Turning the Tide: State Strategies to Meet the Needs of Families Affected by Substance Use Disorder

8:00 am- 3:30pm
Wednesday, August 15, 2018

Hyatt Regency Jacksonville Riverfront
Grand Ballroom 8
225 East Coastline Drive
Jacksonville, FL

Supported by the Health Resources and Services Administration

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Turning the Tide: State Strategies to Meet the Needs of Families Affected by Substance Use Disorder
Preconference Agenda

Hyatt Regency Jacksonville Riverfront
Grand Ballroom 8

Wednesday, August 15, 2018
8:00am – 3:30pm

Goal of Meeting: To provide a forum for state policymakers to identify and share innovative policy solutions to improve outcomes for women and children affected by substance use disorder.

Learning Objectives: Following this meeting, participants will:

- Increase knowledge of state policy considerations for meeting the unique needs of families affected by substance use disorder or opioid use disorder;
- Identify financing and service delivery options to ensure access to continuous care for women affected by substance use disorder; and
- Examine opportunities for cross-agency collaboration and data use to inform policies and programs to support children and pregnant or parenting women affected by opioid or substance use disorder.

8:00 – 8:30am	**Registration and Breakfast**
8:30-8:45am	**Welcome** **Speaker:** • **Karen VanLandeghem**, Senior Program Director, National Academy for State Health Policy
8:45-9:30am	**Understanding the Impact of Substance Use Disorder on Families** The opening session will provide important context about the impact of opioid and substance use disorders for women and children. Topics covered will include: national trends, the intergenerational effects of opioid and substance use disorders, treatment options, and potential policy and funding opportunities for states to address opioid and substance use disorders. **Speaker:** • **Jill Gresham,** Senior Program Associate, Children and Family Futures **Moderator:** *Donna Bradbury, Associate Commissioner, Division of Integrated Community Services for Children & Families, New York State Office of Mental Health*

9:30-10:45am	**State Strategies for Ensuring Access to Continuous Care for Women with Substance Use Disorder** As states look to address the rising rates of substance use disorder among women, they are identifying innovative approaches to providing coverage, implementing and financing innovative treatment programs, and targeting populations of women who are at higher-risk for substance use disorders. This session will feature three states that have implemented programs and policies that address substance use disorder among women. **Speakers:** • **Ashley Harrell,** Senior Program Advisor, Behavioral Health, Virginia Department of Medical Assistance Services • **Kimberly Early,** Policy Director, Pennsylvania Department of Health • **Amy Cooper,** Women's Services Coordinator, Colorado Department of Human Services, Office of Behavioral Health **Moderator:** *Donna Bradbury, Associate Commissioner, Division of Integrated Community Services for Children & Families, New York State Office of Mental Health*
10:45-11:00am	**Break**
11:00am - 12:15pm	**State Data and Programmatic Strategies for Supporting Children Impacted by Substance Use Disorder** Children can be affected by substance use disorder in a variety of ways, whether through prenatal exposure or substance use in the family. Close coordination between child and family-serving agencies is key to ensure that infants and children affected by substance use disorder receive support services. This session will highlight the role of data and cross-agency collaboration to identify and address the needs of children affected by opioid use in the family. **Speakers:** • **Debra Bercuvitz,** Perinatal Substance Use Coordinator, Massachusetts Department of Public Health • **Abby Shockley,** Senior Policy Analyst, Substance Use Services, New Hampshire Department of Health and Human Services **Moderator:** *Donna Bradbury, Associate Commissioner, Division of Integrated Community Services for Children & Families, New York State Office of Mental Health*
12:15-1:00pm	**Networking Lunch**

1:00-2:15pm	**Policy Café Discussions** During this interactive session, participants will join short, small group discussions ("policy cafés") focused on topics essential to state efforts to meet the needs of families affected by substance use disorder. ***Moderator:*** *Jodi Manz, Assistant Secretary, Virginia Office of Health and Human Resources*
2:15-3:30pm	**Identifying Next Steps: What is on the Horizon?** The concluding session will feature representatives from different state agency perspectives sharing key takeaways from the day, identifying unanswered questions, and highlighting potential opportunities and next steps. Participants will raise remaining questions and share strategies for translating the day's discussion into action. **Speakers:** • **Dr. Mary McIntyre**, Chief Medical Officer, Alabama Department of Public Health • **Karen Palombo,** Substance Use Disorder Treatment and Intervention Team Lead, Texas Health and Human Services Commission • **Lesley Scott-Charlton**, Medicaid Health Systems Administrator, Ohio Department of Medicaid ***Moderator:*** *Jodi Manz, Assistant Secretary, Virginia Office of Health and Human Resources*

Turning the Tide: State Strategies to Meet the Needs of Families Affected by Substance Use Disorder

Speaker Biographies

Debra Bercuvitz
Perinatal Substance Use Coordinator
Massachusetts Department of Public Health

Debra Bercuvitz is the Substance Use Coordinator for the Massachusetts' Department of Public Health's Bureau of Family Health and Nutrition. She is currently leading projects to improve Early Intervention referrals and enrollment for babies with neonatal abstinence syndrome. Ms. Bercuvitz has been instrumental in the development of many state initiatives including the perinatal recovery coach workforce, perinatal substance use community collaboratives, IDEA Part C services for substance exposed newborns, and the Plan of Safe Care. She was formerly the director of a home visiting program staffed by peer mentors, working with perinatal women affected by substance use disorders, and their children.

Donna Bradbury
Associate Commissioner
New York State Office of Mental Health, Division of Integrated Community Services for Children and Families

Donna Bradbury directs the Division of Integrated Community Services for Children and Families at the Office of Mental Health. She oversees all community-based children's mental health programs in New York State. She is currently leading the effort to transition children's behavioral health services into Medicaid managed care as part of the larger Medicaid Redesign project. Prior to state service, Donna worked for twelve years for the Rensselaer County Department of Mental Health. She delivered clinical services to children and their families, served as a consultant to Family Court as well as county-operated human service departments and schools, ran a specialized treatment program which successfully prevented institutional placement for many youth, and assisted in the creation and implementation of several interagency initiatives that resulted in children and their families having easier access to better quality services.

Amy Cooper
Women's Services Coordinator
Colorado Department of Human Services, Office of Behavioral Health

Amy Cooper, a Minnesota native, graduated with her Master's in Clinical Psychology with a focus in Addiction Studies from Argosy University. She currently works for the Colorado Department of Human Services in the Office of Behavioral Health as the Women's Services Coordinator. In this role she manages an innovative program for pregnant and parenting women called Special Connections, engages with stakeholders around women's specific issues including Substance Exposed Newborns, and offers program support to community provides offering gender responsive services to women. Previously, Amy worked in residential and outpatient levels of care focusing on women's treatment needs and offender

populations. She also worked for local government on a pilot program for pregnant women to engage in home based substance use and case management services. Amy took interest in working with new clinicians on how to assess and triage clients in a trauma informed manner to help gain a deeper insight into the services needed to support the individuals. Since moving to Colorado Amy has enjoyed working for the State, traveling with her Great Dane, and hiking in the Rockies.

Kimberly Early
Policy Director
Pennsylvania Department of Health

Kimberly Early serves as the Policy Director with the Pennsylvania Department of Health. She has over 16 years of state government experience working in various capacities in the Department of Health and the Department of Human Services. Most recently, Kimberly was the Deputy Director of the Policy Office in the Department of Human Services. She also served in the Office of Legislative Affairs and the Office of Children, Youth and Families within the Department of Human Services. She has experience in family health, quality assurance, and public health accreditation within the Department of Health. Kimberly graduated from the University of Pittsburgh with a Bachelor of Science degree in psychology and Temple University with a Master of Social Work degree. She is a licensed social worker.

Jill Gresham
Senior Program Associate
Child and Family Futures

Jill Gresham serves as a Senior Program Associate with the National Center on Substance Abuse and Child Welfare at Children and Family Futures. In this role, she serves as an advisor and technical consultant to states, counties, tribes and regions across the country in issues related to substance abuse, child welfare and the courts, providing and coordinating various levels of technical assistance. Jill primarily serves the In-Depth Technical Assistance program and provides support to states working to address infants with prenatal exposure from pregnancy through infancy. Jill has 15 years of experience in the substance use disorder treatment field, the majority of which was working with women and mothers. In her roles as clinician and director, she worked closely with Child Protective Services and the court. Prior to joining Children and Family Futures, Jill co-founded and directed New Traditions, an outpatient treatment facility for low income, pregnant and parenting women in Seattle, Washington. Ms. Gresham earned a BA from the University of Massachusetts and an MA in Counseling Psychology from Antioch University Seattle. She is also a certified substance use disorder treatment counselor in Washington State.

Ashley Harrell
Senior Program Advisor
Virginia Department of Medical Assistance Services

Ashley Harrell is the Senior Program Advisor to the Division Director of the Developmental Disabilities and Behavioral Health at the Virginia Department of Medical Assistance Services. Ashley's role in the Medicaid agency over the past several years was leading the implementation of the transformation of the Medicaid substance use disorder treatment services – "Addiction and Recovery Treatment Services or ARTS". ARTS has been recognized nationally as the model for States implementing Substance Use Disorder Demonstration Waivers. Prior to transitioning to Behavioral Health in June 2016, Ashley managed the Maternal and Child Health Division at the Medicaid agency to improve access to and enhance services for women and children eligible for Medicaid. Prior to her work for Medicaid, Ashley worked in a non-for-profit hospital in Petersburg, Virginia in the Skilled Care Unit, Intensive Care Unit and general acute care. Ashley also has several years' experience at Army Community Services at Fort Lee, Virginia as the New Parent Support Program Advisor to promote healthy families through a variety

of services including home visits, support groups, and parenting classes. In this role, Ashley assisted Soldiers and Families learn to methods to cope with stress, isolation, post-deployment reunions, and the everyday demands of parenthood. Ashley is licensed in Clinical Social Work in Virginia as of 2002. Ashley graduated from Virginia Commonwealth University with degrees both in Master's in Social Work as well as a Magna Cum Laude, Bachelor's in Social Work.

Jodi Manz
Assistant Secretary
Virginia Office of Health and Human Resources

Jodi Manz, MSW serves as Assistant Secretary of Health and Human Resources for Virginia in the administration of Governor Ralph Northam. She supports the Governor and Secretary on the development of legislative, budget, and policy initiatives, particularly those regarding Virginia's opioid overdose and addiction crisis. Previously, she served as Assistant Secretary and as Policy Advisor for Health and Human Resources under former Governor Terry McAuliffe.

Dr. Mary McIntyre
Chief Medical Officer
Alabama Department of Public Health

Mary G. McIntyre, M.D., M.P.H., SSBB is Chief Medical Officer for the Alabama Department of Public Health (ADPH). She is board certified in Public Health and General Preventive Medicine through the American Board of Preventive Medicine. She joined ADPH in January 2011, and served as Assistant State Health Officer for Disease Control and Prevention and State Epidemiologist before taking her current position. Prior to beginning her public health career she served in various roles at the Alabama Medicaid Agency including Alabama Medicaid Medical Director. She provided primary care for eleven years mostly in rural Alabama before joining the State. She is a member of the Council of State and Territorial Epidemiologists, the National Academy for State Health Policy, the American Public Health Association, the Alabama Public Health Association, the Association for Professionals in Infection Control and Epidemiology, the American Medical Association, and the Medical Association of the State of Alabama. She is most proud of being a wife and mother to four amazing adults and a grandmother to three.

Karen Palombo
Substance Use Disorder Treatment and Intervention Team Lead
Texas Health and Human Services Commission

Karen Palombo works for the Health and Human Services Commission in the Medical and Social Services Division in the Substance Use Disorder Unit as the Substance Use Disorder Treatment and Intervention Team Lead in Texas. Prior to this experience she has worked in hospital settings, mental health and substance use disorder treatment settings and for 9 years. She graduated from Louisiana State University with her Masters in Social Work. She has three children and currently lives in Austin, Texas.

Lesley Scott-Charlton
Medicaid Health Systems Administrator
Ohio Department of Medicaid

Lesley Scott-Charlton currently serves as a Policy Administrator with the Ohio Department of Medicaid. She has over 20 years of experience in public service, policy development, and systems administration. Mrs. Scott-Charlton spends a great portion of her time presenting on initiatives that serve Ohio's children and families. Her Collaborative efforts include partnerships with the Centers for Medicare and Medicaid Services; the US Department of Health and Human Services; the US Department of Education; State and Local Government agencies; Managed Care Plans; Hospital Associations; and Community organizations. Ms. Scott-Charlton's Associate Degree training was in the field of Mental Health/Chemical Dependency/and Developmental Disabilities. Her confirmed bachelor degree training is in the field of Social Work, and subsequently dual Graduate degree training in School Counseling and Clinical Counseling from Capital University in Columbus, Ohio.

Abby Shockley
Senior Policy Analyst, Substance Use Services
New Hampshire Department of Health and Human Services

Abby is a Senior Policy Analyst, Substance Use Services at the NH Department of Health and Human Services. Her work focuses on several of the Department's substance use disorder (SUD) initiatives, including substance use disorder policy analysis and Medicaid coverage for SUD. Abby coordinates activities across the Department and with other State and Federal agencies, and develops and strengthens relationships with external stakeholders in support of the Department's goals and policies in the area of substance use issues. She currently serves as the Project Director for SUD related programs funded by the Cures Act, including a targeted prevention program for child welfare involved families. Prior to joining DHHS, Abby worked with Bi-State Primary Care Association and the NH Alcohol and other Drug Service Providers Association. Before coming to NH, Abby worked on maternal and child health initiatives in Florida with Healthy Start and the Florida Perinatal Quality Collaborative.

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#NASHPCONF18

SHIFTING TIDES IN STATE HEALTH POLICY

Welcome

8:30AM – 8:45AM

Speaker
Karen VanLandeghem
Senior Program Director
National Academy for
State Health Policy

Opening Keynote

Understanding the Impact of Substance Use Disorder on Families

8:45AM – 9:30AM

Moderator
Donna Bradbury
Associate Commissioner
Division of Integrated
Community Services for Children
& Families, New York State Office
of Mental Health

Speaker
Jill Gresham
Senior Program Associate
National Center on Substance
Abuse and Child Welfare's In-
Depth Technical Assistance
Program, Children and Family
Futures

Note: As a resource, extra slides are included in this presentation that will not be presented at the preconference.

National Academy for State Health Policy | August 15th, 2018

Understanding the Impact of Substance Use Disorder on Families

Jill Gresham, MA, CDP, Senior Associate, National Center on Substance Abuse and Child Welfare

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Acknowledgement

National Center on Substance Abuse and Child Welfare

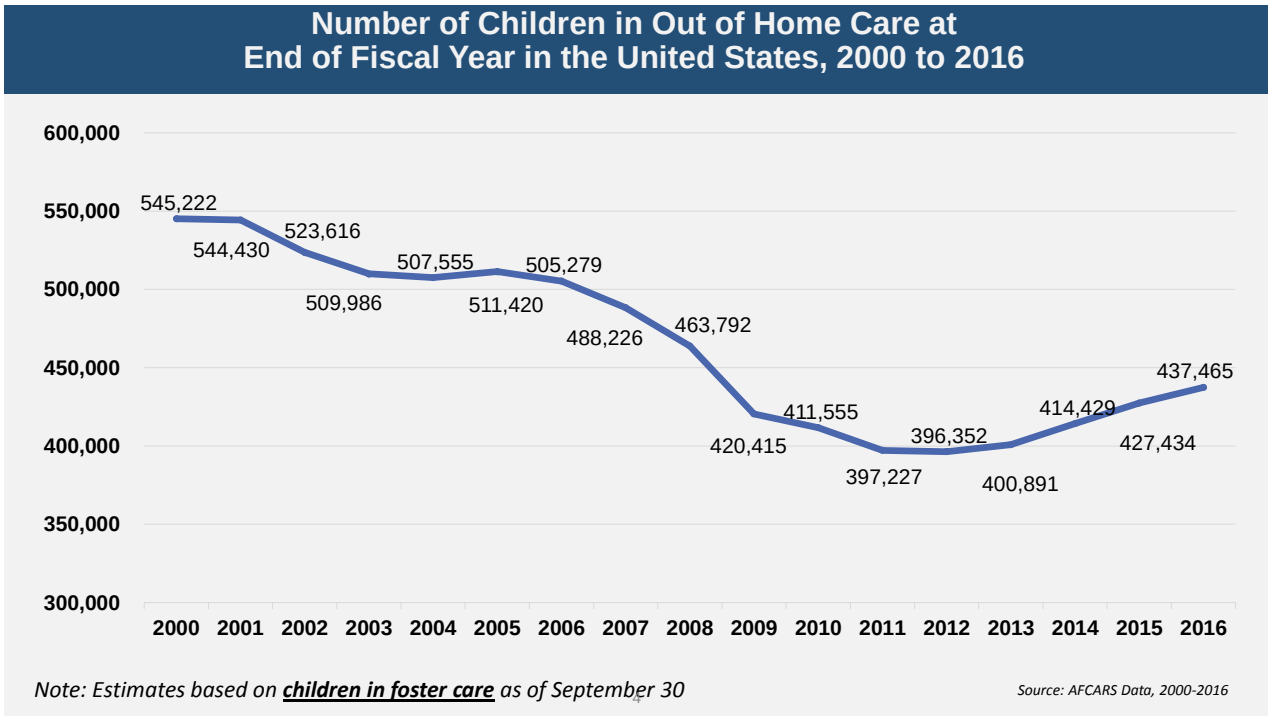
A program funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Administration for Children and Families (ACF), Children's Bureau

Substance Abuse and Mental Health Services Administration SAMHSA www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

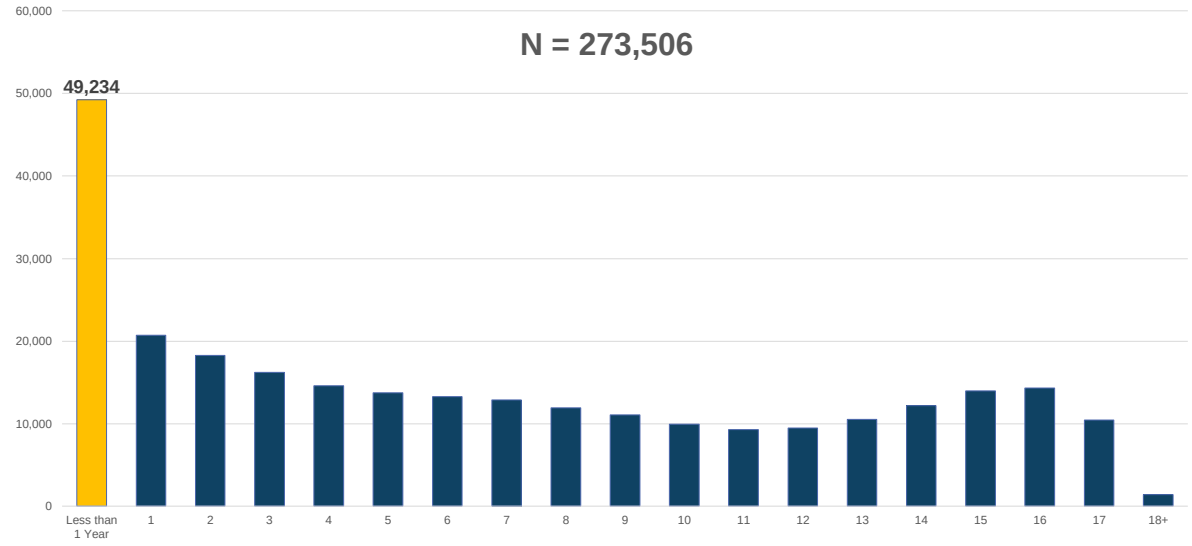
Children's Bureau

www.ncsacw.samhsa.gov | ncsacw@cffutures.org

The Data
• Parental Substance Use in Child Welfare Services
• Treatment for Substance Use Disorders
3


