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Brief Report

Socioeconomic and Clinical Outcomes Following Eat Sleep Console Implementation in Appalachia

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Highlights

What are the main findings?

- ESC implementation was associated with shorter hospitalization and less pharmacological treatment after adjustment for measured differences between epochs.
- Unadjusted differences in foster care discharge and parental involvement did not persist after adjustment.

What are the implications of the main findings?

- ESC may support the care of opioid-exposed newborns in an Appalachian setting.
- Classification-derived resource intensity was lower in the ESC epoch; direct hospital costs were not measured.

Abstract

Background/Objectives: Infants exposed to opioids in utero are at risk of neonatal opioid withdrawal syndrome (NOWS). We compared clinical, family-related, and classification-derived resource outcomes before and after implementation of Eat, Sleep, Console (ESC) in an Appalachian hospital. Methods: This single-center retrospective cohort study compared outcomes of opioid-exposed neonates assessed with Finnegan Scoring system (FNASS) (Epoch 1, $N = 252$) versus the Eat, Sleep, Console (ESC) method (Epoch 2, $N = 100$). Multivariable logistic regression and gamma generalized linear models with log links evaluated outcomes after adjustment for gestational age and maternal tobacco, fentanyl, and methamphetamine exposure. Results: ESC was associated with lower adjusted odds of NOWS classification (adjusted odds ratio (aOR) 0.32, 95% Confidence Interval (CI) 0.19–0.54), rescue morphine (aOR 0.36, 95% CI 0.17–0.75), and morphine taper (aOR 0.32, 95% CI 0.12–0.85). Adjusted mean length of stay was lower (ratio 0.66, 95% CI 0.54–0.79). Adjusted associations with foster care discharge (aOR 0.97, 95% CI 0.49–1.93) and parental involvement (aOR 1.24, 95% CI 0.66–2.32) were not statistically significant. Conclusions: ESC implementation was associated with shorter hospitalization and less pharmacological treatment after adjustment for measured differences between epochs. Unadjusted differences in foster care discharge and parental involvement did not persist after adjustment. The observational, sequential-epoch design precludes causal attribution.

Keywords: Eat Sleep Console (ESC); Finnegan Scoring System (FNASS); research Case Mix Index (r-CMI); Neonatal Opioid Withdrawal Syndrome (NOWS)

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1. Introduction

Infants exposed to opioids in utero are at risk of neonatal opioid withdrawal syndrome (NOWS), a multisystemic clinical syndrome that has been diagnosed at an increasing rate in parallel with rates of opioid use disorder (OUD) among the general population [1]. Historically, NOWS has been diagnosed and managed with clinical suspicion of opioid exposure, confirmatory screening, and assessment with the Finnegan Neonatal Abstinence Scoring System (FNASS) or the Eat, Sleep, Console (ESC) method to determine the need for pharmacological intervention. In recent years, ESC has been shown to decrease length of stay (LOS), pharmacological treatment, and healthcare costs in infants with NOWS [2]. At institutions with universal urine drug screening for pregnant patients admitted to labor and delivery, opioid exposure may be known in infants without clinical signs of NOWS. In these settings, FNASS and ESC may be used to determine the presence of NOWS, although little has been formally written characterizing their use as diagnostic tools.

Universal screening for substance exposure, universal scoring of exposed neonates, and high rates of opioid exposure at our medical center made it possible to compare FNASS and ESC for diagnosis. This study sought to evaluate differences in cohorts of opioid-exposed neonates assessed with FNASS or ESC methods, with rate of NOWS diagnosis as the primary outcome of interest. Secondary outcomes included length of hospital stay (LOS), initiation of pharmacotherapy, discharge to foster care, parental involvement, and resource intensiveness measured as Research-Case Mix Index (r-CMI) [3,4].

2. Methods

This was a single-center, retrospective observational cohort study with a before-and-after comparison of two sequential care epochs. The study was approved by the institutional review board and used chart review of neonates with in utero opioid exposure born at a freestanding women's and children's hospital in Appalachia. Infants in Epoch 1 (n = 252; January 2022–March 2024) were assessed using the Finnegan Neonatal Abstinence Scoring System (FNASS). Infants in Epoch 2 (n = 100; March 2024–April 2025) were managed using ESC. Opioid exposure was identified through universal screening or maternal disclosure. Infant characteristics, substance exposures, comorbidities, and maternal characteristics were collected from the medical record.

