Coordinated Approaches to the Care of Women with Substance Use in Pregnancy

PLANS OF CARE FOR SUBSTANCE-EXPOSED NEWBORNS AND THEIR FAMILIES

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Agenda

- Federal and State Law Changes
- Implementation and Planning
- Roles of Prenatal Care Providers, Discharge Planners, and Insurance Care Coordinators
- Plan of Care Portal and Forms
- Best Practices
- Resources

Federal Law

The 2016 Comprehensive Addiction and Recovery Act (CARA) amended the Child Abuse Prevention and Treatment Act (CAPTA) to require that states identify and report annually on the following:

- Number of substance-exposed infants born;
- Number of substance-exposed infants for whom a **Plan of Care** has been created; and
- Number of infants with a **Plan of Care** for whom referrals were made to appropriate services, including services for affected family members or caregivers.

State Law

New Mexico has passed a law supporting CARA amendments to CAPTA.

The new law…

- Gives CYFD until January 1, 2020 to develop rules that guide stakeholders in the care of newborns who exhibit physical, neurological, or behavioral symptoms consistent with prenatal drug exposure or fetal alcohol spectrum disorder.
- Specifies that the rules are to include guidance on the creation of a **Plan of Care** for any substance-exposed newborn.
- Provides that pregnant women who communicate use of drugs or alcohol will be offered supports through a **Plan of Care**.
- Provides that CYFD shall be notified if a baby is born substance-exposed, in addition to receiving referrals for suspected abuse or neglect if such referrals are warranted.

Wait! We now Notify *and* Refer?

CYFD Notification

To comply with federal reporting requirements under CARA, CYFD must be notified of any infant born substance-exposed. The notification is accomplished by providing a copy of the Plan of Care to CYFD through a portal being designed for this purpose.

CYFD Referral or Report

As in the past, you are expected to report a family to CYFD Child Protective Services if you reasonably suspect that abuse or neglect (either or both) are occurring or are likely to occur in the postpartum phase.

Key Elements of Implementation

Notification and Copy of Plan of Care to CYFD

- Lets CYFD know that a substance-exposed infant has been born
- Includes providing a copy of the Plan of Care to CYFD