Number of Children in Out of Home Care at End of Fiscal Year in the United States, 2000 to 2016
600,000
550,000
500,000
450,000
400,000
350,000
300,000
545,222
544,430
523,616
509,986
507,555
511,420
505,279
488,226
463,792
420,415
411,555
397,227
396,352
400,891
414,429
427,434
437,465
2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016
Note: Estimates based on children in foster care as of September 30
Source: AFCARS Data, 2000-2016

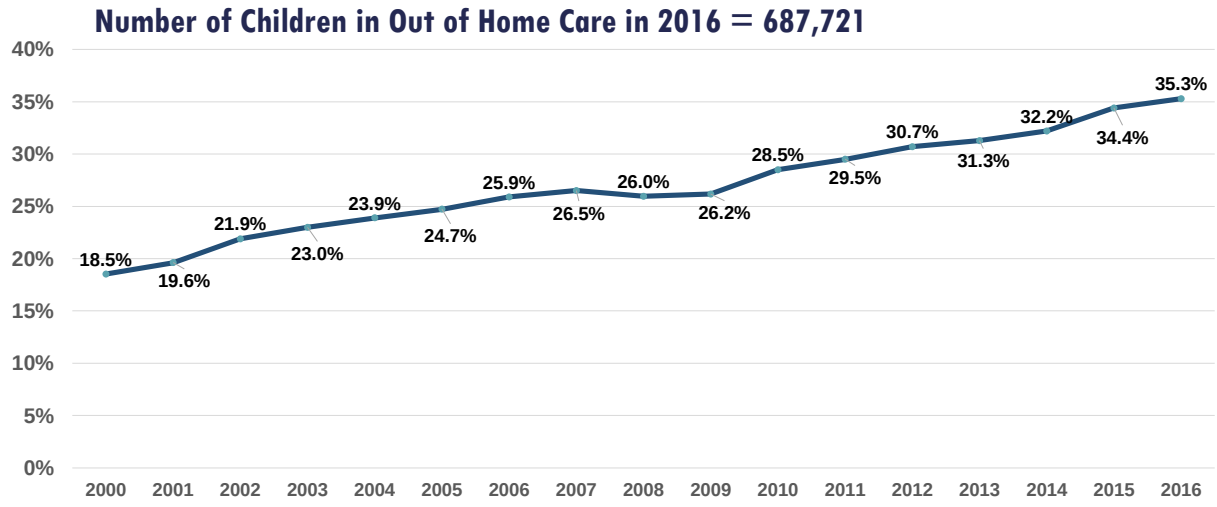
Number of Children who Entered Foster Care, by Age at Removal in the United States, 2016



*Note: Estimates based on **children who entered out of home care** during Fiscal Year*

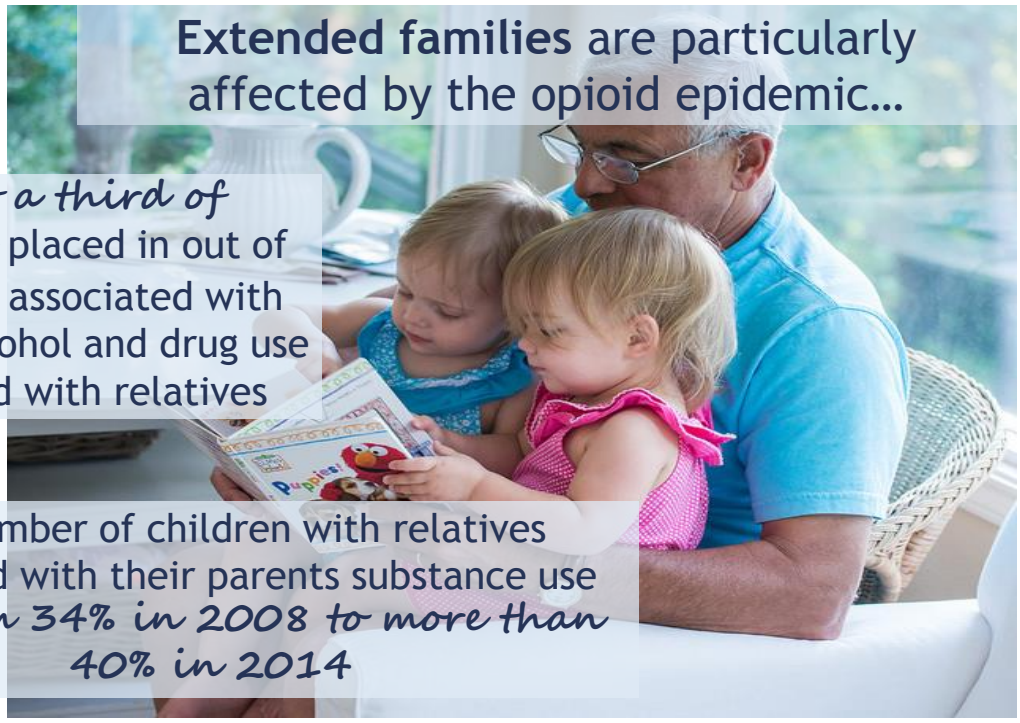
Source: AFCARS Data, 2016

Prevalence of Parental Alcohol or Other Drug Use Reported as a Contributing Factor for Reason for Removal in the United States, 2000 to 2016

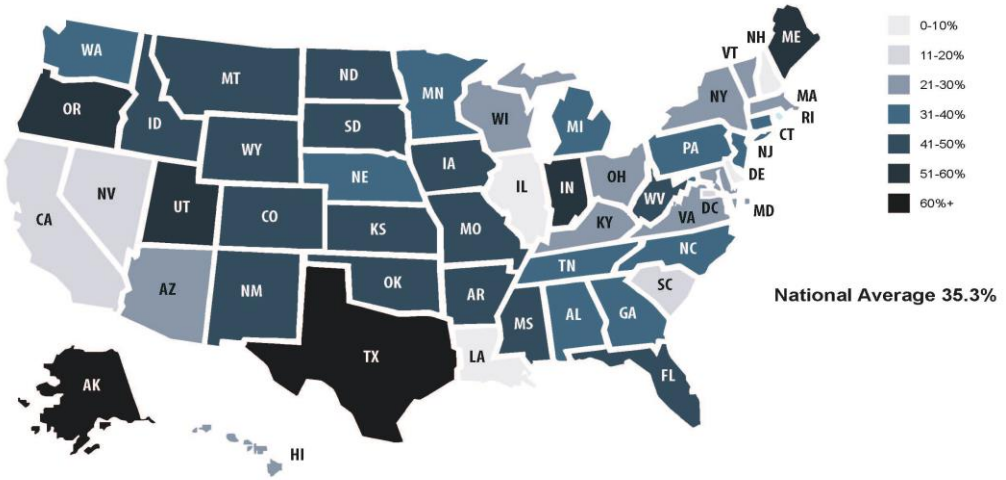


*Note: Estimates based on **all children in out of home care at some point** during Fiscal Year*

Source: AFCARS Data, 2000-2016



Prevalence of Parental Alcohol or Other Drug Use as a Contributing Factor for Reason for Removal by State, 2016

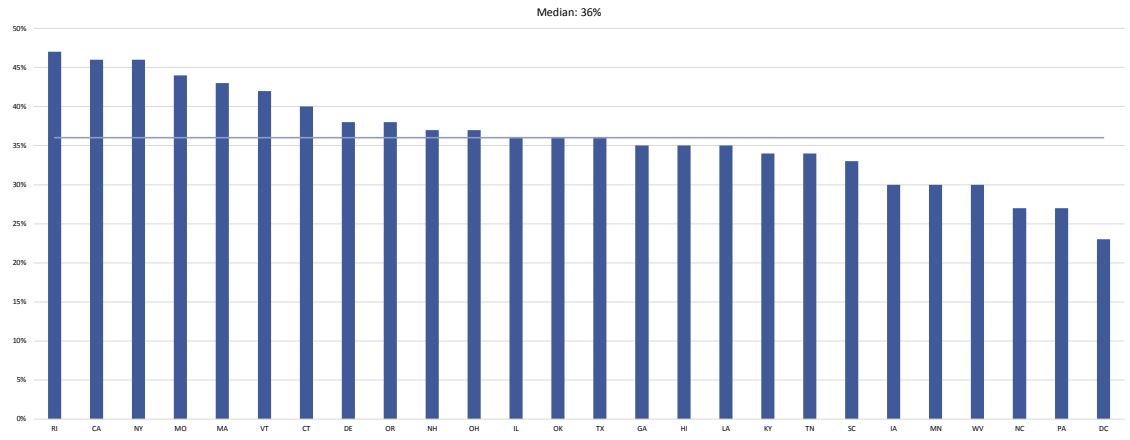


Efforts in data collection have improved in recent years, but significant undercount remains in some states.

Note: Estimates based on all children in out-of-home care at some point during Fiscal Year 8

Source: AFCARS Data, 2016

Initiation Rates of Alcohol & Other Drug Dependence Treatment, Age 18 and Older by State, 2015



Note: This measure reports the percentage of individuals who initiated treatment within 14 days of a diagnosis of AOD dependence. Data was measured from January 1, 2015 to November 5, 2015. Twenty-four states did not report data on this measure and are not included.
Source: Medicaid Scorecard, 2018 (link: https://www.medicaid.gov/state-overviews/scorecard/index.html), 2018 Centers for Medicare and Medicaid Services

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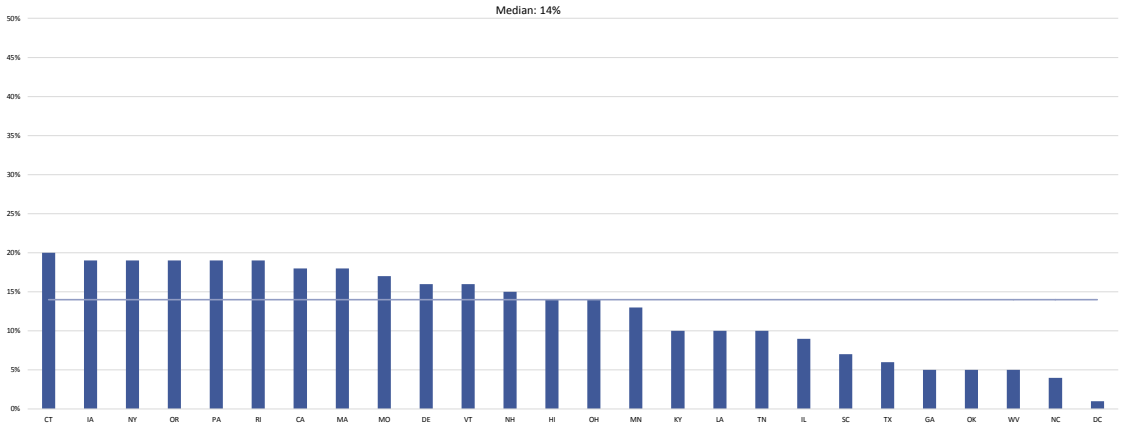
Engagement Rates of Alcohol & Other Drug Dependence Treatment, Age 18 and Older by State, 2015



Note: This measure reports the percentage of individuals engaged in 2 or more AOD treatment activities within 30 days of the initial visit. Data was measured from January 1, 2015 to November 5, 2015. Twenty-four states did not report data on this measure and are not included.
Source: Medicaid Scorecard, 2018 (link: https://www.medicaid.gov/state-overviews/scorecard/index.html), 2018 Centers for Medicare and Medicaid Services

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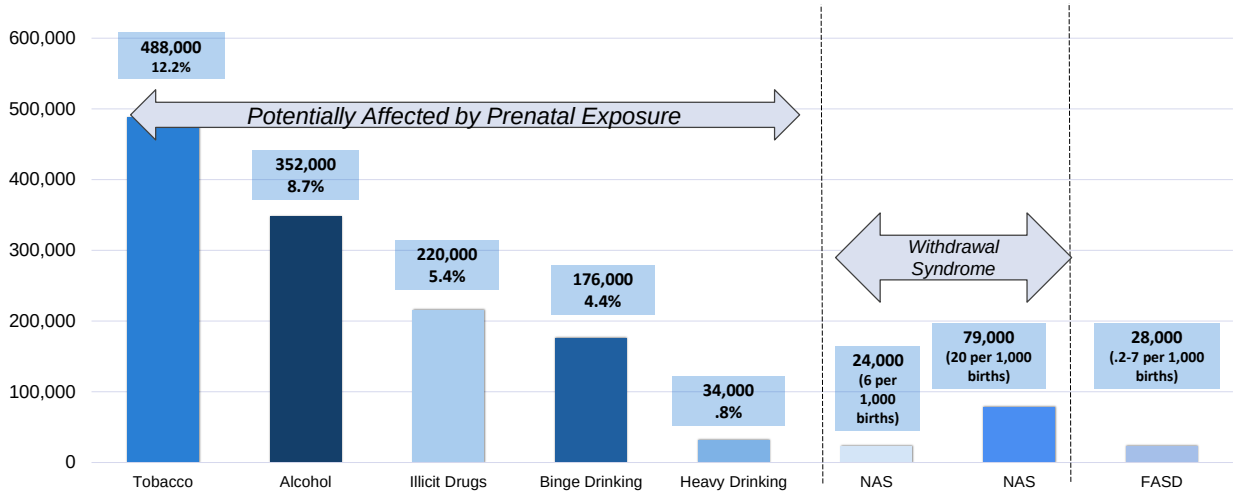
Estimated Number of Infants Affected by Prenatal Exposure, by Type of Substance and Infant Disorder, 2016



(National Vital Statistics Report, 2017; NSDUH, 2017; Patrick et al., 2015; Milliren et. al, 2017; May & Gossage, 2001)

11

Assistant Secretary on Planning and Evaluation (ASPE) Study on Substance Misuse and Child Welfare

Quantitative

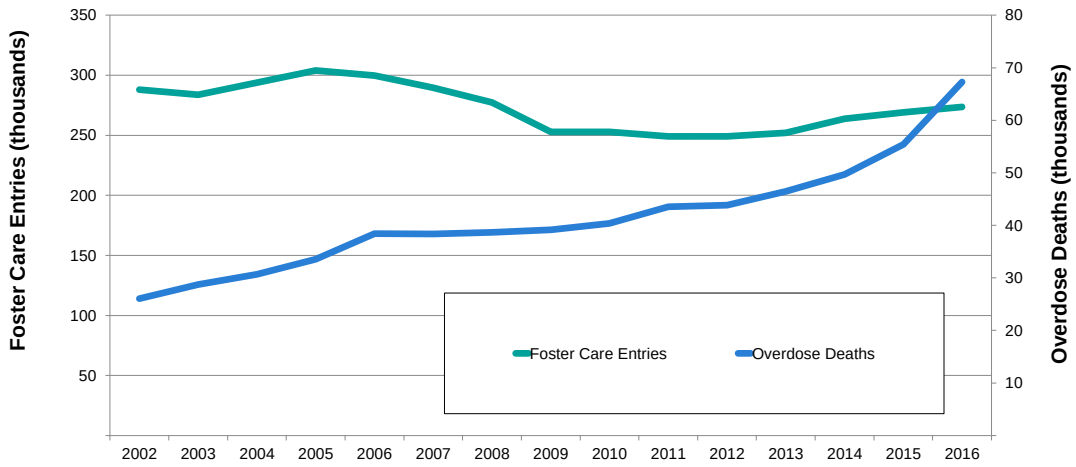
- Identify the effect of substance use prevalence and drug death rates on child welfare caseloads, including:
  - Total reports of child maltreatment
  - Substantiated reports of child maltreatment
  - Foster care entries

Qualitative

- Interviews with over 170 professionals to understand barriers and practice challenges

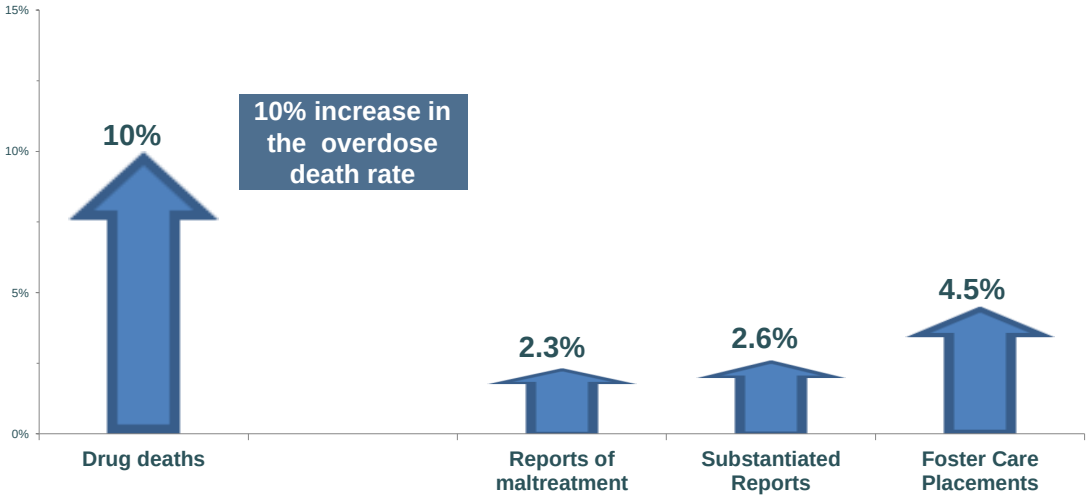
ASPE, 2018

Quantitative Study Findings



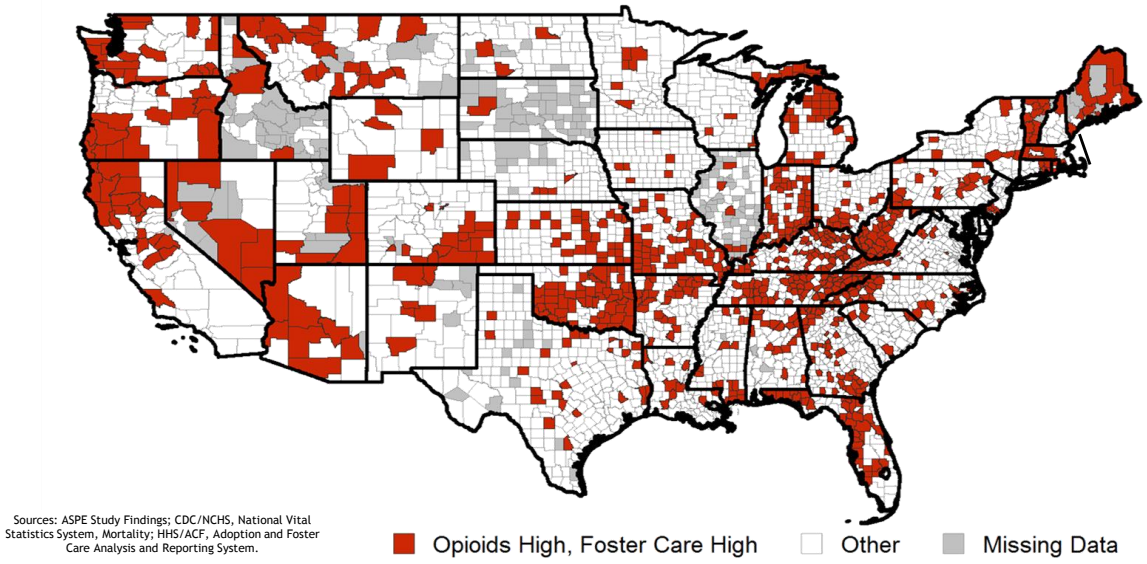
Sources: ASPE (2018) CDC/NCHS, National Vital Statistics System, Mortality; HHS/ACF, Adoption and Foster Care Analysis and Reporting System.

