians tended to view maternal and family wellbeing, including maternal OUD recovery, history of trauma, emotional functioning, and family resources, as topics of priority. One clinician expressed a perception of their role as “not just taking care of kids, but these moms and these families.” However, there was variability in how maternal recovery and wellness were addressed within the clinic visit. Some clinicians noted that they consistently ask about maternal recovery and wellness, discuss coping strategies, and educate mothers on how these factors can affect parenting and child outcomes. Others noted that they tend not to initiate these discussions as they feel awkward or worry about causing offense. There was also variability in how mothers perceived questions about their recovery. Some reported feeling safe to share this information and noted that it was important for their child’s pediatrician to know, whereas others described concern about being judged. Both mothers and clinicians discussed the importance of connecting families with resources and the benefits of having social workers integrated into the primary care practice to help address challenges resulting from poverty and lack of physical resources.

Supporting Health Education and Care Related to Neonatal Abstinence Syndrome.—Participants described heightened maternal anxiety about mild residual signs of NAS after discharge home and noted that education about NAS is an important priority for early WCC visit content. As one mother stated, “...there was a lot of questions that I asked about how [my child] is going to be, how it affects him, because I had no clue.” Clinicians noted that even when mothers receive education about NAS prior to the birth of their child, they often require ongoing education and reassurance in the primary care setting. Mothers generally described information they received from their child’s pediatrician about NAS and long-term implications as helpful.

DISCUSSION

For mothers in treatment for OUD and their children, WCC visits is part of the multidisciplinary spectrum of services and supports that may optimize family outcomes. Child development, behavior, parenting practices, and nutrition are priorities for anticipatory guidance during WCC visits, as they are for all families. However, stigmatization of mothers

with OUD and other barriers to care may carry unique implications for both pediatric clinician and maternal informational needs when addressing these topics. Our findings suggest that attending to WCC priorities for this population requires more visit time than typically allocated, resources to address social determinants of health, and clinician understanding about OUD.

Prioritized clinical topics included routine issues affecting all young children (i.e. toddler behaviors) as well as navigating specialized pediatric healthcare needs. Child development, behavior, parenting practices, and nutrition are all profoundly shaped by psychosocial and environmental conditions, with poverty increasing the risk for childhood chronic illness and poor health outcomes.²⁴ For children of mothers with OUD, the impact of poverty cannot easily be disentangled from the impact of prenatal opioid exposure, and methodologically the issue of psychosocial and environmental confounding is a near-constant threat to any research on outcomes for this population.^{25,26} Recent studies support the notion that conditions associated with poverty – i.e. housing instability, transportation difficulty, social isolation, educational attainment, caregiver stress – are key drivers of health and healthcare disparities for children affected by maternal OUD.^{12,27}

However, the stigma and bias surrounding maternal OUD are specific to this patient population and likely permeate their experiences of healthcare including pediatric visits.⁶ Even after adjusting for poverty, children with prenatal opioid exposure are less likely to receive recommended WCC.^{12,13} Previous exploration of barriers to WCC for mothers in treatment for OUD has revealed stigmatizing experiences in the pediatric office, insufficient time during the encounter, and a perceived lack of relevant anticipatory guidance.^{9,10} In our interviews, clinicians emphasized maternal knowledge gaps and low confidence as important aspects of WCC for this population, which may itself reflect clinician bias. Mothers also reported wanting more time and information during WCC visits, which suggests knowledge gaps but also may reflect the impact of experienced stigma on their confidence. Overall, building maternal confidence seems to be particularly important goal when caring for this population that could be shared across multidisciplinary teams.

Furthermore, discussions about NOWS/NAS and maternal OUD recovery are unique to this population. Although NAS/NOWS is typically diagnosed and managed during the birth hospitalization, our results indicate that ongoing education and reassurance about NAS/NOWS with families is also important in the primary care setting. This information may be particularly helpful for mothers who perceived a lack of counselling prenatally or during the birth hospitalization, or whose infants are experiencing potential signs of residual NAS/NOWS after discharge (e.g., fussiness or feeding difficulty).^{28–31} Maternal OUD recovery was raised as a potentially salient topic, but clinicians and mothers expressed varying comfort discussing this during WCC visits. This is consistent with other studies suggesting that mothers with OUD are often worried about being judged or blamed, and that pediatricians often lack knowledge about or connection to OUD treatment programs.^{27,32} Currently there are no training requirements for pediatric clinicians to learn about treatment of substance use disorders in adults and how this may impact pediatric patients, although the American Academy of Pediatrics has begun collating some online informational resources.⁷