All infants that had opioid exposure were included for each epoch using the International Classification of disease codes; ICD-10 = P04.14 (newborn exposed to maternal opiate) and ICD-10 = 96.1 (neonatal abstinence syndrome) for our chart searches. The EPIC™ electronic medical record system (EPIC Systems, Verona, WI, USA) has a robust database, and our data capture is accurate, so we are certain that we were able to include all newborns meeting these criteria. Each chart was reviewed for opioid and other substance or medication exposure and for NOWS classification. Classification for NOWS was based on two sequential FNASS scores of 8 in Epoch 1 or documentation by bedside nurses of difficulty with one or more ESC domains in Epoch 2. Medication use was also reviewed. The clinical protocol employed in our mother-baby unit and the NICU permitted a single rescue dose of oral morphine (0.05 mg/kg) followed by an oral morphine taper if necessary. The taper begins at 0.05 mg/kg every 3 h, with stabilization for 72 h followed by reductions in dose and dosing frequency over 7–10 days. When morphine alone does not adequately control withdrawal symptoms, clonidine is added at 1–2 micrograms/kg every 6 h, maintained until morphine is discontinued, and then weaned over 3–4 days.

The EPIC™ electronic medical record system can also be linked to maternal charts in order to collect maternal data.

Parental involvement was assessed by reviewing daily nursing, social work, and physician documentation for parental presence during rounds, participation in care, and involvement in feeding, as well as documentation of parental absence or telephone communication.

A research case mix index (r-CMI) framework has previously been described [3–5]. For this study, research diagnosis-related group (r-DRG) weights were assigned for opioid exposure without NOWS (r-DRG 794; weight 1.5) or NOWS (r-DRG 793; weight 4.2) by a single investigator (M.J.P.). The r-CMI was calculated as the average assigned weight within each cohort. The source MS-DRG weights and study-specific r-DRG weights are presented in the figure in the Results. These research weights should be distinguished from the source MS-DRG weights; in particular, the values 4.2 for r-DRG 793 and 1.5 for r-DRG 794 are rounded values of the corresponding MS-DRG weights.

Continuous and categorical characteristics were summarized using descriptive statistics and compared across epochs using appropriate parametric, nonparametric, or categorical tests. To address confounding by differences in patient characteristics between epochs, multivariable logistic regression models were fitted for binary outcomes, with the Finnegan epoch as reference. Models were adjusted for gestational age and maternal tobacco, fentanyl, and methamphetamine exposure. Length of stay and r-CMI were evaluated using gamma generalized linear models with log links and robust standard errors. Effect estimates are reported as adjusted odds ratios (aORs) or adjusted mean ratios with 95% confidence intervals and two-sided p-values [6]. Complete-case analyses were performed, with the analytic sample determined by availability of the outcome and included covariates. The r-CMI is a classification-derived resource intensity measure, not a direct cost estimate.

Sample Size and Statistical Precision

No a priori sample-size or power calculation was performed. We used the Statistical Package for the Social Sciences (SPSS V32.0, Armonk, NY, USA) to complete the analyses for this study. The sample size was determined by all eligible records available during the predefined study periods, yielding 352 infants: 252 in the FNASS epoch and 100 in the ESC epoch. Consistent with STROBE guidance, we assessed the precision of the findings using effect estimates and 95% confidence intervals rather than calculating observed post hoc power. The unequal cohort sizes and small numbers of some outcomes limit precision, particularly for secondary outcomes and adjusted models. Nonsignificant findings should not be interpreted as evidence of equivalence or absence of a clinically meaningful association.

3. Results

Infant and maternal characteristics are summarized in the Table 1. In the unadjusted comparison, NOWS classification was less frequent in the ESC epoch than in the FNASS epoch (29.0% vs. 61.0%; $p = 0.001$). Foster care discharge was also less frequent (19.2% vs. 32.7%; $p = 0.01$), and parental involvement was more frequent (80.0% vs. 65.0%; $p = 0.01$). After adjustment for gestational age and maternal tobacco, fentanyl, and methamphetamine exposure, ESC was associated with lower odds of NOWS classification (aOR 0.32, 95% CI 0.19–0.54; $p < 0.001$), rescue morphine (aOR 0.36, 95% CI 0.17–0.75; $p = 0.006$), and morphine taper (aOR 0.32, 95% CI 0.12–0.85; $p = 0.022$). Adjusted mean length of stay was lower (ratio 0.66, 95% CI 0.54–0.79; $p < 0.001$). Adjusted associations with foster care discharge (aOR 0.97, 95% CI 0.49–1.93; $p = 0.936$) and parental involvement (aOR 1.24, 95% CI 0.66–2.32; $p = 0.509$) were not statistically significant (Figure 1).