Study Findings: Relationship of Substance Use and Child Welfare Indicators



Sources: ASPE (2018) CDC/NCHS, National Vital Statistics System, Mortality; HHS/ACF, Adoption and Foster Care Analysis and Reporting System.

Counties where Rates of Drug Overdose Deaths and Foster Care Entries were both above the National Median in 2015



Sources: ASPE Study Findings; CDC/NCHS, National Vital Statistics System, Mortality; HHS/ACF, Adoption and Foster Care Analysis and Reporting System.

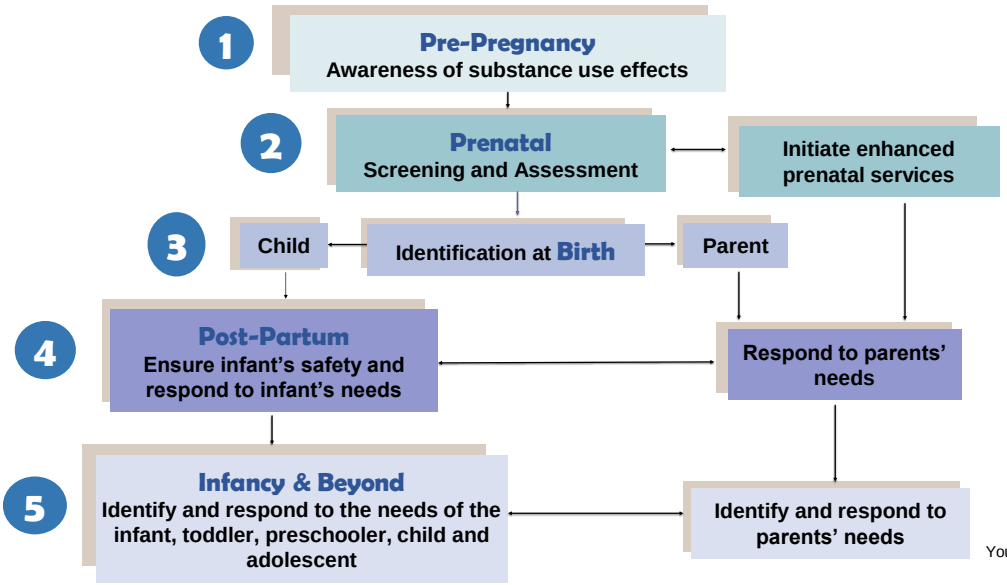
Qualitative Findings from the ASPE Study: Services to New Mothers

Factors that undermine the effectiveness of agencies' responses to families

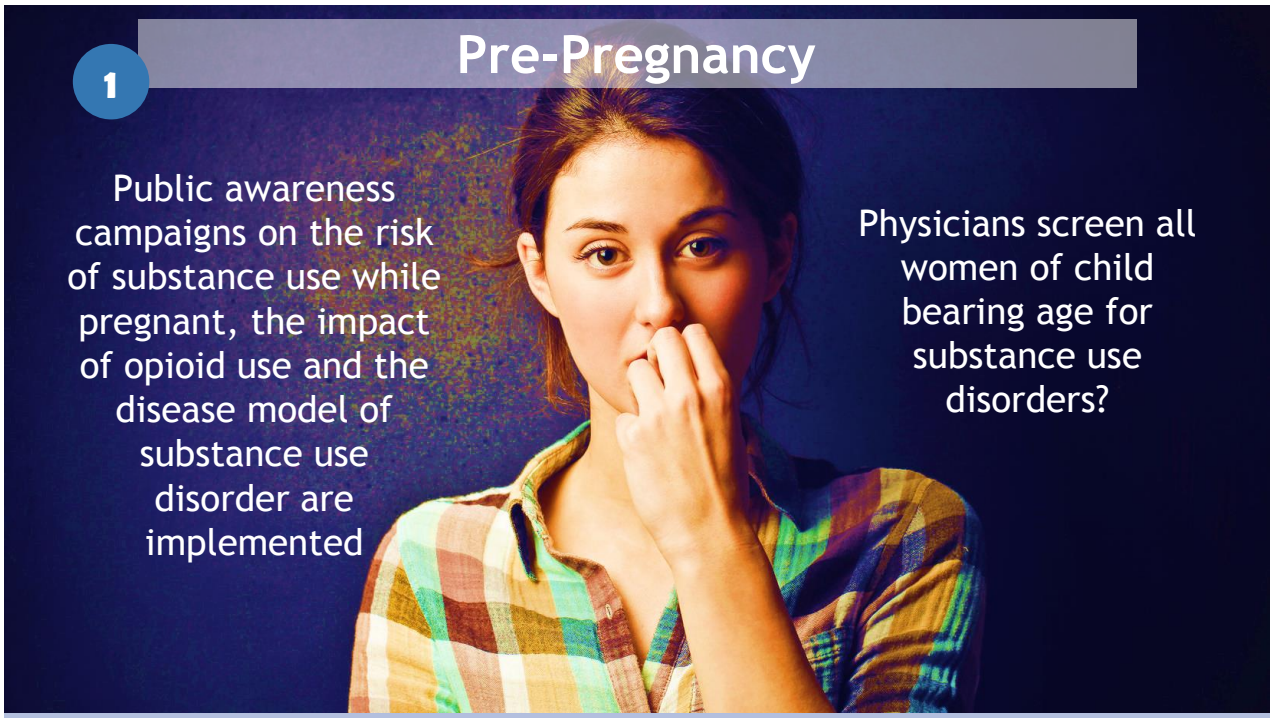
- Lack of treatment specific to pregnant women
- Clients received repeated detoxification without engagement in on-going treatment
- Mistrust of Medication Assisted Treatment (MAT)
- Family-friendly treatment options were limited
- Haphazard substance use assessment practices
- Barriers to collaboration
- Shortages of trained staff

(Radel et al., 2018)

Policy and Practice Framework: 5 Points of Intervention



Young, Gardner, et al., 2009



2 Prenatal Period

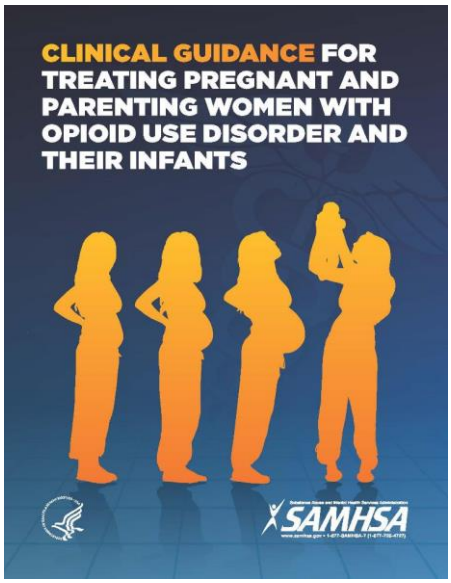
- Universal prenatal screening using an evidence-based tool
- Cross-system providers acknowledge Medication Assisted Treatment (MAT) as effective treatment of opioid use disorders for pregnant women
- MAT providers educate pregnant women on the risks of Neonatal Opioid Withdrawal Syndrome (NOWS)
- MAT and OB/GYN providers join the treatment team and share information on progress, concerns

Integrated Treatment Works

Kaiser Early Start – Substance Use and Mental Health Care embedded with prenatal care provider

- Birth outcomes among Early Start moms were same as non-drug-using women
- Cost effective – net cost benefit of $6 million (50,000 individuals)
- Early Start expanded to all Kaiser Northern California OB clinics

Goler, N. C., Armstrong, M. A., Osejo, V. M., Hung, Y. Y., Haimowitz, M., & Caughey, A. B. (2012). Early start: a cost–beneficial perinatal substance abuse program. *Obstetrics & Gynecology*, *119*(1), 102-110.



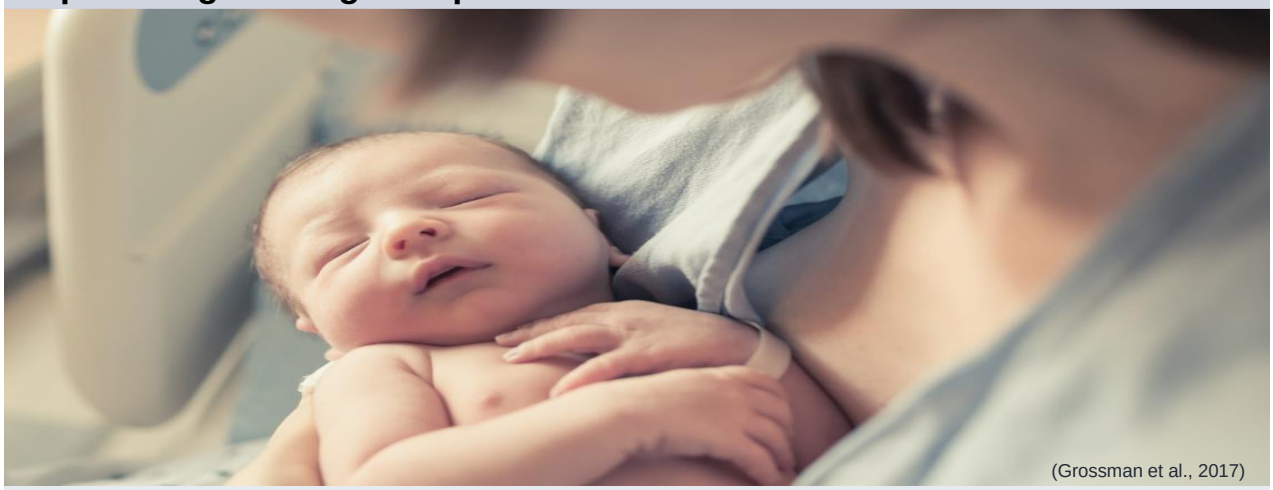
Comprehensive, national guidance for optimal management of pregnant and parenting women with opioid use disorders and their infants.

The Clinical Guide helps healthcare professionals and patients determine the most clinically appropriate action for a particular situation and informs individualized treatment decisions.

Available for download here: https://store.samhsa.gov/shin/content//SMA18-5054/SMA18-5054.pdf

- Hospitals universally screen mothers at delivery
- Infants are tested based on identified criteria and policies
- Hospitals understand and follow notification criteria
- Pediatricians are identified ***before*** hospital discharge and participate in the POSC
- Non-pharmacological treatments for NAS are used, including breastfeeding and rooming in where not contraindicated

Interventions for infant treatment focused **on simplified approach to assessment, nonpharmacological therapies, care outside of the NICU** and **empowering messages to parents** led to…



…substantial and sustained **decreases** in average **length of stay**, proportion of **infants treated with morphine**, and **hospital costs**.

Supported by the Health Resources and Services Administration

What was different?

- Used **eat**, **sleep** and **console** assessment
- No automatic transfer to NICU
- No automatic prescribing
- Moms and babies were transferred and stayed together on the general hospital floor

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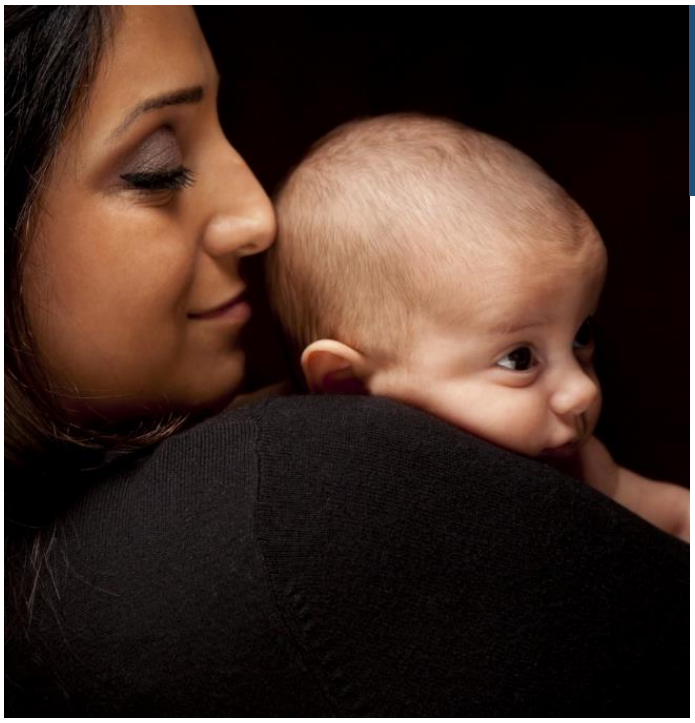
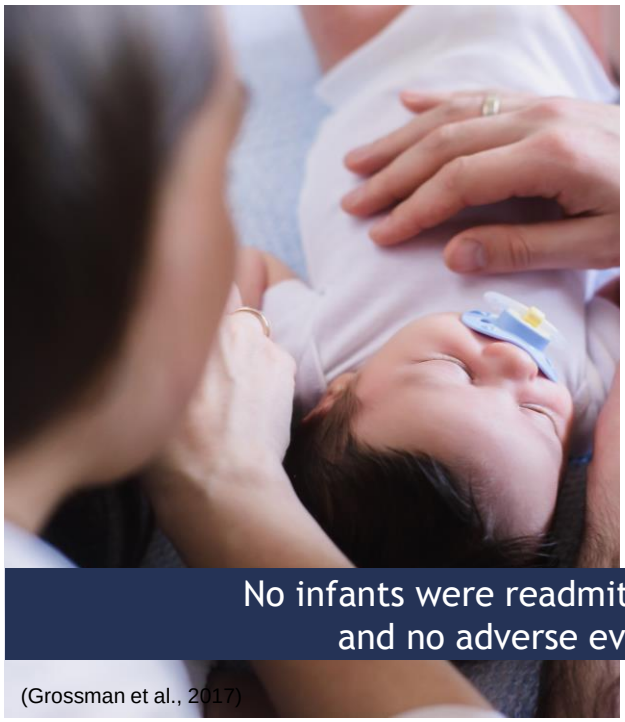
(Grossman et al., 2017)



Changes from this program affected hospital culture including…

- Additional bonding time
- Increased breastfeeding
- More time for observation of parenting capacity
- Opportunities for real-time parenting support

(Grossman et al., 2017)



Benefits of the Approach in this Study Site

- Length of hospital stay for infants

22.4 to 5.9 days

- Infants receiving pharmacological treatment

98% to 14%

- Hospital costs per family

$44,824 to $10,289

No infants were readmitted for treatment of NAS and no adverse events were reported

(Grossman et al., 2017)

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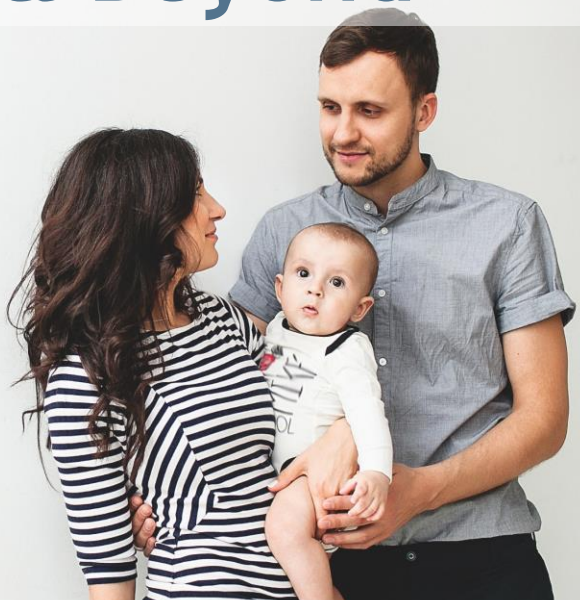
- Mothers and caregivers are informed on what to expect after delivery and how to support the infant
- All providers receive training on non-pharmacological interventions
- Infants receive a referral to early intervention services
- Discharge plans are completed for both mother and infant and shared with all providers

5 Infancy & Beyond

- Regular screenings are occurring through childhood and adolescence
- Early Intervention referrals are consistent
- Providers coordinate services to address the needs of the family