Lastly, mitigating child safety concerns was emphasized as a priority by clinicians, but less so by mothers. Clinician discussions focused on sleep safety and general living environment. The topic of child protective services was not specifically prompted in our interviews, nor was it raised by any mothers or clinicians in the study. As mandated reporters, pediatric clinicians are responsible for contacting child protective services whenever they have concerns about physically or emotionally harmful parent behaviors, while also balancing the need for parental trust and a therapeutic relationship. OUD treatment providers can support pediatric clinicians in developing a transparent, thoughtful, and consistent approach to child protective services involvement that centers child and maternal wellness and complies with local and state jurisdictions. Future research may evaluate the preferences of mothers and pediatric clinicians for discussing this topic in primary care.

Key strengths of this study are the inclusion of parents and clinicians, the use of a standardized interview guide, validity testing with study participants, and our multidisciplinary research team. However, the clinician perspectives represent a single urban clinic and were relatively homogenous in terms of views expressed. Their perspectives may differ substantially from clinicians practicing in rural or community-based settings. Over half of maternal participants reported their infants received pharmacologic treatment for NAS. This suggests a local practice pattern for birth hospitalization that emphasizes NICU admission and traditional NAS/NOWS scoring, which may also limit generalizability of our findings to other settings (e.g., hospitals that use Eat, Sleep, Console). Although mothers were mostly non-Hispanic white, our sample's racial distribution is consistent with other research cohorts of mothers in treatment for OUD.^{11,30} Selection bias and social desirability (of both maternal and clinician responses) are also potential limitations. These data represent opinions only and are not based on direct measurement or observation of WCC visits. Lastly, other family caregivers were not included and may have different perspectives.

Study findings are being used to develop a structured, modular WCC visit curriculum for mothers in treatment for OUD and their children that incorporates these priorities to support more robust and standardized anticipatory guidance. Furthermore, we will be co-locating WCC visits at the site of maternal OUD treatment, and utilizing a group WCC visit format to afford longer visit times and in-depth discussion.^{33,34} Our preliminary data, reported elsewhere, suggests that group WCC is an acceptable visit format to mothers with OUD for information sharing and peer learning.³⁵ Regardless of setting or format of the WCC visit, our findings indicate the need for strengthened partnership between pediatric clinics and OUD treatment providers to bolster clinician knowledge and comfort, and to reduce bias. More time during the WCC encounter also seems to be necessary. Building on our results and previously published guidance from national organizations,³⁶ we propose that to reduce stigma and improve quality of WCC for families affected by maternal OUD, pediatric clinicians should:

1. Demonstrate familiarity with important child medical history – including type and duration of prenatal substance exposures, course of the birth hospitalization, and subspecialty care needs – to strengthen communication and interpersonal dynamics with the family.

2. Provide comprehensive, child-specific anticipatory guidance that includes evidence-based information about child development after prenatal substance exposure, as well as routine health information important for all children.
3. Acknowledge, and reinforce throughout the WCC visit, their understanding of the parent as an expert on their child.
4. Identify social determinants of health (e.g. housing, food insecurity) and connect families to resources and supportive services.
5. Assess parental desire to disclose their OUD treatment status, and if they choose to disclose, clinicians should emphasize respect and knowledge about OUD as a medical condition and the impact of stigma surrounding OUD.

CONCLUSION

Study findings support WCC visits as an important aspect of the healthcare continuum for mothers in treatment for OUD, and underscore the potential role for pediatric clinicians as partners with OUD treatment providers to support the entire family. Much of the clinical content emphasized by our study participants is relevant for all pediatric populations. However, maternal OUD presents specific considerations for addressing these topics that may be well suited for testing in a more integrated model of WCC.

ACKNOWLEDGMENTS

The authors acknowledge Aditi Kale and Elizabeth Franko for their contributions to data analysis, and Hannah Steiger for her contribution to participant recruitment and enrollment. This study was supported by the Agency for Healthcare Research and Quality (AHRQ), 1R18HS027399-01. The funding agency was not involved in the study design; in the collection, analysis and interpretation of data; in the writing of the report; and in the decision to submit the article for publication.