Table 1. Infant and maternal characteristics by assessment epoch.

Characteristic	FNASS ($n = 252$)	ESC ($n = 100$)	p-Value
Infant data			
Case Mix Index	3.2 ± 1.3	2.3 ± 1.2	0.001
Gestation (weeks)	37 ± 3	38 ± 2	0.01
Male	46.0%	44.0%	NS
Twin	2%	7.0%	0.05
C-Section	40.5%	37.0%	NS
Instrumented vaginal deliveries	4.8%	6.0%	NS
Apgar 1 min	8 ± 2	8 ± 1	NS
Apgar 5 min	9 ± 1	9 ± 1	NS
Length of Stay (days)	11 ± 13	6 ± 4	0.001
Monitored Bed	57.0%	26.0%	0.05
Z score for weight	−0.49 ± 0.98	−0.38 ± 0.86	NS
Large for gestational age (LGA)	2.8%	6.0%	0.05
Small for gestational age (SGA)	21.8%	16.0%	NS
Microcephaly (<3% for gestational age)	9.9%	6.1%	NS
Neonatal opiate Withdrawal Syndrome (NOWS)	61.0%	29.0%	0.001
One-time dosing morphine	29.0%	9.1%	0.001
Morphine taper	17.0%	5.0%	0.001
Clonidine taper	4.8%	1.0%	NS
Breast milk	29.1%	37.4%	NS
Formula	91.2%	87.0%	NS
Hydrolyzed formula	38.6%	28.3%	NS
Foster Care	32.7%	19.2%	0.01
Parental involvement	65.0%	80.0%	0.01
Maternal data			
Maternal age (yrs)	31 ± 5	28 ± 5	
Maternal Drug treatment program	71.7%	81.4%	NS
Maternal Tobacco	65.3%	50.0%	0.01
Maternal Marijuana	24.6%	15.5%	NS
Maternal Methadone	13.7%	11.3%	NS
Maternal Buprenorphine	46.4%	41.2%	NS
Maternal Buprenorphine-Naloxone	31.9%	38.1%	NS
Maternal Heroin	9.7%	6.2%	NS
Maternal Fentanyl	21.0%	6.2%	0.001
Maternal OxyContin/Oxycodone	4.0%	4.1%	NS
Maternal Benzodiazepine	3.6%	3.2%	NS
Maternal Methamphetamine	24.2%	11.3%	0.02
Maternal Cocaine	12.1%	8.2%	NS
Maternal Gabapentin	9.3%	8.2%	NS
Maternal Inhalants	8%	5.2%	0.01
Maternal Selective Serotonin Reuptake Inhibitor (SSRI)	20.6%	23.7%	NS
Maternal Alcohol	1.2%	1.0%	NS

NS, not statistically significant.

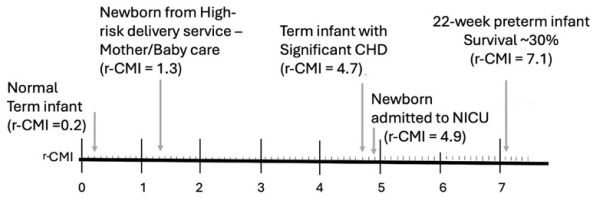
One-time morphine dosing was reported in 9.1% of the ESC cohort and 29.0% of the FNASS cohort ($p = 0.001$). Morphine taper use was 5.0% and 17.0%, respectively ($p = 0.001$). Reported length-of-stay summaries were 6 ± 4 days for ESC and 11 ± 13 days for FNASS ($p = 0.001$). Maternal tobacco exposure (50.0% vs. 65.3%; $p = 0.01$), fentanyl exposure (6.2% vs. 21.0%; $p = 0.001$), and methamphetamine exposure (11.3% vs. 24.2%; $p = 0.02$) were less frequent in the ESC epoch. Maternal enrollment in an opioid use disorder treatment program did not differ significantly between epochs.