Services that Support Families

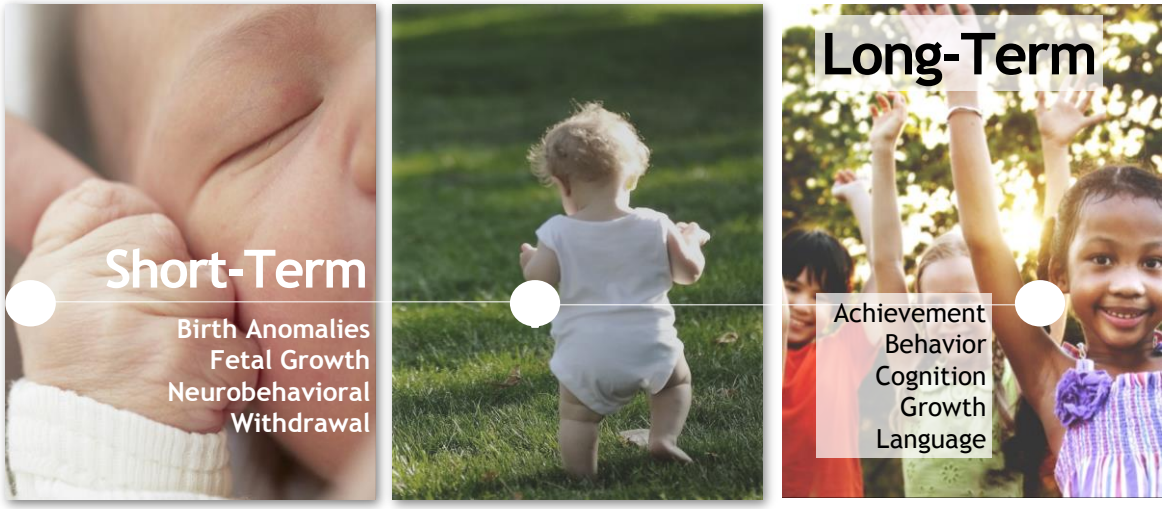
The American College of Obstetricians and Gynecologists, Committee on Obstetric Practice, American Society of Addiction Medication. Committee Opinion: Opioid Use and Opioid Use Disorder in Pregnancy. Number 711, August 2017. https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Opioid-Use-and-Opioid-Use-Disorder-in-Pregnancy

Substance Exposed Infants: State Responses to the Problem. https://ncsacw.samhsa.gov/files/Substance-Exposed-Infants.pdf

Effects of Substance Exposure

American Academy of Pediatrics Technical Report

Comprehensive review of ~275 peer reviewed articles over 40 years (1968-2006)



(Behnke & Smith, 2013)

Short-Term Effects of Prenatal Exposure

	Growth	Anomalies	Withdrawal	Neurobehavioral
Alcohol	**Strong Effect**	**Strong Effect**	No Effect	Effect
Nicotine	Effect	No consensus	No Effect	Effect
Marijuana	No Effect	No Effect	No Effect	Effect
Opiates	Effect	No Effect	**Strong Effect**	Effect
Cocaine	Effect	No Effect	No Effect	Effect
Methamphetamine	Effect	No Effect	**Lack of Data**	Effect

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(American Academy of Pediatrics, Behnke & Smith, 2013)

Long-Term Effects of Prenatal Exposure

	Growth	Behavior	Cognition	Language	Achievement
Alcohol	**Strong Effect**	**Strong Effect**	**Strong Effect**	Effect	**Strong Effect**
Nicotine	**No consensus**	Effect	Effect	Effect	Effect
Marijuana	No Effect	Effect	Effect	No Effect	Effect
Opiates	No Effect	Effect	**No consensus**	**Lack of Data**	**Lack of Data**
Cocaine	**No consensus**	Effect	Effect	Effect	**No consensus**
Methamphetamine	**Lack of Data**	**Lack of Data**	**Lack of Data**	**Lack of Data**	**Lack of Data**

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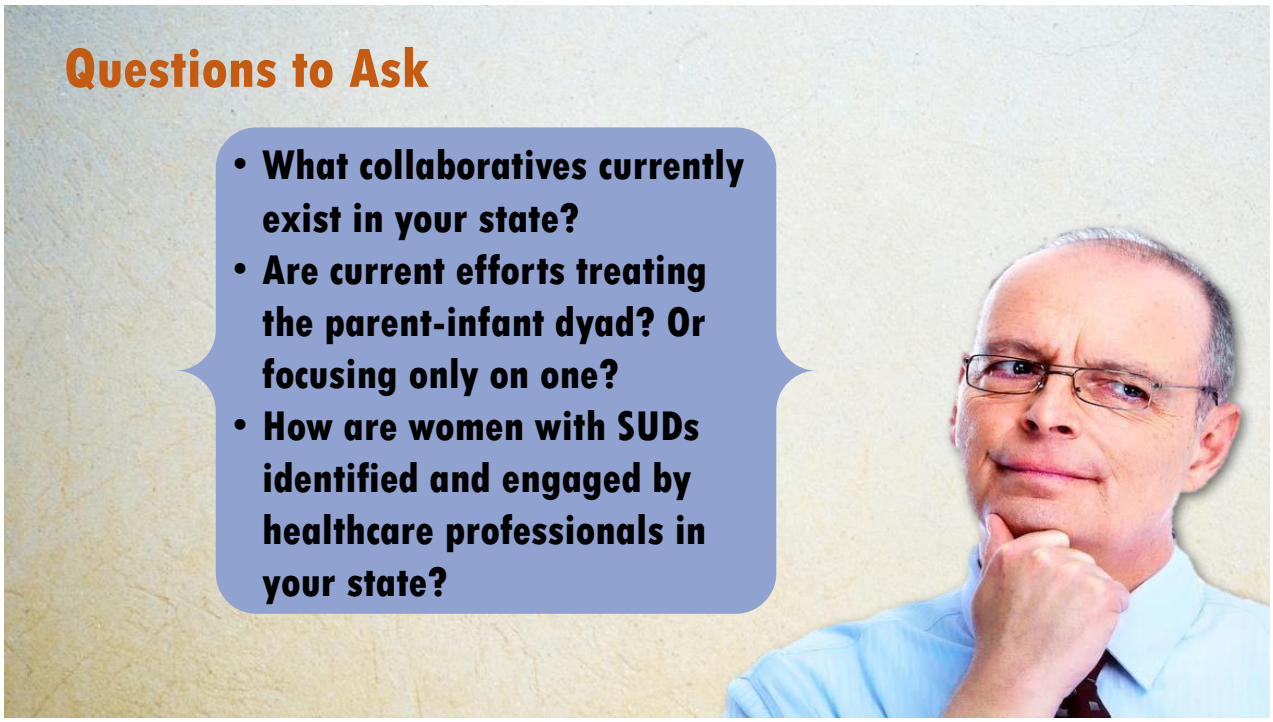
(American Academy of Pediatrics, Behnke & Smith, 2013)

American Academy of Pediatrics (AAP) 2013 Technical Report
Prenatal substance abuse: Short- and long-term effects on the exposed fetus

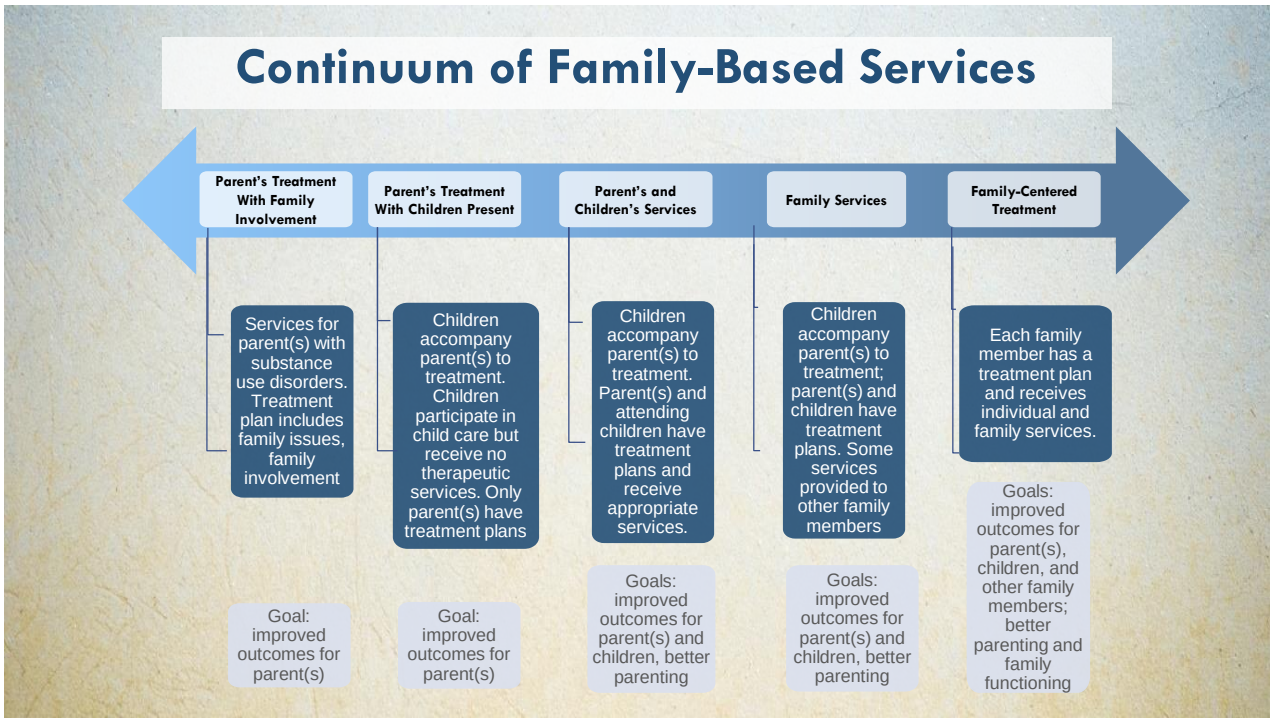
Key Takeaways:

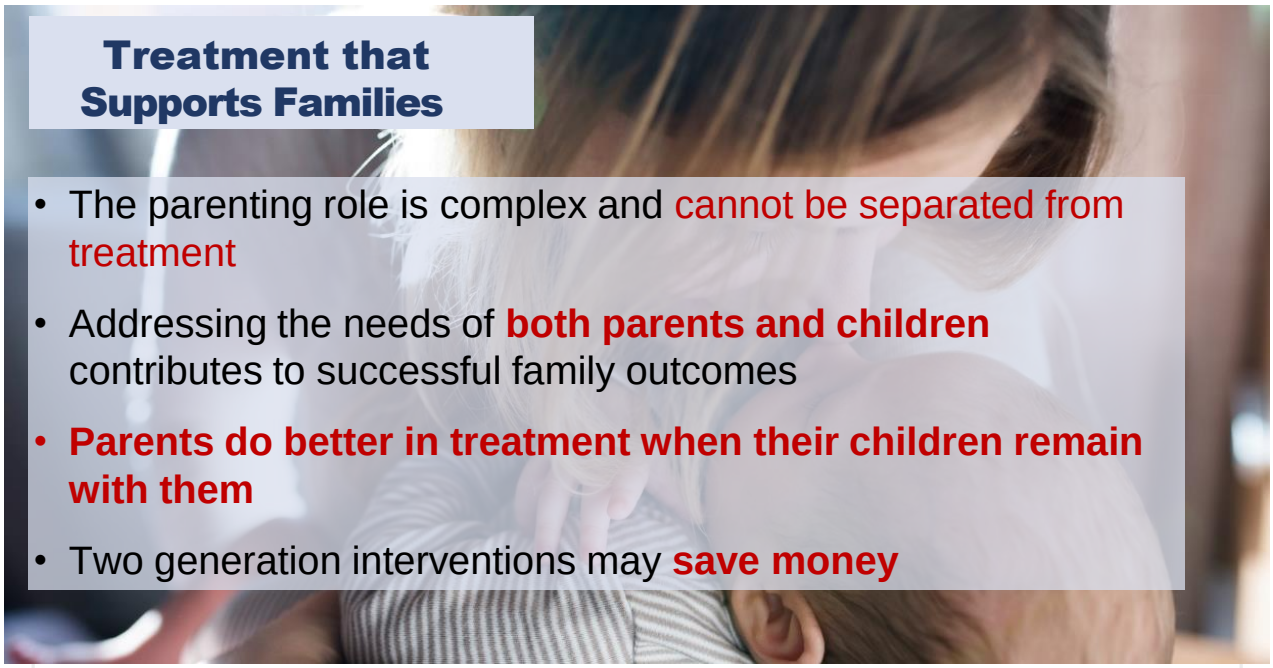
- While opioids have a strong effect on short-term withdrawal symptoms, other substances such as alcohol, cocaine, marijuana and nicotine show more areas of effect on long-term outcomes.
- Prenatal exposure to alcohol has effects in 9 of 10 domains studied including short-term/birth outcomes and long-term outcomes.
- There are some substances and outcomes for which there is not consensus or not enough data to determine consensus.

(American Academy of Pediatrics, Behnke & Smith, 2013)



We Know What Works
• Family Centered Treatment
• Services to support the parent-child relationship and family recovery
• Cross-system collaboration


Continuum of Family-Based Services
Parent's Treatment With Family Involvement
Parent's Treatment With Children Present
Parent's and Children's Services
Family Services
Family-Centered Treatment
Services for parent(s) with substance use disorders. Treatment plan includes family issues, family involvement
Children accompany parent(s) to treatment. Children participate in child care but receive no therapeutic services. Only parent(s) have treatment plans
Children accompany parent(s) to treatment. Parent(s) and attending children have treatment plans and receive appropriate services.
Children accompany parent(s) to treatment; parent(s) and children have treatment plans. Some services provided to other family members
Each family member has a treatment plan and receives individual and family services.
Goal: improved outcomes for parent(s)
Goal: improved outcomes for parent(s)
Goals: improved outcomes for parent(s) and children, better parenting
Goals: improved outcomes for parent(s) and children, better parenting
Goals: improved outcomes for parent(s), children, and other family members; better parenting and family functioning



National Center on Substance Abuse and Child Welfare. (2017). Understanding Substance Use Disorder Treatment in Your Community: A Discussion Guide for Child Welfare and Court Professionals to Identify the Best Treatment Fit For Families. *Substance Abuse and Mental Health Services*

Peer Recovery Support Matters

A Randomized Control Trial of Recovery Coaches in Child Welfare
Cook County, IL (n=3440)

Comprehensive Screening & Assessment + **Early Access to Treatment** ≠ **Consistently High Reunification Rate**

(Ryan et al., 2017)

Peer Recovery Support Matters

A Randomized Control Trial – Cook County, IL (n=3440)

Comprehensive Screening & Assessment + Early Access to Treatment +

= 31% increase in reunification

(Ryan et al., 2017)

Medication Assisted Treatment

As part of a comprehensive treatment program, MAT has been shown to:

- Increase retention in treatment
- Decrease illicit opioid use
- Decrease criminal activities, re-arrest and re-incarceration
- Decrease drug-related HIV risk behavior
- Decrease pregnancy related complications
- Reduce maternal craving and fetal exposure to illicit drugs

(Fullerton et al., 2014; The American College of Obstetricians and Gynecologists, 2012; Dolan et al., 2005; Gordon et al., 2008; Havnes et al., 2012; Kinlock et al., 2008)

NONFATAL OPIOID OVERDOSE AND ASSOCIATION WITH MORTALITY: A COHORT STUDY

Of **17,500** Adults who suffered **Non-Fatal Overdoses** (Boston, 2012-2014):

In the year after their overdose, only **30% received any of the 3 FDA approved medications** for addiction treatment (Methadone, Buprenorphine, Naltrexone)

Death rates of those who received medication **were about half the rates of those who did not receive medication**

Fewer than 40% of US treatment facilities offer any FDA approved medication

Larochelle MR, Bernson D, Land T, Stopka TJ, Wang N, Xuan Z, et al. Medication for Opioid Use Disorder After Nonfatal Opioid Overdose and Association With Mortality: A Cohort Study. Ann Intern Med. [Epub ahead of print 19 June 2018] doi: 10.7326/M17-3107

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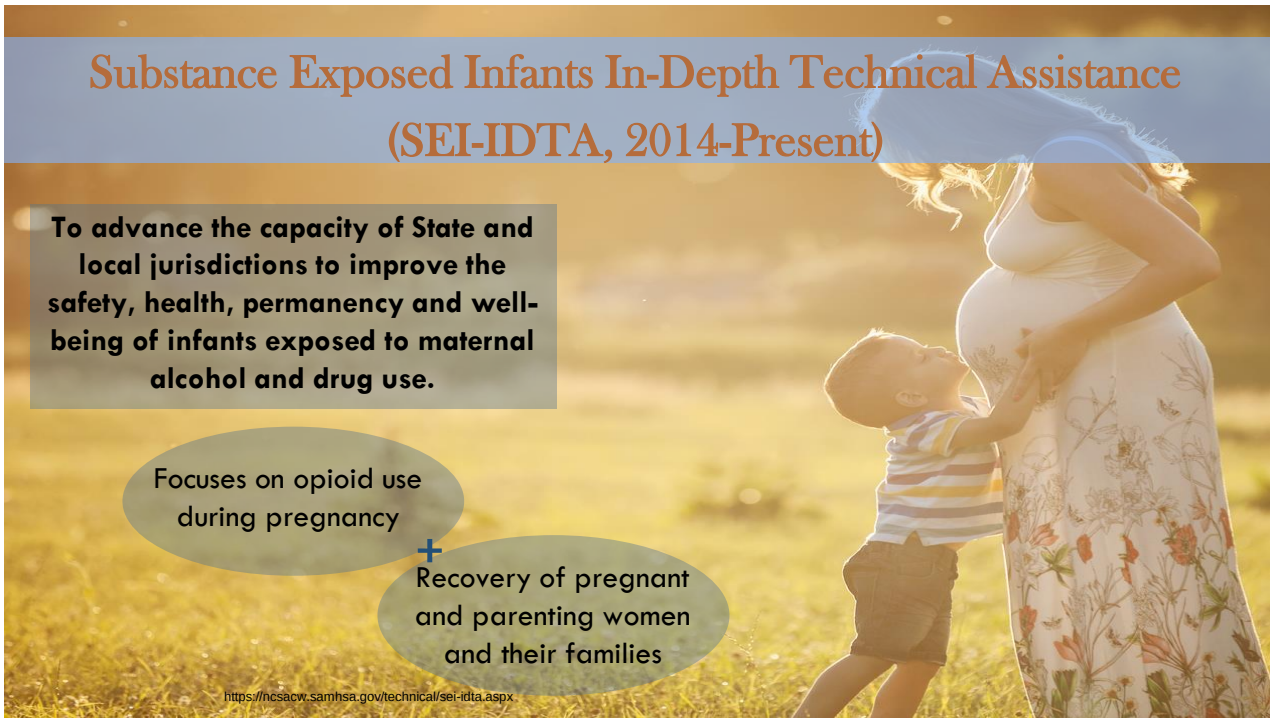
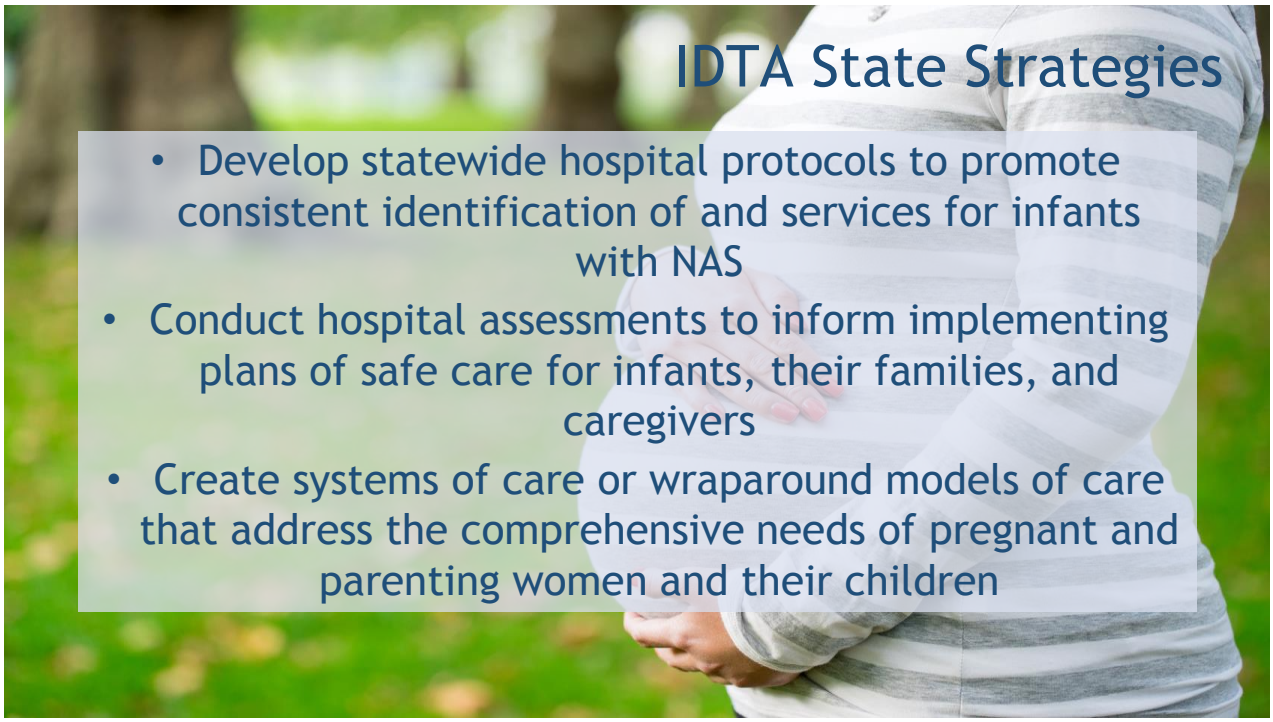
The Necessity of Collaboration