Copy of Plan of Care to NM DOH

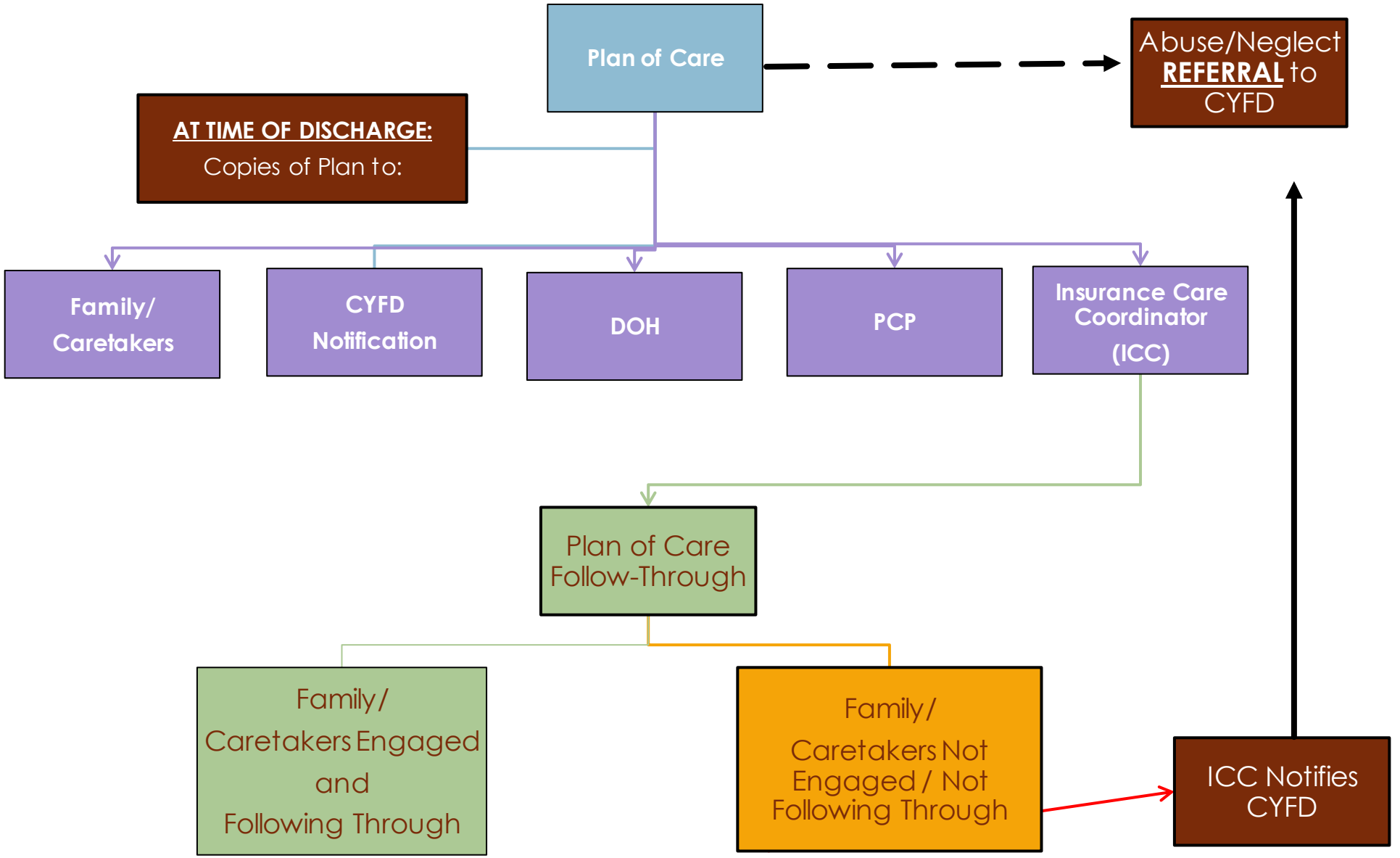
- Allows integration of substance-exposure and Plan of Care with broader epidemiological data
- Sets the stage for insurance and care coordination for families lacking these supports

What is a Plan of Care?

A Plan of Care is a document created by a healthcare professional and involved family members or caretakers to ensure the safety and well-being of an infant born substance exposed.

The Plan of Care:

- Identifies the newborn and his/her primary caretakers
- Details prenatal substance exposures
- Indicates the post-discharge housing plan
- Details support services engaged prenatally or referred to since delivery for infant and affected family/caregivers
- Notes referral to CYFD Child Protective Services, if applicable


Plan of Care
Abuse/Neglect REFERRAL to CYFD
AT TIME OF DISCHARGE:
Copies of Plan to:
Family/ Caretakers
CYFD Notification
DOH
PCP
Insurance Care Coordinator (ICC)
Plan of Care Follow-Through
Family/ Caretakers Engaged and Following Through
Family/ Caretakers Not Engaged / Not Following Through
ICC Notifies CYFD

Timeline

Prenatal Period

- Consider need for Plan of Care at birth
- Educate family/caretakers about Plans of Care

Time of Birth

- Develop Plan of Care with the family or caregivers
- Refer to CYFD Child Protective Services if concerned about abuse / neglect

Time of Discharge

- Fax Plan of Care to Insurance Care Coordinator, DOH, and PCP
- Notify CYFD (with copy of Plan) through designated portal

Prenatal Care:

Scenarios that could trigger the need for a Plan of Care at birth

A pregnant woman enters prenatal care and screens positive for substance use, including alcohol or marijuana. Substance use behavior is determined to be a dependency with known risks to the neonate.

A pregnant woman and her family are enrolled in wrap-around services including treatment for Substance Use Disorder. Infant is expected to deliver with substance exposure (even if limited to treatment medications).

Wild Card

Wild Card

Wait a minute!

Do I have to talk with my prenatal patient about a Plan of Care in these scenarios?