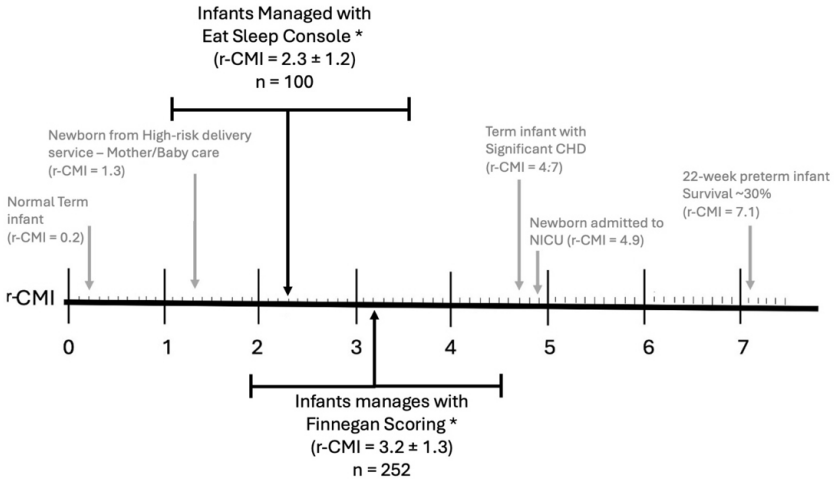
MS-DRG	Description	MS-DRG weight	r-DRG weight
795	Normal Newborn	0.2024	0.2
794	**Newborn with Significant Problems**	**1.4946**	**1.5**
793	**Newborn with Major Problems**	**4.2225**	**4.2**
792	Preterm Newborn without Major Problems	2.4804	2.5
791	Preterm Newborn with Major Problems	4.1107	4.1
790	Preterm Newborn less than 26 weeks or Newborn with Respiratory Distress Syndrome (surfactant deficiency)	6.0189	6.0
789	Newborn that dies or is transferred to another facility	1.8252	1.8

For r-DRG assessment, the weight of r-DRG 789 (1.8) is added to r-DRG for infant that dies. For this project we limited selection of r-DRG to

MS-DRG	Description	MS-DRG weight	r-DRG weight
794	**Newborn with Significant Problems**	**1.4946**	**1.5**
793	**Newborn with Major Problems**	**4.2225**	**4.2**

r-CMI graph, spanning the spectrum of neonatal care from normal newborn (r-CMI = 0.2) to a 22 week preterm infant (r-CMI = 7.1)





r-CMI graph showing significantly lower value for ESC compared to infants managed with Finnegan scoring

Figure 1. Neonatal MS-DRG categories and research weights, and r-CMI values from both epochs. The values for the weights of the MS-DRGs & r-DRGs for neonates are detailed in the above graphic. For the present study, assignment was limited to r-DRG 794 with weight 1.5 (opioid exposure without NOWS) and r-DRG 793 with weight 4.2 (NOWS). The cohort comparison was statistically significant; the asterisk * denotes $p < 0.01$. Gray reference points on the r-CMI graph provide contextual benchmarks rather than contemporaneous control groups.

Mean maternal age was 31 years in the FNASS epoch and 28 years in the ESC epoch. At least 80% of mothers in each epoch had at least one prenatal visit, and at least 70% were enrolled in a medication for opioid use disorder (MOUD) program. Reported maternal BMI values were approximately 29–30 kg/m^2, and hepatitis C positivity ranged from 30% to 37%.

The r-CMI was lower in the ESC cohort than in the FNASS cohort (2.3 ± 1.2 vs. 3.2 ± 1.3; unadjusted $p = 0.001$), as shown in the Figure 1. This measure reflects the assigned research classification weights and is not a direct measure of hospital expenditure.

4. Discussion

The benefits of ESC have been previously documented. A meta-analysis was published, reviewing 18 studies that bolster the benefits of ESC over FNASS for the care of infants exposed to maternal opioids [7]. In our population in Appalachia, the transition to ESC took some time to establish, requiring education of caregivers & families as to the importance of family presence needed to make this management successful. ESC was successfully integrated into the care of opioid exposed newborns in our mother-baby unit, where there has been a reduction in LOS and a reduction in pharmacotherapy initiation between the two epochs, similar to other studies [2]. We set out to assess the socioeconomic and clinical outcomes to see if there have been any significant improvements since altering the scoring tool, utilizing a retrospective pre-post intervention chart review with Epoch 1 using FNASS and Epoch 2 using ESC. These outcomes may reflect other distinctions between the two epochs, most notably shifting trends in substance use in our catchment area, with Epoch 2 having relatively less polysubstance exposure, methamphetamine use, and fentanyl use, despite similar buprenorphine and methadone use and similar rates of enrollment in Medications for Opioid Use Disorder (MOUD) programs. These changes may also reflect general shifts in substance use and social isolation during the COVID-19 pandemic. We believe that the maternal use of these substances increased during the pandemic. Reviewing maternal data from the tail end of the pandemic period, 2022, showed methamphetamine use at 36%, fentanyl use at approximately 25%, and inhalant use at nearly 10%.