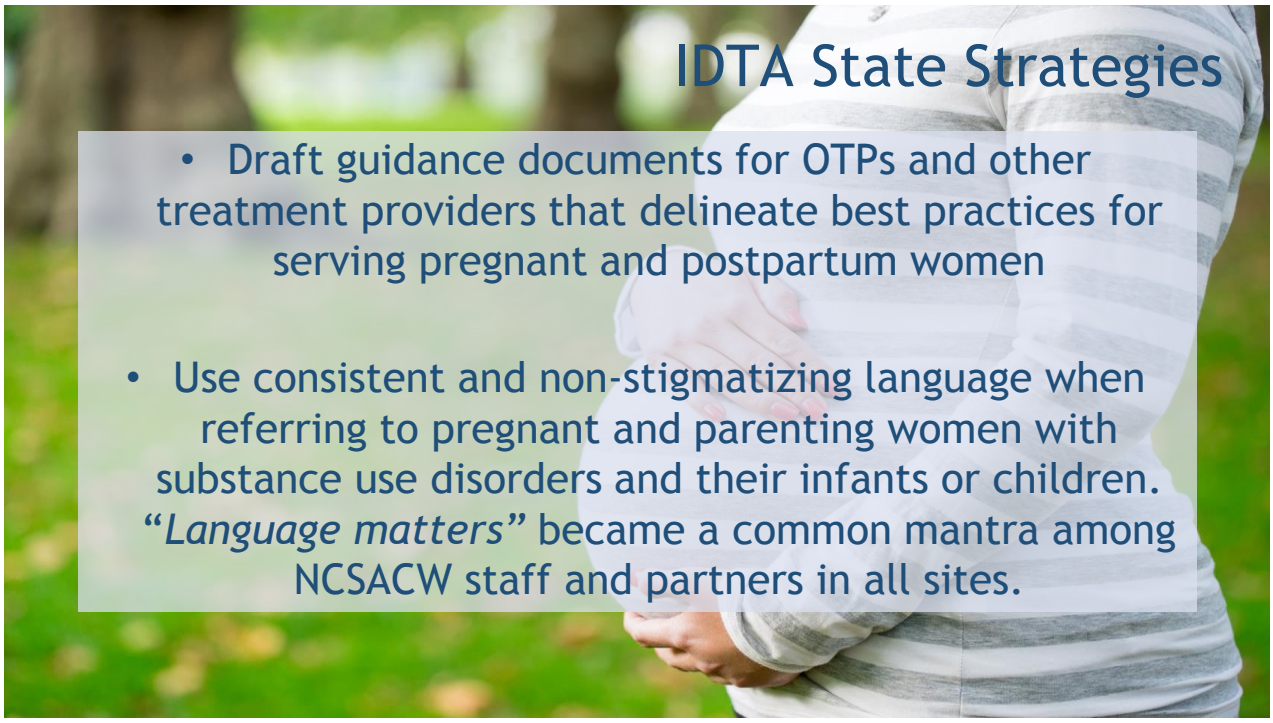
- **Multi-generational problems** can only be addressed through a coordinated approach across multiple systems
- Collaboration across systems that includes agreement on **common values**, enhanced communication and information sharing, **blended and braided funding** and **data collection** for **shared outcomes**…
- …results in improved outcomes for families:

Increased treatment engagement and retention	Fewer children removed	Increased family reunification	Fewer children reentering to the system

(Boles, et al., 2012; Dennis, et al., 2015; Drabble, 2010)


Substance Exposed Infants In-Depth Technical Assistance
(SEI-IDTA, 2014-Present)
To advance the capacity of State and local jurisdictions to improve the safety, health, permanency and well-being of infants exposed to maternal alcohol and drug use.
Focuses on opioid use during pregnancy
+
Recovery of pregnant and parenting women and their families
https://ncsacw.samhsa.gov/technical/sei-idta.aspx


IDTA State Strategies
• Develop statewide hospital protocols to promote consistent identification of and services for infants with NAS
• Conduct hospital assessments to inform implementing plans of safe care for infants, their families, and caregivers
• Create systems of care or wraparound models of care that address the comprehensive needs of pregnant and parenting women and their children


IDTA State Strategies
• Draft guidance documents for OTPs and other treatment providers that delineate best practices for serving pregnant and postpartum women
• Use consistent and non-stigmatizing language when referring to pregnant and parenting women with substance use disorders and their infants or children. "*Language matters*" became a common mantra among NCSACW staff and partners in all sites.

IDTA State Strategies
• Provide outreach and engagement in tribal communities of American Indian women in prenatal care and the development of treatment models that do not conflict with tribal beliefs
• Develop state policies and procedures for hospital notifications of infants and the development of a Plan of Safe Care model

Medications used to Treat Opioid Use Disorders

- **Methadone** (50 year research base)
- **Buprenorphine** (Subutex; 2010- MOTHER Study)

} **Used During Pregnancy**

- **Buprenorphine-Naloxone Combination** (Suboxone®; Zubsolv)
- **Naltrexone Extended-Release** (Vivitrol®) – Once per Month injection
- **Naloxone** (Narcan®) – Reverses overdose

"…opiate dependence is a medical disorder and … pharmacologic agents are effective in its treatment."

(NIH, 2017; Jones et al., 2012)

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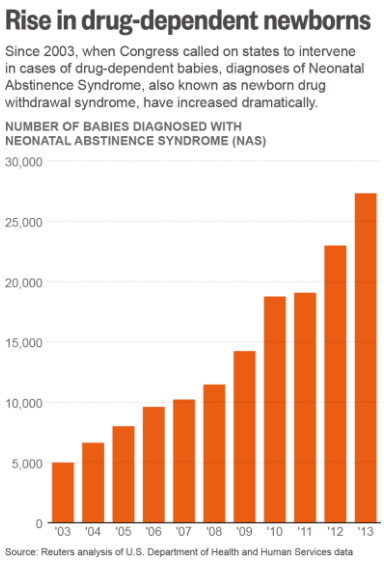
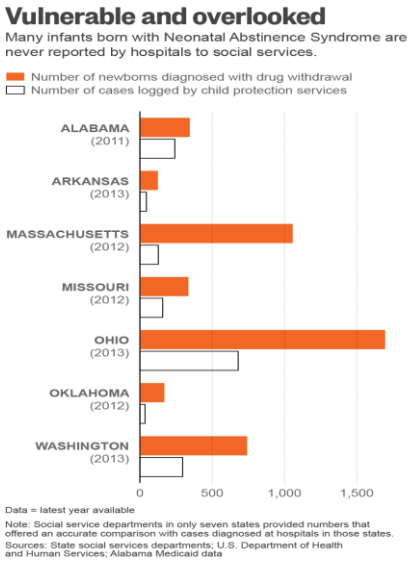
Duff Wilson & John Shiffman
Helpless and Hooked, December 2015, Reuters

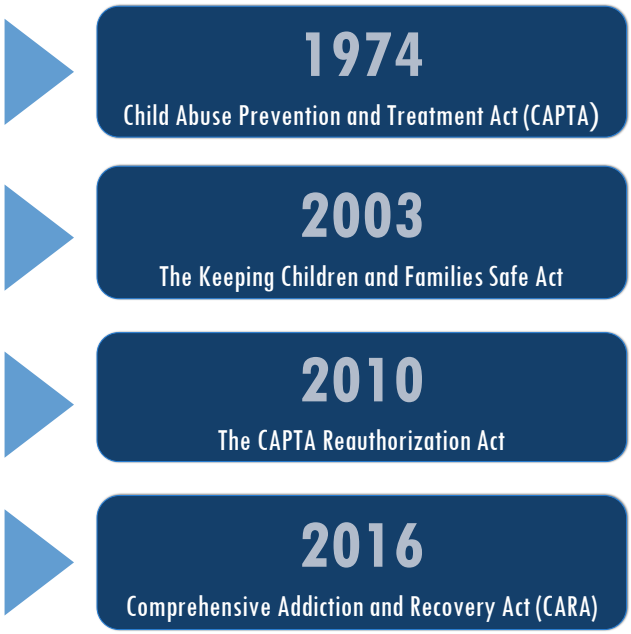




Most states ignore 2003 federal law

"A lot of officials – nurses, social workers – say, 'We don't report when the mother is trying to get better.' I always come back and say, 'Well, it's not about the mother. What about the baby?'"

"There's no doubt this baby was at risk, and the mother had already been on drugs. I don't know what transpired at the hospital."



Primary Changes in **CAPTA** Related to Infants with Prenatal Substance Exposure

Important to note that Tribes don't participate in the CAPTA grant thus do not make assurances regarding programs and policies

2016 Comprehensive Addiction and Recovery Act (CARA)

- Further clarified population requiring a Plan of Safe Care:

> "Born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder," specifically removing "illegal"

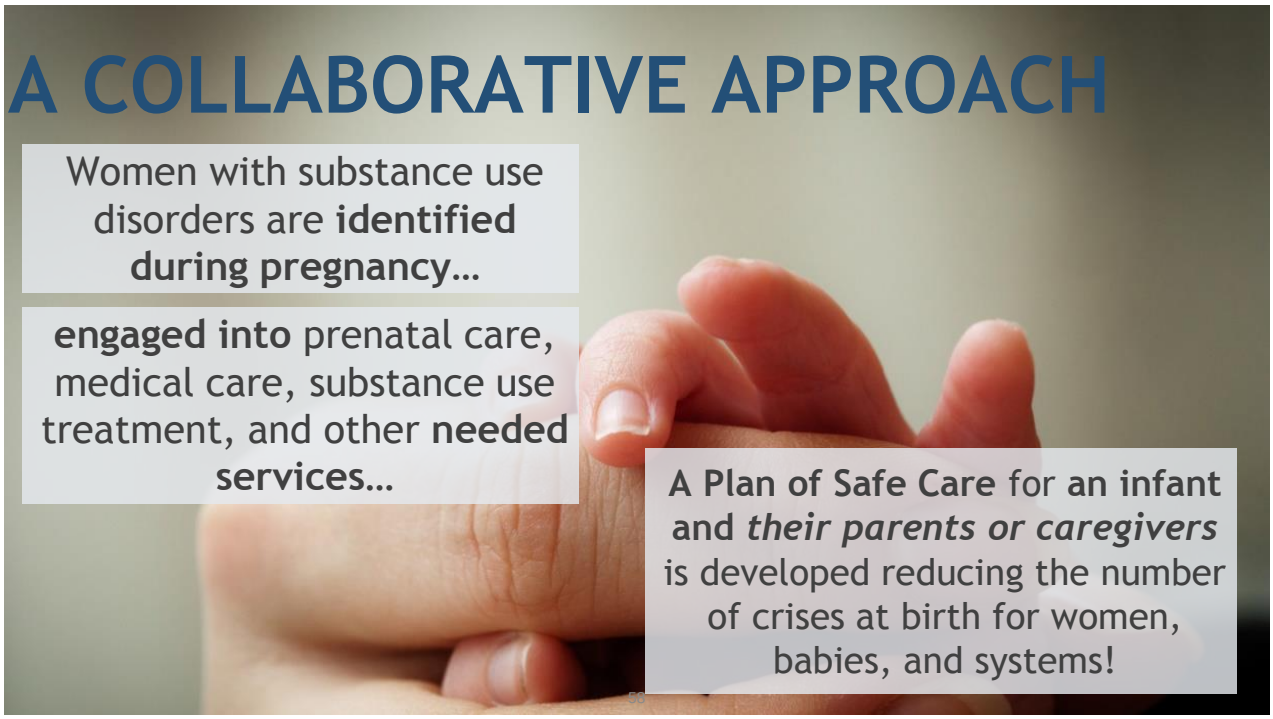
- Required the Plan of Safe Care to include needs of both the infant and family/caregiver:

> "the **development of a Plan of Safe Care** for the infant born and identified as being affected by substance abuse or withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder to ensure the safety and well-being of such infant following release from the care of healthcare providers, including through –
> (I) **addressing the health and substance use disorder treatment needs of the infant and affected family/caregiver**'"

2016 Comprehensive Addiction and Recovery Act (CARA)

- **Specified data reported by States**, to the extent practicable, through National Child Abuse and Neglect Data System (NCANDS)
  - The number of infants identified as being affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or Fetal Alcohol Spectrum Disorder
  - The number of infants for whom a Plan of Safe Care was developed
  - The number of infants for whom referrals were made for appropriate services—including services for the affected family or caregiver

- Specified **increased monitoring and oversight**
  - Children's Bureau through the annual CAPTA report in the State plan
  - States to ensure that Plans of Safe Care are implemented and that families have referrals to and delivery of appropriate services



Three Potential Populations

1. Using legal or illegal drugs, on an opioid medication for chronic pain or on medication (e.g., benzodiazepines) that can result in a withdrawal syndrome and **does not have a substance use disorder**
2. Receiving medication assisted treatment for an opioid use disorder (Buprenorphine or Methadone) or is **actively engaged in treatment** for a substance use disorder
3. **Misusing** prescription drugs, or is using legal or illegal drugs, **meets criteria for a substance use disorder,** not actively engaged in a treatment program

Domains that might be in a Plan of Safe Care

- Primary, Obstetric and Gynecological Care
- Substance Use and Mental Health Disorder Prevention and Treatment
- Parenting and Family Support
- Infant Health and Safety
- Infant and Child Development

No one template fits the needs of all communities, settings or families

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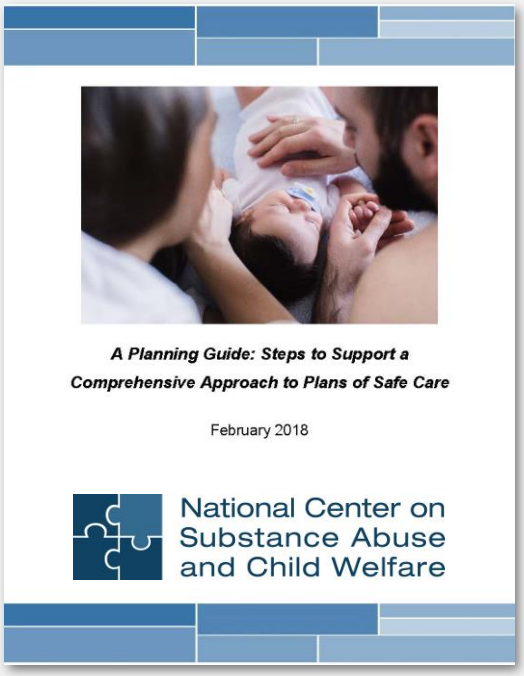
Plans of Safe Care benefit from being…

- *Interdisciplinary* across health and social service agencies
- Based on the results of a *comprehensive, multidisciplinary assessment*
- *Family focused* to meet the needs of each family member as well as overall family functioning and well-being
- Completed, when possible, in the prenatal period to facilitate *early engagement* of parent(s) and communication among providers
- *Easily accessible* to relevant agencies
- Grounded in *evidence-informed practices*

Preparing for baby's safe arrival and beyond



PLAN OF SAFE CARE PLANNING GUIDE TA TOOL (2018)

Designed as a planning guide that NCSACW can assist with to further your communities' efforts in developing a comprehensive approach to implementing Plans of Safe Care

ncsacw@cffutures.org

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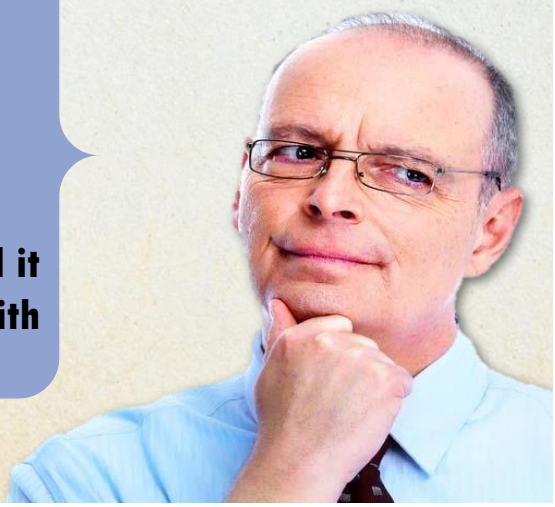
Questions to Ask

- **Has your state rolled out a POSC? For which infants?**
- **Is the POSC used as a collaborative tool? Who is involved?**
- **Is a prenatal POSC used in your community? How could it support pregnant women with SUDs?**



2018/19 Opportunities

- Comprehensive Addiction and Recovery Act (CARA) 2016 amended the Child Abuse Prevention and Treatment Act (CAPTA)
  - Modified Plans of Safe Care Requirements
  - Omnibus Budget Act 2018
- Family First Prevention Services Act (FFPSA)