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Table 1.

Self-reported characteristics of study participants (N=30)

Parents in Treatment for OUD (N=30)		33	(23–44)
Age in years, mean (range)			
Race, n (%)			
White		25	(83)
Black or African American		3	(10)
American Indian		1	(3)
Other (not specified)		2	(7)
Ethnicity, n (%)			
Hispanic		3	(10)
Non-Hispanic		27	(90)
Marital Status, n (%)			
Married		3	(10)
Not married, but in committed relationship		13	(43)
Divorced/Separated		4	(13)
Single, not in a relationship		8	(27)
Widowed		2	(7)
Highest level of education, n (%)			
8 th grade or less		1	(3)
Some high school, did not graduate		7	(23)
High school graduate or GED		7	(23)
Some college or 2-year degree		14	(47)
4-year college graduate		1	(3)
Infant received pharmacotherapy for NAS, n (%)		19	(63)
Pediatric Clinicians (N=13)			
Age in years, mean (range)		42	(26–62)
Gender, n (%)			
Female		12	(92)
Male		1	(8)
Race, n (%)			

White	12	(92)
Black or African American	1	(8)
Ethnicity, n (%)		
Hispanic	1	(8)
Not Hispanic	12	(92)
Role in primary care office, n (%)		
Resident/trainee	3	(23)
Attending physician	9	(69)
Nurse	1	(8)
Hours worked per week, n (%)		
31–40 h	4	(31)
41–50 h	6	(46)
51–60 h	2	(15)
61–70 h	1	(8)
Experience working with mothers in treatment for OUD, n (%)	13	(100)
Confidence working with families affected by substance use, n (%)		
Not at all confident	0	(0)
Not very confident	2	(15)
Somewhat confident	4	(31)
Very confident	7	(54)
Previous education or training in substance use, n (%)	12	(92)

Table 2. Interview prompts and corresponding domains of the Consolidated Framework for Advancing Implementation Research (CFIR)

Parental Interview Prompt	CFIR Domain	Clinician Interview Prompt
At your child's appointments, was there ever something you talked about with the doctor that was helpful or useful? (Clarification: What have you learned the most about?)	Intervention	As a primary care provider, what are your most common concerns for infants and young children whose mothers are in treatment for opioid use disorder (OUD)?
What do you wish you could have discussed more with your child's doctor?		What do you believe are the core (necessary) components of well child care for children whose mothers are in treatment for OUD?
What kind of information would be helpful to discuss in a group with a pediatrician and other moms?	Individuals involved	Do these components differ from well child care for the general population of children that you care for? If so, how?
Was there anyone else at your provider's office that provided you with useful information, such as a nurse?		What has your training and experience been in working with families affected by OUD?
Are you interested in meeting other moms with a child of the same age?		How interested would you personally be in conducting group well child care visits?
If you were given the option of group pediatric care at Family Center, what would make you more likely to participate?		How would you describe the current relationship between your pediatric office and the [university- affiliated OUD treatment] program?
How would you feel about group pediatric care counting towards participation in your treatment program?	Inner setting	What resources would be needed for your practice to successfully provide group well child care?

Table 3.