Maternal characteristics describe the clinical and social context of this cohort. Mean maternal age was 31 years in the FNASS epoch and 28 years in the ESC epoch. In both epochs, most mothers had at least one prenatal visit and were enrolled in a MOUD program. Maternal BMI was reported as approximately 29–30 kg/m^2. These BMI data do not establish maternal nutritional status. Hepatitis C positivity ranged from 30% to 37%, and maternal tobacco exposure was 65.3% in the FNASS epoch and 50.0% in the ESC epoch. These findings support the importance of integrated maternal and neonatal care [5,8–10].

ESC emphasizes family involvement and support [11,12]. Although parental involvement was more frequent and foster care discharge less frequent in the unadjusted ESC comparison, neither association remained statistically significant after adjustment. Although need for foster care was reduced with ESC, a rate of 19.2% is much higher than US national average of 0.5% [13] These findings therefore do not establish that ESC independently increased parental participation or reduced foster care placement. In contrast, the associations with less pharmacological treatment and shorter hospitalization persisted after adjustment for the measured covariates.

The lower r-CMI in the ESC epoch is consistent with the lower frequency of NOWS classification. Because the r-CMI was constructed from the assigned weights for exposure and NOWS, the difference should be interpreted as a change in classification-derived resource intensity. Actual hospital costs, reimbursement, and resource consumption were not directly measured.

Limitations and Sample Size Considerations

This single-center, retrospective, sequential-epoch comparison is susceptible to residual confounding and secular changes in substance exposure, clinical care, and discharge practices. NOWS classification used different assessment criteria in the two epochs; therefore, a lower classification rate does not establish a reduction in the underlying biological incidence of withdrawal or the diagnostic superiority of ESC. Parental involvement was abstracted from clinical documentation and may be affected by documentation practices. The smaller ESC cohort and low frequencies of some outcomes limit precision and may affect the stability of multivariable estimates. In particular, the confidence intervals for foster care discharge (aOR 0.97, 95% CI 0.49–1.93) and parental involvement (aOR 1.24, 95% CI 0.66–2.32) encompass clinically relevant associations in both directions. These findings do not establish equivalence or exclude a meaningful association. Because r-CMI was derived from exposure and NOWS classifications, it is not independent evidence of resource consumption and does not quantify actual costs or cost savings.

5. Conclusions

In this retrospective cohort of opioid-exposed newborns in Appalachia, ESC implementation was associated with shorter hospitalization and less pharmacological treatment after adjustment for measured differences between epochs. Unadjusted differences in foster care discharge and parental involvement showed significant improvement with ESC, though these changes did not persist after adjustment. The lower classification-derived r-CMI does not establish direct cost savings but does suggest a decrease in utilization of hospital resources. The sequential-epoch observational design precludes causal attribution, and larger studies with more precise estimates are needed to clarify family-related outcomes. Future research should use standardized measures of parent participation, examine longer-term infant and family outcomes, and directly measure hospital use and costs to quantify the economic impact of ESC implementation.

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Informed Consent Statement: Patient consent was waived because this was a retrospective review and identifying patient information was removed from the analytical datasets.

Data Availability Statement: De-identified data are available if requested after approval.

Conflicts of Interest: The authors declare no conflicts of interest.

Abbreviations

ACOG	American College of Obstetrics and Gynecology
ESC	Eat Sleep Console
FNASS	Finnegan scoring system
Level IV NICU	A Neonatal Intensive Care Unit that provides the highest and most advanced level of medical care available for premature and critically ill newborns as outlined by the American Academy of Pediatrics

MOUD	Medications for Opioid Use Disorder
NOWS	Neonatal opioid Withdrawal Syndrome
OUD	Opioid Use Disorder
r-CMI	research Case Mix Index
r-DRG	research Diagnosis Related Group

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