Appropriated for Fiscal Year 2018

Omnibus Budget Act of 2018 Added Significant Funds to Address the Opioid Crisis in all three agencies that have a role with Families with Substance Use Disorders in Child Welfare or Family Treatment Courts

- Office of Justice Programs
  - Office of Juvenile Justice and Delinquency Prevention
- Administration on Children, Youth and Families
  - Children's Bureau
- Substance Abuse and Mental Health Services Administration
  - Center for Substance Abuse Treatment

Funds will be contracted by September 30, 2018

$60 million
CAPTA state grants to implement Plans of Safe Care

Just Appropriated

$40 million
Regional Partnership Grants
Kinship Navigator Programs

$40 million
ACF to provide substance abuse and mental health services to families in CWS

Funds will be contracted by September 30, 2018

$70 million
SAMHSA Drug Courts

Opportunities

$1 billion
Treatment funds to SAMHSA for states

35%
SAMHSA budget increase

WWW.SITE2MAX.PRO
Free PowerPoint & KeyNote Templates

$330 million to the **OFFICE OF JUSTICE PROGRAMS (OJP)** for comprehensive **opioid abuse reduction** activities, *including as authorized by CARA*:

$75 million for Drug Courts representing a 92% **increase**
$30 million Mental Health Courts & Adult and Juvenile Collaboration Program Grants Program
$30 million for Residential Substance Abuse treatment for State Prisoners Grants
$20 million Veterans Treatment Courts Program
$30 million Prescription Drug Monitoring Program
$145 million Comprehensive Opioid Abuse Program

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$282.5 million to the **OFFICE OF JUVENILE JUSTICE AND DELINQUENCY PROGRAMS (OJJDP)**

$60 million for Drug Abuse Education, Prevention, and Treatment Program Grants
$94 million Youth Mentoring Grants
$27.5 million for Delinquency Prevention Programs
$21 million for Victims of Child Abuse Programs
$76 million for Missing and Exploited Children Programs
$2 million for Judicial Child Abuse Training Programs
$2 million for Program to Improve Juvenile Indigent Defense

$5 million Tribal Youth Programs
$4 million for gang and youth violence education, prevention and intervention
$500 thousand for Children of Incarcerated Parents information and resources website
$2 million competitive grants focusing on girls in juvenile justice system
$8 million for community-based violence prevention initiatives
$8 million for opioid affected youth initiative

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$140 million

to CHILDREN'S BUREAU & ADMINISTRATION ON CHILDREN, YOUTH AND FAMILIES (ACYF)

$60 million for Child Abuse Prevention and Treatment Act with an emphasis on Infants with Prenatal Exposure and Plans of Safe Care

- 2018 Bill passed out of HELP Committee to continue this funding level for five years specific to implementing Plans of Safe Care

$20 million Regional Partnership Grants*

- Announced April 2018, forecast for 10 grants up to $1.9 Million for 3 years

$20 million Kinship Navigator Programs

$40 million Substance Abuse and Mental Health Treatment for Families in Child Welfare Services

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Over $1.6 Billion

to SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

$1 Billion for Substance Abuse Treatment

$84 million for Medication-Assisted Treatment

$53.8 million for the National Child Traumatic Stress Network

$30 million for Screening, Brief Intervention, Referral and Treatment (SBIRT)

$29.9 million for pregnant and post-partum women

$8.7 million for Opioid Treatment Programs/Regulatory Activities

$5 million for Building Communities of Recovery

$2.4 million for Recovery Community Services Program

$1.9 million for disaster response

$1 million for Improving Access to Overdose Treatment

70

Considerations as you attend workshops:

- What should your data dashboard include?
- How are POSCs being implemented in your community?
- How can new funds be used to support family-centered care?
- What opportunities exist for local collaboratives to implement cross-system solutions that work for families?

National Center on Substance Abuse and Child Welfare

Children and Family Futures
Strengthening Partnerships, Improving Family Outcomes

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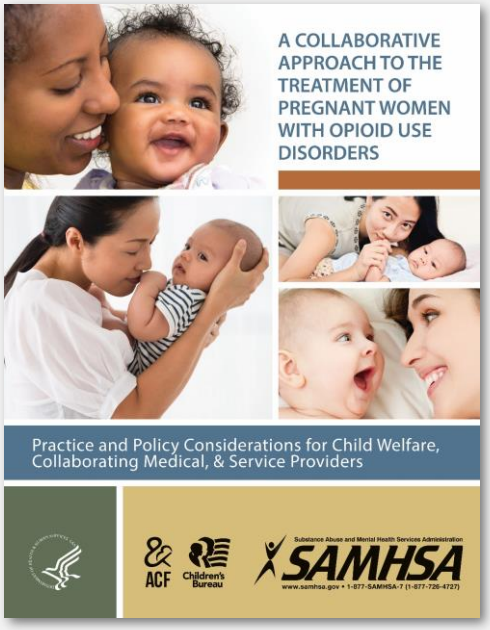


Purpose: Support the efforts of States, Tribes and local communities in addressing the needs of pregnant women with opioid use disorders and their infants and families

Audience

- Child Welfare
- Substance Use Treatment
- Medication Assisted Treatment Providers
- OB/GYN
- Pediatricians
- Neonatologists

National Workgroup

- 40 professionals across disciplines
- Provided promising and best practices; input and feedback over 24 months

Available for download here: https://www.ncsacw.samhsa.gov/files/Collaborative_Approach_508.pdf

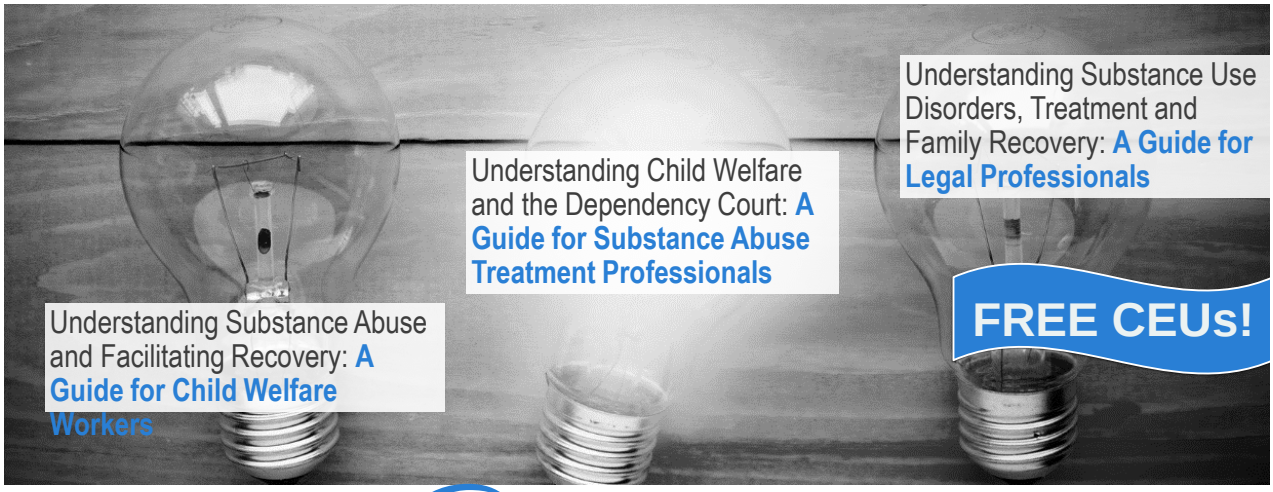
NCSACW Resources

- Publications
- Online Resource Inventory
- Webinars
- Online Tutorials
- Toolkits
- Video

Please visit:

http://www.ncsacw.samhsa.gov/

NCSACW Online Tutorials Cross-Systems Learning



www.ncsacw.samhsa.gov/.org

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Resources To Help Address The Opioid Crisis

For Families Involved in the Child Welfare System

In-Depth Technical Assistance

https://ncsacw.samhsa.gov/technical/sei-idta.aspx

- 18 months of technical assistance to strengthen collaboration and linkages across systems focused on infants with prenatal substance exposure
- 11 sites: Connecticut, Delaware, Florida, Kentucky, Maryland, Minnesota, New Jersey, New York, North Carolina, Virginia, West Virginia

Web-based Resource Directory

https://ncsacw.samhsa.gov/resources/videos-and-webinars/webinars.aspx

- Includes research, training materials, webinars and videos, site examples and other resources
- Topics include medication-assisted treatment, neonatal abstinence syndrome, infants with prenatal substance exposure, and supporting families with opioid use disorders

Technical Assistance : Developing a Comprehensive Approach to Plans of Safe Care

- Identifying planning steps for developing a comprehensive approach to Plans of Safe Care
- Questions to engage partners in considering a communities Plan of Safe Care approach
- Examples of state and local legislation, policies and templates

ncsacw@cffutures.org I 1-866-493-2758 I https://ncsacw.samhsa.gov/

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National Center on Substance Abuse and Child Welfare

Children and Family Futures
Strengthening Partnerships, Improving Family Outcomes

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State Strategies for Ensuring Access to Continuous Care for Women with Substance Use Disorder

9:30AM – 10:45AM

Moderator
Donna Bradbury
Associate Commissioner
Division of Integrated Community Services for Children & Families, New York State Office of Mental Health

Speaker
Kimberly Early
Policy Director
Pennsylvania Department of Health

Speaker
Ashley Harrell
Senior Program Advisor, Behavioral Health
Virginia Department of Medical Assistance Services

Speaker
Amy Cooper
Women's Services Coordinator
Colorado Department of Human Services Office of Behavioral Health

VIRGINIA MEDICAID ADDICTION RECOVERY AND TREATMENT SERVICES PROGRAM: INCREASING TREATMENT FOR WOMEN WITH SUBSTANCE USE DISORDER

ASHLEY HARRELL, MSW
SENIOR BEHAVIORAL HEALTH PROGRAM ADVISOR
VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Overview

- Medicaid Addiction and Recovery Treatment Services (ARTS) Program
  - Overview of ARTS benefit and 1115 waiver
  - Outcomes from ARTS after first year
  - Increases in Treatment for Pregnant Women with Substance Use Disorder
  - Lessons learned
- Medicaid Managed Care Innovations
- Virginia Neonatal Perinatal Collaborative

Virginia Medicaid Coverage of Substance Use Disorder Services before ARTS

Incomplete Care Continuum

Limited Coverage

- Residential treatment was not covered for non-pregnant adults. Utilizing more expensive inpatient detox.
- Fragmented System: Substance use disorder treatment was separated from mental and physical health services.
- Pregnant women lose eligibility and coverage for treatment 60 days after delivery.

Lack of Providers

- Rates for substance use disorder treatment had not been increased since 2007.
- Providers were not reimbursed for the actual cost of providing care.
- System severely limited the number of providers willing to provide services to Medicaid members.
- Providers struggled to understand who to bill for services. Consumers did not know where to seek services.

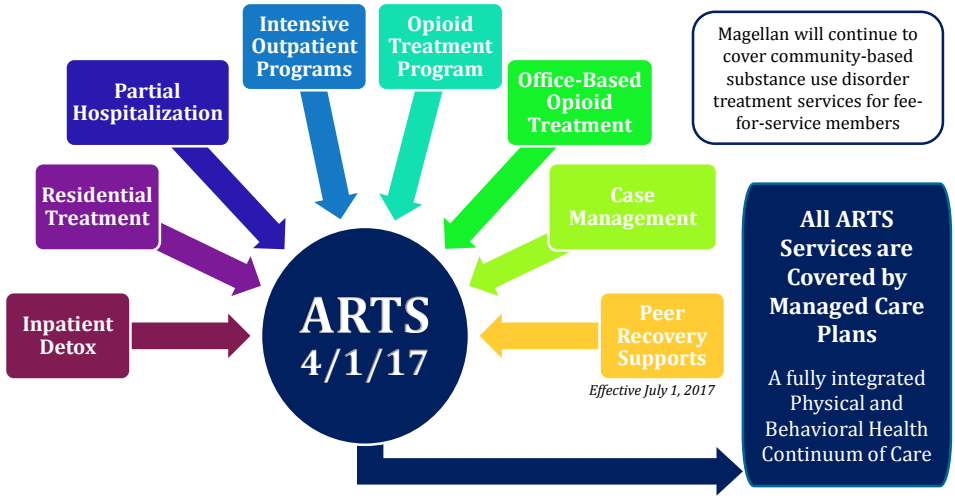
Limited Access to Services

Addiction and Recovery Treatment Services (ARTS) Benefit

Changes to Virginia Medicaid Substance Use Disorder (SUD) Benefit approved in Spring 2016 with Bipartisan Support

1. Expand short-term SUD inpatient detox to all Medicaid /FAMIS members
2. Expand short-term SUD residential treatment to all Medicaid members
3. Increase reimbursement for existing Medicaid/FAMIS SUD treatment services
4. Add Peer Support services for individuals with SUD and/or mental health conditions
5. Require SUD Care Coordinators at DMAS contracted Managed Care Plans
6. Organize Provider Education, Training, and Recruitment Activities

ARTS Program: Transforming the Delivery System of Medicaid SUD Services



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SUD Transformation 1115 Demonstration Waiver

Approved by CMS in December 2016

- Allows Virginia to draw down federal matching $ for IMDs – SUD residential treatment facilities > 16 beds
- Resulted in significant increase in number and size of SUD residential treatment facilities
- Requires Virginia to implement national American Society of Addiction Medicine (ASAM) to create evidence-based continuum of addiction treatment
- Requires robust independent waiver evaluation – partnering with Virginia Commonwealth University

6

ARTS Preferred Office-Based Opioid Treatment Providers

Required Core Team Members

- Member
- Buprenorphine-waivered practitioner (physician, NP or PA)
- Licensed credentialed addiction treatment professionals (e.g., LCSW, LPC, licensed clinical psychologist, etc.)
- Nurse

Optional Team Members

- Pharmacists
- Peer Recovery Specialists
- Substance Use Care Coordination
  - This can be designated team member whose only function is to perform care coordination or a team member such as the nurse or LCSW who performs dual roles in the clinic.

7 DMAS

Increases in Addiction Providers Due to ARTS

Over 350 new Addiction Treatment Provider Organizations in Medicaid

Addiction Provider Type	# of Providers before ARTS	# of Providers after ARTS	% Increase in Providers
Inpatient Detox (ASAM 4.0)	Unknown	103	NEW
Residential Treatment (ASAM 3.1, 3.3, 3.5, 3.7)	4	78	↑ 1850%
Partial Hospitalization Program (ASAM 2.5)	0	13	NEW
Intensive Outpatient Program (ASAM 2.1)	49	72	↑ 47%
Opioid Treatment Program	6	29	↑ 383%
Office-Based Opioid Treatment Provider	0	79	NEW

8 DMAS

VCU Evaluation: Outcomes From First Year of ARTS

Increase in total number of Substance Use Disorder Outpatient Providers

		Before ARTS (Apr 2016-Mar 2017)	After ARTS (Apr 2017-Mar 2018)	% Change
	Total number of SUD Outpatient Providers	1,087	2,965	↑173%
By Provider Type	Physicians	261	1,571	↑502%
	NP	25	188	↑652%
	Counselors and SW	300	457	↑52%
	Other	501	749	↑50%

VCU Evaluation: Outcomes From First Year of ARTS

Increase in total number of Opioid Use Disorder Outpatient Providers

		Before ARTS (Apr 2016-Mar 2017)	After ARTS (Apr 2017-Mar 2018)	% Change
	Total number of OUD Outpatient Providers	570	1,352	↑137%
By Provider Type	Physicians	128	586	↑358%
	NP	13	66	↑408%
	Counselors and SW	142	236	↑66%
	Other	287	464	↑62%

Supported by the Health Resources and Services Administration

VCU Evaluation: Outcomes From First Year of ARTS

More members are receiving treatment for all Substance Use Disorders (SUD) and Opioid Use Disorder (OUD)

	Before ARTS (Apr 2016-Mar 2017)	**After ARTS** (Apr 2017-Mar 2018)	% Change
Members with SUD receiving treatment	15,703	24,615	↑ 57%
Members with OUD receiving treatment	10,092	14,917	↑ 48%

VCU Evaluation: Outcomes From First Nine Months of ARTS

Decrease in total number of prescriptions and members with prescriptions for Opioid pain medications

	Before ARTS (Apr 2016-Mar 2017)	**After ARTS** (Apr 2017-Mar 2018)	% Change
Total number of prescriptions for opioid pain medication	549,442	399,678	↓ 27%
Number of prescriptions per 10,000 members	3,811	2,761	↓ 28%

VCU Evaluation: Outcomes From First Ten Months of ARTS

Fewer Emergency Department visits related to Substance Use Disorder (SUD) and Opioid Use Disorder (SUD)

	Before ARTS (Apr 2016-Jan 2017)	**After ARTS** (Apr 2017-Jan 2018)	% Change
ED Visits Related to SUD	24,962	21,445	↓ 14%
ED Visits Related to OUD	5,016	3,756	↓ 25%

VCU Evaluation: Outcomes From First Ten Months of ARTS

Fewer inpatient hospitalizations related to Substance Use Disorder (SUD) and Opioid Use Disorder (SUD)

	Before ARTS (Apr 2016-Jan 2017)	**After ARTS** (Apr 2017-Jan 2018)	% Change
Hospitalizations Related to SUD	13,182	12,650	↓ 4%
Hospitalizations Related to OUD	3,520	3,315	↓ 6%

VCU Evaluation: Outcomes for Pregnant Women

Increase in pregnant members with Substance Use Disorder receiving treatment

	Before ARTS Apr, 2016 - Mar, 2017	After ARTS Apr, 2017 - Mar, 2018	Percent Change
Total number of pregnant members with a substance use disorder (SUD)	2,993	3,188	7%
Pregnant members with SUD receiving any SUD treatment	**62**	**575**	**827%**
Percent receiving treatment	2%	18%	780%

VCU Evaluation: Outcomes for Pregnant Women

Increase in pregnant members with Opioid Use Disorder receiving treatment

	Before ARTS Apr, 2016 - Mar, 2017	After ARTS Apr, 2017 - Mar, 2018	Percent Change
Total number of pregnant members with an opioid use disorder (OUD)	1,028	1,056	3%
Pregnant members with OUD receiving any OUD treatment	42	262	524%
Percent receiving OUD treatment	4%	25%	507%

Why ARTS is Achieving These Outcomes

Critical Elements for Successful ARTS Implementation

- Intensive stakeholder engagement – collaborated with MCOs, state agencies, and providers to design and implement ARTS
- System transformation using national ASAM criteria
- Increased reimbursement for evidence-based treatment
- Innovative delivery models for Medication Assisted Treatment – Preferred Office-Based Opioid Treatment providers
- Implementation of CDC Opioid Prescribing Guidelines with MCOs
- Collaboration with other state agencies
  - *Department of Health*: trained over 850 providers in Addiction Disease Management and launched Project ECHO for providers
  - *Department of Behavioral Health*: trained over 400 providers in ASAM; and trained over 1,000 Peer Recovery Support Specialists
  - *Department of Health Professions*: Boards of Medicine, Nursing, and Dentistry implemented opioid regulations based on CDC guidelines

Leveraging Medicaid Managed Care

Medicaid Managed Care RFP and Contracts

- In recent RFP for Medallion 4.0 program, Medicaid Managed Care plans were required to propose:
  - Innovations to increase access to treatment for pregnant women with Substance Use Disorder
  - Innovations to improve outcomes for Substance-Exposed Infants including infants with Neonatal Abstinence Syndrome

Leveraging Medicaid Managed Care

Magellan Complete Care of Florida Mother Baby Connections

- Obstetrics Integrated Care Case Management (OB-ICCM)
  - Specialized, intensive intervention for pregnant moms with SMI and SUD
  - Addresses the increased risk of perinatal complications for mother and infant
  - Promotes medication assisted treatment for opioid use disorder
  - Promotes psychiatric treatment adherence for SMI
  - Acknowledges longer post-partum follow up needs
- Role of OB Integrated Case Manager
  - RNs or Masters-level professionals who provide intensive case management through pregnancy and up to 8 weeks post-partum
  - Assists with coordination of care, working closely with the enrollee's OB, often in consultation with a perinatologist, primary behavioral health specialist, and the local addiction medicine specialist at the treatment program for opioid addiction
  - Coordinates complex care arrangements and connect members to services
  - Supports and empowers members and caregivers to effectively manage their ongoing conditions, adhere to treatment and medication, adopt a healthy lifestyle

Virginia Neonatal Perinatal Collaborative (VNPC)

Implementation of SAMHSA Maternal Opioid Bundle

- Team of expert clinicians providing technical assistance and education to support hospitals in implementation of SAMHSA AIM bundle for Obstetric Care for Women with Opioid Use Disorder
- Identifying resources for care in the community and help hospital system identify services that are lacking
- Exploring use of Virginia Department of Health led Project ECHO to support implementation by multiple hospitals simultaneously

Resources

DMAS ARTS website:
http://www.dmas.virginia.gov/#/arts

Please email questions regarding the ARTS program to
sud@dmas.virginia.gov

Pennsylvania Strategies to Meet the Needs of Families Affected by Substance Use Disorder

Kimberly Early
Director, Office of Policy

August 15, 2018

Pennsylvania's Strategy

Fighting the Opioid Epidemic

- Prevention
- Rescue
- Treatment

Opioid Data Dashboard

Supported by the Health Resources and Services Administration

Prevention

- Prescription Drug Monitoring Program
- Drug Take-Back Boxes
- Opioid Stewardship
- Prescribing Guidelines
- Medical Student Education
- Medical Provider Training
- Get Help Now PSA

Rescue

- Issued a standing order prescription for Naloxone for first responders and the general public.
- Expanded first responder access to Naloxone.