Qualitative themes and example responses

Themes	Representative Quotes
<p><i>Improving knowledge and confidence related to child development, behavior, and nutrition</i></p>	<ul style="list-style-type: none"> • “[More information on] how to handle my son’s anger and how to effectively discipline him. I wanted to talk to his doctor about it... but I’m going to have to find out on my own. [M120]” • I always wish that they would talk more about feeding, the different stages basically. In the beginning they don’t tell you anything...As a new parent, sometimes you’re just like, “What do I do?” And you just keep giving them baby food. But by my third kid I’m like, “Oh yeah, I can make some scrambled eggs, I can dice up fruit.” Stuff that you don’t maybe think about or know about. I feel like health obviously is important, eating right, eating healthy, and it would be helpful if we can be taught. [M121] • “The other thing I’ve noticed is that many moms have very low confidence in their ability to parent. I find that they’re second guessing their decisions. They’re second guessing a child’s, what they perceive as normal or not normal. So we typically see babies more often in the office for things that are either normal or minor that the mothers are having some difficulty coping with...I think this comes from either not great role models in parenting or lack of role models for parenting. As we know, it takes a village to raise a child. [C3] • It’s the knowledge gaps, topics that I might take for granted in a family with a different kind of background, that I have to devote time to. I had a visit a couple days ago that I basically walked through sample meal plans for every meal of the day with a mom...whereas normally I would talk about what kinds of foods are okay, what kinds of foods are not okay. It took at least three times as long. [C11]
<p><i>Mitigating child safety concerns</i></p>	<ul style="list-style-type: none"> • I have a bad issue with them sleeping with me. I’m trying to get them into their own beds... I’d like to find out ways for her to not drink so many bottles in the middle of the night...so I can get her in her own bed. [M154] • Safety’s a really big one. I think it’s knowledge gaps, spending more time on the walker. Sometimes there are some challenges related to the living circumstance with some of our families that may be living in one of these group, mommy and me homes, where there may be like limited space. Sometimes talking about safe sleep and safe behavior winds up needing to be tailored specifically, to their needs. [C11]
<p><i>Addressing complex health and subspecialty needs through care coordination</i></p>	<ul style="list-style-type: none"> • My daughter has cleft palate and cleft lip, so they’re really careful with her. They’re really excellent, actually. They take their time to explain the situation to me. They don’t look at me like I’m dumb. Like, Oh, you don’t understand this? They don’t get frustrated. They break it down to me...Everything that they talked to me about, it’s really useful because I don’t know nothing about cleft lips. They taught me how to feed her. They took the time and taught me how to position her, stuff like that. [M117] • Helping to make sure that they are comfortable taking care of the baby, if the baby has any additional needs like has had slow weight gain or issues with their development... If the baby was in the NICU for a while and moms are concerned about their overall development and how they’re progressing. We certainly talk about that at every visit, but those babies, they need early intervention. Those babies need NICU follow up. Making sure that parents understand all of that and then all of that stuff is in progress. [C9] • I think navigating the healthcare system can be a challenge for anyone, but in particular, when you’re dealing with a population where the mom might have multiple healthcare needs and the baby might have multiple healthcare needs, trying to navigate the system for both individuals, I think can be hard. [C1]
<p><i>Acknowledging maternal health and wellbeing</i></p>	<ul style="list-style-type: none"> • I was just in for her 12 month shots last week or two weeks ago, and because I’m living [in a shelter], when she asked where I’m living, if I’m still living with the father, I definitely told her I was in a shelter and she didn’t seem to judge me. She actually asked if I needed any help with food or shelter, anything. [M125] • A pediatrician’s goal is to take care of the entire family. I think that some general pediatricians are equipped to, especially in infancy, talk about maternal health, postpartum depression, breastfeeding. General pediatricians, especially in this population, need to be equipped with taking care of moms that may have this type of addiction...not just taking care of kids, but these moms and these families. [C15] • I don’t always know how to navigate the conversation [about recovery]... I feel like I don’t always address it head on with the family because I find it’s an awkward conversation to have and I don’t want to offend anyone by bringing it up. So I think it’s just an uncomfortable topic to talk about. [C5]

Themes	Representative Quotes
<p><i>Supporting health education and care related to Neonatal Abstinence Syndrome</i></p>	<ul style="list-style-type: none"> • Going through the NAS stuff, then I was really nervous and scared and I didn't know how to take care of her. So they really helped me with that. Like with being a better mom. [M142] • Most [visits] focus on him with his NAS, because this is the first time I had a child born with opiates, so I didn't know much about it at all. So there was a lot of questions that I asked [PCP] about how [my child] is going to be, how it affects him, because I had no clue. [M168] • There are persistent symptoms that babies will have that makes their mothers very nervous. It usually is centering around excessive crying, or excessive gas, or feeding issues. And, this is probably due to their opiate exposure and not to any other organic issue...moms get really focused on those sorts of symptoms...it goes back to their lack of confidence in their abilities to interpret what's going on with their babies. [C3] • And coping with lingering symptoms of withdrawal after babies go home, say from the nursery, if they're still crying a lot or difficult to console family's abilities to manage or handle that. [C2]

Note. M = Mother, C = Clinician.