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Treatment

- Medicaid Expansion
- Centers of Excellence
- PA Get Help Now Helpline
- PA Coordinated Medication Assisted Treatment

Pennsylvania's Strategy

- Centers of Excellence
- 21st Century Cures Grant
- Disaster Declaration

- Neonatal Abstinence Syndrome
  - Epi-Aid
  - CAPTA

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Strategies for Pregnant Women

- Recovery Home Model
- Opioid Prescribing Guidelines

pennsylvania
DEPARTMENT OF HEALTH

Services to Pregnant and Postpartum Women

- The model includes the delivery of the following services directly or in collaboration with other health care, SUD, and community partners:
  - Obstetrical services and prenatal/perinatal/postpartum care
  - Medication assisted treatment
  - Behavioral health/SUD counseling

Services to Pregnant and Postpartum Women

- Case management services, including coordination of prenatal and pediatric care
- Recovery support services
- Active follow-up with program participants

Centers of Excellence

- Seven COEs provide services to pregnant and parenting women:
  - Family First Health
  - Magee-Women's Hospital of UPMC
  - Penn Presbyterian Medical Center

Centers of Excellence

- Reading Hospital and Health System
- Temple University Hospital
- Thomas Jefferson University Maternal Addiction, Treatment, Education, and Research
- Wedge Recovery Centers

Task Force

- Safe and Effective Prescribing Practices Task Force
  - Convened by the Department of Health and the Department of Drug and Alcohol Programs.
- Membership - state agencies, medical associations, provider advocates and community members.

Task Force

- Guidelines for 11 medical specialties on the safe and effective use of opioids in the treatment of pain.
- Process to develop and adopt the guidelines.

Opioid Prescribing Guidelines

- Treating Chronic Non-Cancer Pain
- Emergency Department Pain Treatment Guidelines
- Opioids in Dental Practice
- Opioid Dispensing Guidelines
- Obstetrics & Gynecology Opioid Prescribing Guidelines
- Geriatric Pain
- Use of Addiction Treatment Medications in Treatment of Pregnant Patients with OUD
- Safe Prescribing Benzodiazepines for Acute Treatment of Anxiety & Insomnia
- Safe Prescribing of Opioids in Orthopedics and Sports Medicine
- Safe Prescribing of Opioids in Pediatric and Adolescent Populations
- Safe Prescribing for Workers' Compensation

Pregnant Patients

- Use of Addiction Treatment Medications in the Treatment of Pregnant Patients with OUD.
- Address stabilization, treatment and recovery management for OUD during pregnancy.
- Based on ACOG, Federal Guidelines and other professional organizations directives.

Pregnant Patients

- Pregnant patients should be co-managed.
- During pregnancy, medication assisted treatment is the standard of care.

Pregnant Patients

- Guidelines
  - The use of methadone for the treatment of OUD in women who are pregnant.
  - The use of buprenorphine for the office-based treatment of OUD in women who are pregnant.
  - Guidelines for breastfeeding in mothers receiving methadone or buprenorphine.

Obstetrics and Gynecology

- Obstetrics and Gynecology Opioid Prescribing Guidelines.
- More than 140,000 women give birth in PA each year.
- Addresses the use of opioids for the treatment of pain in pregnant patients, during and immediately following delivery, and while breastfeeding.

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Obstetrics and Gynecology

- Guidelines
  - Patient screening for SUD.
  - Use of opioids for the treatment of pain in women of childbearing age.
  - Use of opioids for the treatment of pain during pregnancy.
  - Use of opioids for the treatment of pain during and following delivery.

Obstetrics and Gynecology

- Guidelines
  - Use of opioids for the treatment of pain in women who are breastfeeding.
  - Treatment of pain during pregnancy, labor and delivery, and postpartum in patients receiving medication-assisted treatment for OUD.

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Obstetrics and Gynecology

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Kimberly Early

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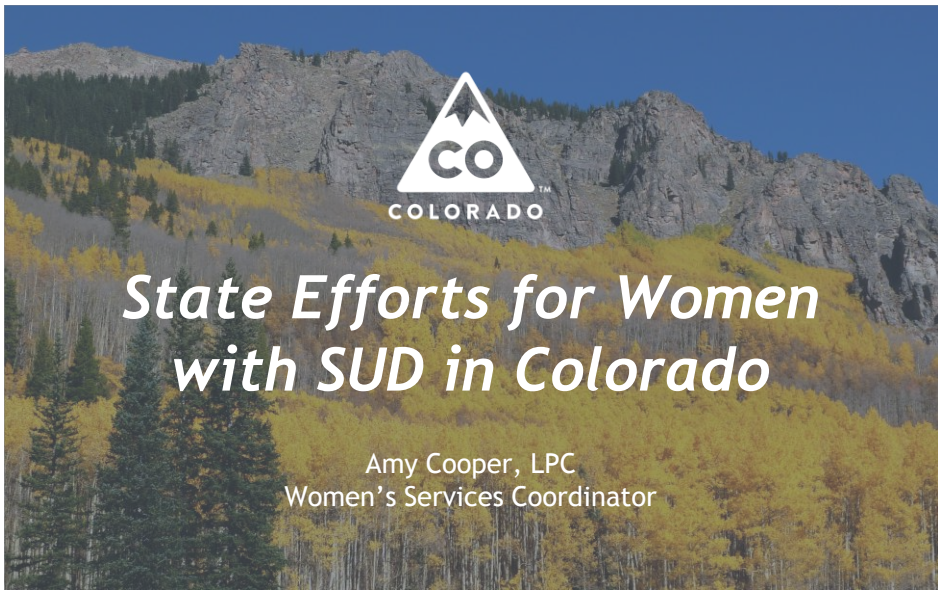

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Special Connections

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Department of Human Services

2

Special Connections

- Developed in 1992
- Combined effort between Medicaid and Colorado Department of Human Services
- Federal Waivered Program
- Measuring birth weight outcomes

Special Connections

- Mother's Connection Campaign: https://mothersconnection.com/

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Special Connections

- Program Challenges:
  - Eligibility limitations
  - Capacity

COLORADO 5

COLORADO

Peer Support Specialists/Navigators

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Peer Support Specialists/Navigators

- Current use of peers has been increased in Colorado
- Peers are used in recovery efforts in addition to outreach and treatment
- STR Grant money was used for training and certification costs

Peer Support Specialists/Navigators

- Women's services utilize peers to navigate systems (i.e. Childcare, TANF, sober housing, employment)
- Peers often help supplement Case Managers
- Sober living and community resources outside of state funded programs

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Women in the Criminal Justice System

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Women in the CJS

- Jail Based Behavioral Health Services (JBBS)
- Efforts to increase clinician access in county jails
- Improving efforts around MAT services for women and men in jails

Child Care for Women in SUD Treatment

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Child Care for Women in Tx

- CCAP Prioritization
- Mobile Licensed Childcare
- Multi-provider operated childcare center

State Data and Programmatic Strategies for Supporting Children Impacted by Substance Use Disorder

11:00AM – 12:15PM

Moderator
Donna Bradbury
Associate Commissioner
Division of Integrated Community Services for Children & Families, New York State Office of Mental Health

Speaker
Debra Bercuvitz
Perinatal Substance Use Coordinator
Massachusetts Department of Public Health

Speaker
Abby Shockley
Senior Policy Analyst, Substance Use Services
New Hampshire Department of Health and Human Services

Commonwealth of Massachusetts
Department of Public Health
Helping People Lead Healthy Lives In Healthy Communities

A Broader Look at Perinatal Opioid Use in Massachusetts: What Can We Learn from Public Data Sets And How Can We Use Data for Programmatic Decisions?

National Academy for State Health Policy 31st Annual State Health Policy Conference
August 15, 2018

Debra Bercuvitz, MPH
Massachusetts Department of Public Health

Commonwealth of Massachusetts
Department of Public Health
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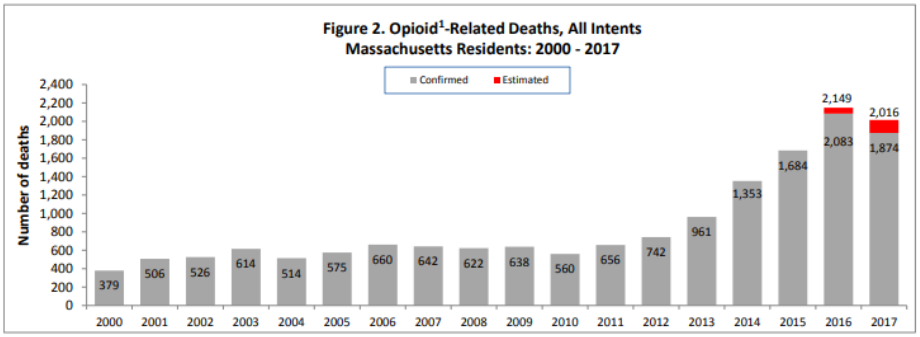
Where We Are Now



1 Opioids include heroin, opioid-based prescription painkillers, and other unspecified opioids.

Source: Data Brief: Opioid-Related Overdose Deaths Among Massachusetts Residents - May 2018
https://www.mass.gov/lists/current-opioid-statistics

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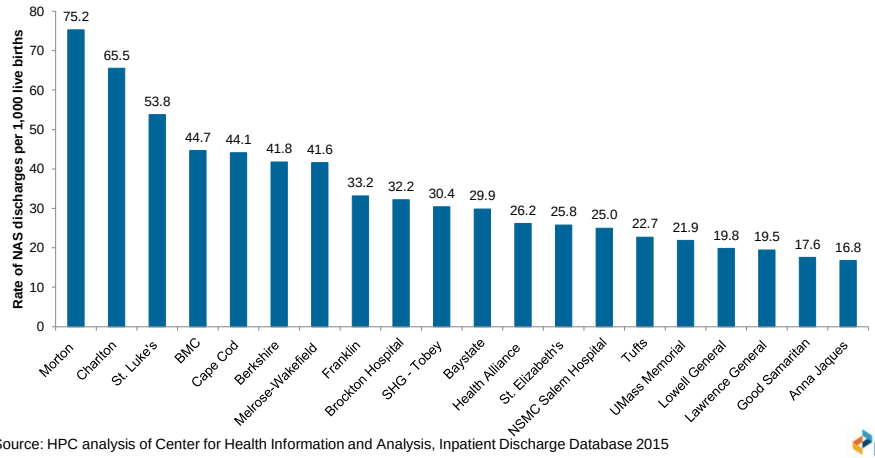
MA hospitals with highest rates of NAS in 2015



Source: HPC analysis of Center for Health Information and Analysis, Inpatient Discharge Database 2015

Notes: NAS discharges were identified using ICD-9-CM diagnosis code 779.5 (drug withdrawal syndrome in a newborn). Only includes hospitals with 12 or more NAS discharges.

HPC

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Legislative Facilitators of Cross-Agency Collaboration

- Chapter 55 Legislation to Study Opiate Overdoses
  - Provided the Legal Basis for Data Sharing
  - New "Chapter 237, Public Health Data Warehouse" legislation enables ongoing data sharing
- Interagency Task Force On Newborns With Neonatal Abstinence Syndrome
  - Provided Opportunity for Broad Input on Needs (multi methods data collection)
  - Impetus for NAS Dashboard

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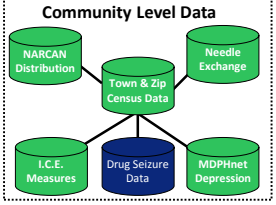
Chapter 55 Data Mapping

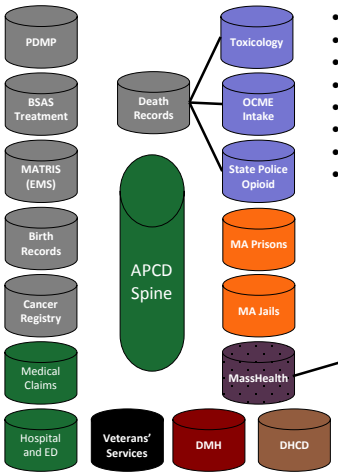
Data Sources

- Public Health
- Medical Claims & Hospital
- MassHealth
- Mental Health
- Public Safety
- Jails & Prisons
- Other Law Enforcement
- DHCD (Homelessness)
- Veterans' Services
- Service Flags
- Aggregate (Town, Zip, etc.)

Community Level Data



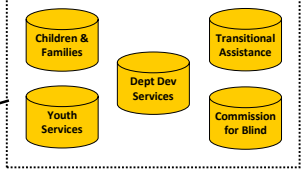
Chapter 55 Data Structure



System Attributes

- Linkage at individual level
- Longitudinal (5 year history)
- Data encrypted in transit & at rest
- Limited data sets unlinked at rest
- Linking and analytics "on the fly"
- No residual files after query completed
- Analysts can't see data
- Automatic cell suppression

Service Indicator Flags



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Chapter 55: Partners Coming Together

Academic

- Brandeis University
- Boston University
- Brown University
- Harvard Medical School
- Harvard School of Public Health
- Massachusetts College of Pharmacy and Health Sciences
- Massachusetts Institute of Technology
- Northeastern University
- Tufts University
- University of Massachusetts Amherst
- University of Massachusetts Boston
- University of Massachusetts Medical School

Hospitals & Private Industry

- Baystate Health
- Beth Israel Deaconess Medical Center
- Boston Medical Center
- Brigham & Women's Hospital
- Children's Hospital
- GE
- IBM
- Liberty Mutual
- Massachusetts General Hospital
- Massachusetts League of Community Health Centers
- McKinsey & Company
- The MITRE Corporation
- Partners Healthcare
- PwC
- Rand Corporation

State and Federal Government Agencies

- Boston Public Health Commission
- Center for Health Information and Analysis
- Department of Housing and Community Development
- Department of Mental Health
- Department of Correction
- Department of Public Health
- Executive Office of Health and Human Services
- Executive Office of Public Safety and Security
- Federal Bureau of Investigation
- High Intensity Drug Trafficking Area (NE)
- Health Policy Commission
- Massachusetts Sheriffs' Association
- MassIT
- Office of the Chief Medical Examiner
- State Auditor's Office

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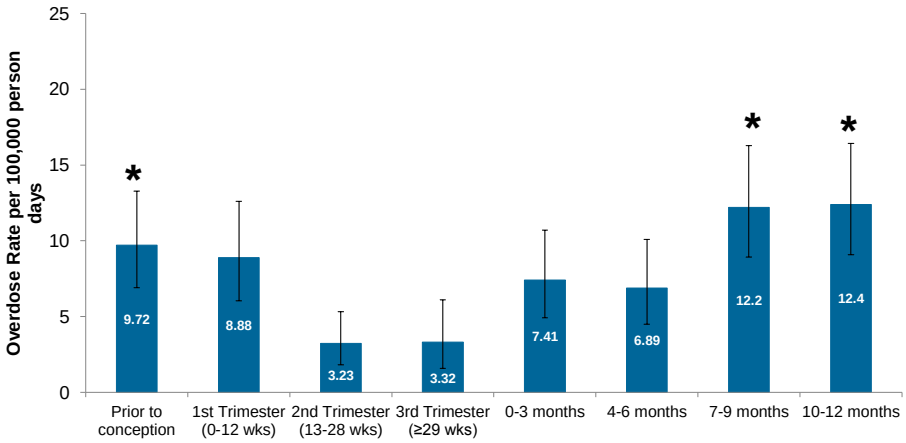
Perinatal Opioid Overdose Rates among Women with OUD in Year Prior to Delivery (n=4,154)



**Significantly different from 3rd Trimester, Error bars indicate 95% confidence intervals (Poisson)*

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Source: Schiff et al. Fatal and Nonfatal Overdose Among Pregnant and Postpartum Women in Massachusetts. Obstet Gynecol. 2018 Jul 10. Epub ahead of print

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Statewide "dashboard" of key metrics to monitor progress on aspects of care

Pre-pregnancy/Prenatal

- Perinatal opioid exposure incidence
- Maternal use of medication-assisted therapy
- Timeliness of Prenatal Visits GA at first prenatal visit, # of prenatal visits, prenatal care adequacy index
- Frequency of ongoing prenatal care
- % of women receiving contraception counseling

Birth/Inpatient/Neonatal

- Opioid-exposed newborn incidence whose mothers receiving MAT
- Number of newborns who are opioid exposed
- Average LOS due to NAS for opioid-exposed infants
- Inpatient pharmacologic therapy for infants with NAS
- Rooming-in ability
- Breastfeeding rates (eligibility, initiation, continuation at time of discharge) for infants with NAS
- % of SEN/NAS mothers with polypharmacy/co-morbidities

Postnatal/Post-Discharge

- Readmissions for infants with NAS within the first 6 months post-discharge
- Relapse for mothers on MAT within the first 12 months
- Occurrence and Timeliness of Postpartum Visits
- Pediatric primary care visits in first 15 months
- % NAS/SEN newborn with HepC follow-up within 18 months
- % maternal relapse when a child is placed in foster care (6/12 months post-birth)
- % maternal relapse when a child remains with biological family (6/12 months post-birth)
- % mothers involved in MAT (6/12 months post-birth)
- % mothers involved in EI (6/12 months post-birth)
- % of SENs referred to EI and who receive EI services in the first 12 months of life

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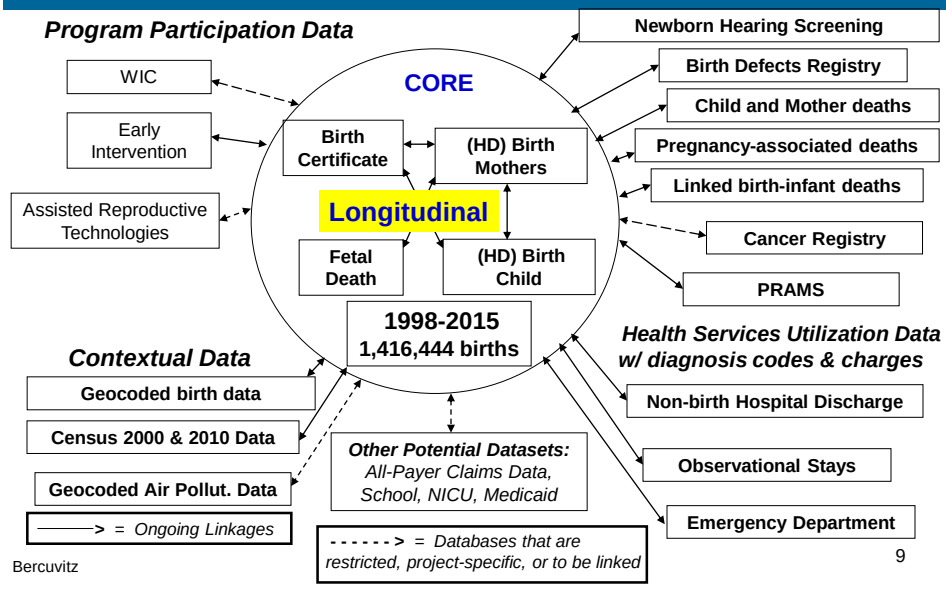
PELL Data System



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NEONATAL ABSTINENCE SYNDROME DASHBOARD

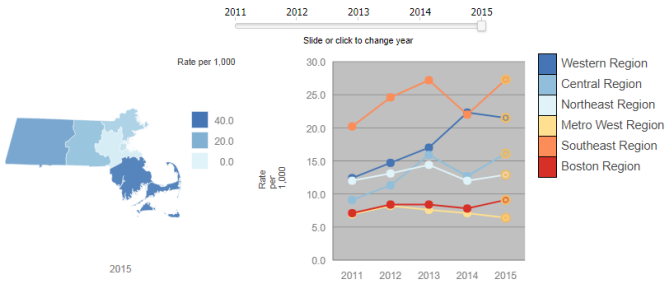
Overview | Pregnancy (Prenatal) | Birth (Neonatal) | Infancy (Post Discharge) | About these data

How would you like to view the data? Grouped by:

○ Overall ○ Insurance Type ○ Race / Ethnicity ○ Mother's Age ○ Mother's Education ○ Gestational Age ○ Birthweight ○ Method of Delivery
◉ EOHHS Regions

Number of infants diagnosed with NAS per 1,000 live births

Intrauterine exposure to opioids and other substances can have a substantial effect on newborn infants in the form of many withdrawal symptoms known as Neonatal Abstinence Syndrome (NAS). Not all infants exposed during pregnancy experience withdrawal symptoms. For this measure, infants with NAS were identified using diagnosis codes in delivery hospitalization records. A complete list of the codes used can be found by clicking the "About these data" button above.



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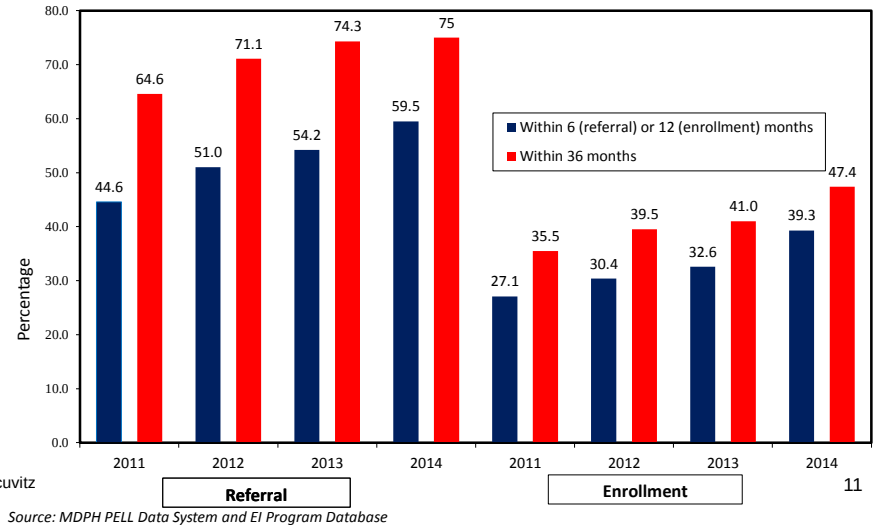
Early Intervention Referral and Enrollment among Infants Diagnosed with Neonatal Abstinence Syndrome (NAS): Massachusetts, 2011–2014



Source: MDPH PELL Data System and EI Program Database

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Using data to improve EI referral and enrollment

- EI Early Engagement Pilot
  - Hospital visit without paperwork to families of babies with NAS
- Early Intervention Quality Improvement Project
  - Improving quantity and quality of hospital referrals to EI

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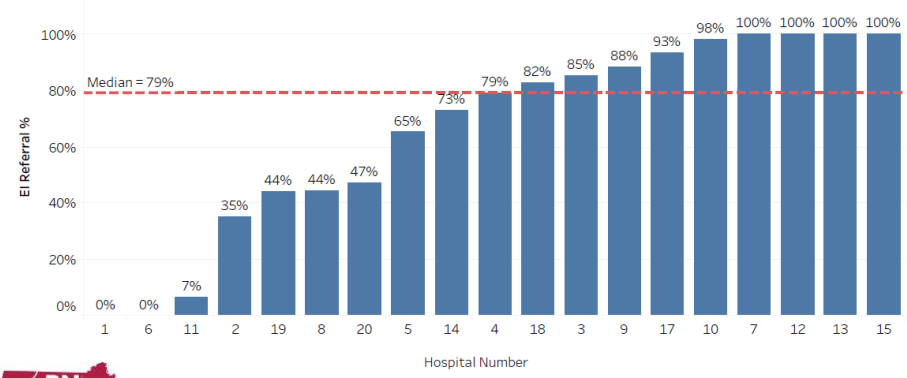
Percent of OENs Referred to Early Intervention By Hospital
January 1, 2007 – March 31, 2018



OEN = Opioid exposed newborn

Source: PNQIN Project Database

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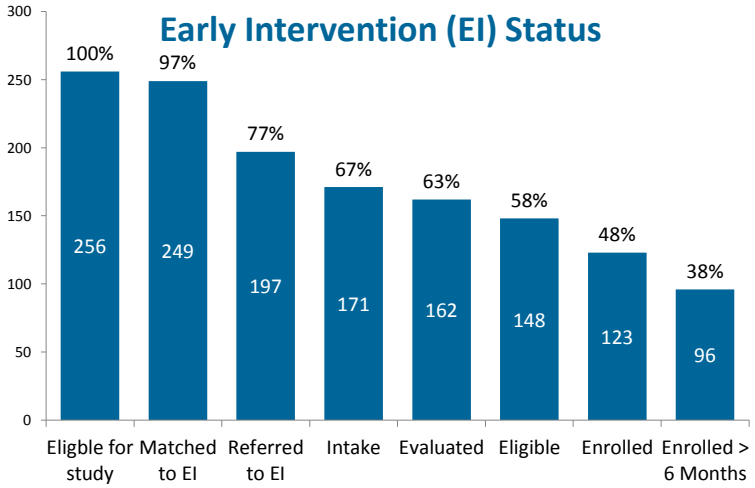
Sample Hospital QI Project—Preliminary



Conclusion: Statewide Initiatives

- Data integration and reporting to inform programs and policies
- Expanding treatment, recovery, and parenting supports
- Improving neonatal care for NAS
- Promoting greater usage of Early Intervention services
- Implementing Plans of Safe Care

The Evolution of Strength to Succeed:

How data drove the design of a cross-Departmental collaboration to address the needs of children affected by the opioid crisis

National Academy for State Health Policy 31st Annual State Health Policy Conference
August 15, 2018

Abby Shockley
NH Department of Health and Human Services

Agenda

- Background
- The data that drove the program
- Key program components
- Expected outcomes
- Lessons Learned
- Questions

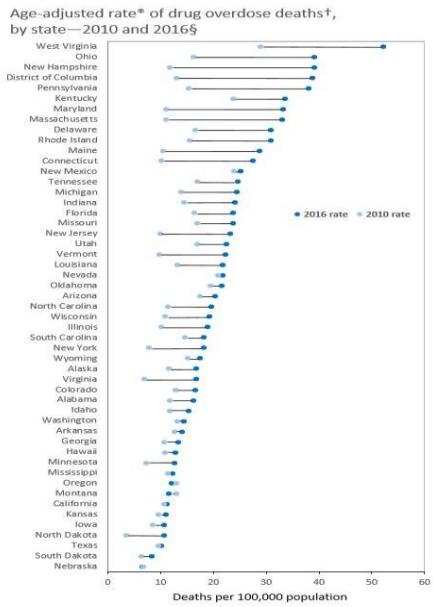
Background

- 21st Century Cures Act
  - State Targeted Response to the Opioid Crisis Grant
  - NH eligible for up to $3.1M/year for two years

- Funding specific to opioid use disorder (OUD)

- Funding goals:
  - increasing access to treatment,
  - reducing unmet treatment need, and
  - reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for OUD

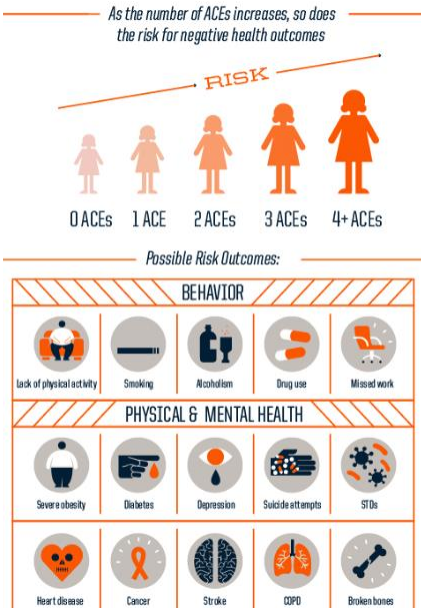
Background (cont.)



The data that drove the program

- **Governor's Commission on Alcohol and other Drugs: Prevention Taskforce**
  - Identified early childhood prevention as major gap in system
  - Emerging research on the value of early childhood prevention/intervention

  - Recommendations:
    - Expand Evidence-based home visiting programs for families at risk.
    - Support Community-based programs that target the sources of toxic stress in childhood.
    - Support Prevention Direct Services targeting at-risk students (K-12) and parents



Source: https://www.rwjf.org/en/library/infographics/the-truth-about-aces.html

The data that drove the program

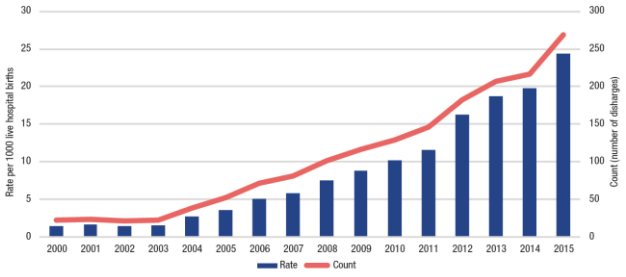
- **Division of Children, Youth and Families (NH's Child Welfare Agency)**

Removals	2017	2016	2015	2014	% Change 2014 - 2017
Age 0 – 2	253	228	148	118	114%
Age 3 – 5	158	109	98	59	167%
Age 6 – 8	95	79	52	42	126%
Age 9 – 11	67	54	51	26	158%
Age 12 – 14	68	46	44	25	172%
Age 15+	47	31	36	42	12%
TOTAL	**688**	**547**	**429**	**312**	**-**
Percent of children removed with allegations of substance abuse, drug abuse, or poisoning/noxious gases in assessment	53% (N=365)	60% (N=329)	48% (N=208)	44% (N=137)	166%
Percent of children born "drug-exposed" at time of referral and allegation founded	7% (N=49)	5% (N=28)	5% (N=22)	4% (N=14)	250%
Percent of children removed from their home where substance abuse was a risk factor at time of referral	67% (N=461)	52% (N=286)	62% (N=266)	59% (N=185)	149%

Source: https://www.dhhs.nh.gov/dcyf/documents/adequacy-enhance-assess-070318.pdf

The data that drove the program

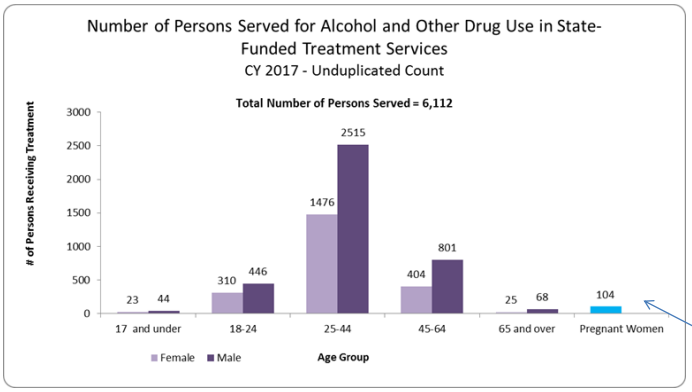
- **Division of Public Health Services**
  - 2005 -2015: the number of infants diagnosed with neonatal abstinence syndrome (NAS) increased fivefold, from 52 to 269
  - NAS births accounted for 24.4 of 1,000 live hospital births in 2015 (2.4%)
  - NH's home visiting program: 37% of caregivers served by the program were assessed as "known or suspected of substance misuse."



Source: https://carsey.unh.edu/publication/opioid-nas-nh

The data that drove the program

- **Bureau of Drug and Alcohol Services**
  - Two specialty programs in the state serving pregnant women with SUD
    - 88 pregnant women served in SFY16 (time of STR application)



1.7%

Key Program Components

Eligible Population:

1) Open case with DCYF
2) Substance use disorder as component of case
3) Child(ren) up to age 10 involved (in home or out of home)

Program: Strength to Succeed

Single point of entry ensuring-

1) Rapid Access to Treatment

2) Parent Partner Peer Support

3) Home Visiting- Direct Prevention Services

4) Caregiver Support

5) Parent and Child Substance Use Disorder Education

6) Cross-training of professions (Addictions services & DCYF)

Expected Outcomes

Minimum required data elements: (client and program level)
- Demographics - Primary drug of choice - Treatment access/services received
- # and ages of children served - Living arrangements for children - # of Parent Partners

Goals Supported by Program Activities	Mandatory Performance Measures
- Mitigate initiation or delay onset of substance use in children - Reduce caregiver strain and improve supports - Increase positive parenting skills and knowledge of child development - Reduce/mitigate childhood trauma - Increase protective factors in the family - Increase likelihood of reunification	**Contractors must:** • Provide evidence-based home visiting services to 100% of the families referred to the program that required home visiting services as part of their treatment plan • Increase training opportunities for the early childhood and home visiting workforce in substance misuse prevention, recovery and trauma informed care by three trainings per CY and increase the knowledge of substance misuse prevention, recovery and trauma informed care among the early childhood and home visiting workforce as demonstrated by an increase of 10% in aggregate as measured quarterly from training pre-test to training post-tests • Ensure that 80% of families referred to the program receive access to treatment or interim treatment services within 48 hours of referral

Lessons Learned

- Value of Parent Partner
  - Break down parent resistance to engagement
- Infant Plan of Safe Care
  - Opportunities for clarification and use
- Treatment capacity
- Importance of DCYF buy-in and continued involvement
- Limited ability to reach parents before “open cases”
- Constance QI process
- Multidisciplinary program design and implementation team
  - Division for Behavioral Health (BDAS, CBHC, BMHS)
  - Division for Children, Youth and Families
  - Division of Public Health Services
  - Cross-system data team

Questions and Comments

Policy Café Discussions

1:00PM - 2:15PM

Moderator
Jodi Manz
Assistant Secretary
Virginia Office of Health and Human Resources

In this session, participants will discuss specific topics in small groups ("policy cafés").

Topics will include:

- Prevention and early intervention
- Treatment
- Data
- Workforce
- Social determinants of health
- Trauma
- Special populations

Further instructions will be provided during the session.

Identifying Next Steps: What is on the Horizon?

2:15PM – 3:30PM

Moderator
Jodi Manz
Assistant Secretary
Virginia Office of Health and Human Resources

Speaker
Karen Palombo
Substance Use Disorder Treatment and Intervention Team Lead
Texas Health and Human Services Commission

Speaker
Dr. Mary McIntyre
Chief Medical Officer
Alabama Department of Public Health

Speaker
Lesley Scott-Charlton
Medicaid Health Systems Administrator
Ohio Department of Medicaid

Additional Resources

Massachusetts

Journey Recovery Project: Interactive Web Resource for Pregnant and Parenting Women with Concerns about Substance Use

https://journeyrecoveryproject.com/

Maine

The SnuggleME Guidelines: Tools for Caring for Women with Addiction and their Babies

https://www.maine.gov/dhhs/SnuggleME/documents/SnuggleME-2018-GuidelinesFINAL.pdf

https://www.maine.gov/dhhs/SnuggleME/documents/SnuggleME-Trifold-for-Providers-FINAL.pdf

Texas

Presentation about the Mommies Program

http://www.nationalperinatal.org/resources/Documents/2018%20Conference/Friday/Palombo.pdf