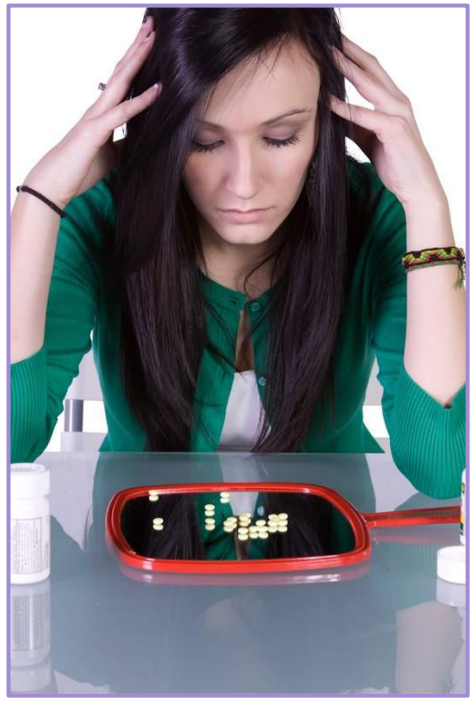
A pregnant woman enters prenatal care and discloses that she used marijuana in the first trimester to manage nausea and vomiting.

A pregnant woman enters prenatal care and discloses that she has had a glass of wine from time to time, even since she learned that she was pregnant.

A pregnant woman discloses that she was using medically prescribed opioids for pain management before she became pregnant and that she continues to use these medications in pregnancy.

Wild Card

Questions that may help you decide



Is this pregnant woman:

- Chemically dependent?
- Abusing Substances?
- At risk for alcohol and/or substance use?

Does this pregnant woman's use behavior have the potential to affect her child's early learning capacity and brain development?

Teaching and learning opportunities

Marijuana

- Pregnant women using marijuana (or reporting having used marijuana) for nausea and vomiting may not be aware that there are safer alternatives to marijuana to control these symptoms.
- Pregnant women may not be aware that marijuana use during pregnancy may affect neonate brain development and early learning capacity.

Teaching and learning opportunities

Alcohol and Nicotine

- You can work with expectant moms to make a distinction between episodic alcohol use and alcohol dependency.
- Breastfeeding (normally recommended) is not appropriate if the mother-to-be is alcohol dependent.

- Smoking during pregnancy can cause tissue damage in the unborn baby, particularly in the lungs and brain.
- Studies also suggest a relationship between tobacco use and miscarriage.
- Smoking cessation medications may be safer than continuing to smoke tobacco.

Plan of Care Triggers at Discharge and Post-Discharge

How will you know when federal and state law requirements for a Plan of Care are actually kicking in?

We cannot describe every possible scenario in which development of a Plan of Care and notification to CYFD (with or without referral to Child Protective Services) would be appropriate.

We've tried to compile some typical scenarios here. Please help us fill in the Wild Cards.

Plan of Care Trigger Scenarios

Hospital Discharge Planners

A pregnant woman enters into medical care for delivery and reports substance use during her pregnancy. She received very little to no prenatal care.

A pregnant woman enters into medical care for delivery and reports substance use ***in treatment or relapse*** during her pregnancy.

A newborn tests positive for treatment or non-treatment substance exposure with no prior disclosure from birth mother.

Wild Card

Plan of Care Trigger Scenarios

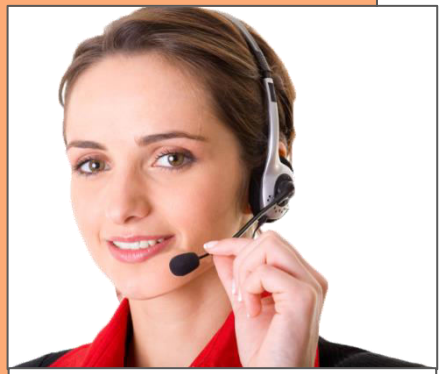
Insurance Care Coordinators

A pregnant woman is referred to Care Coordination through her insurance provider. The woman discloses to her Care Coordinator that she struggles with substance use. This may include alcohol or marijuana.

A pregnant woman is referred by a healthcare provider for Care Coordination. She is in treatment for substance use disorder.

Mother and infant have been discharged. Insurance Care Coordinator receives referral on newborn and parent. Parent discloses that infant was substance-exposed in utero. There is no Plan of Care.

Wild Card



Plan of Care, role of the infant's Primary Care Physician

- Baby is discharged from the hospital, parents bring baby for first well check following discharge. You have records from the hospital indicating the baby was exposed to substances.
- Does this baby have a Plan of Care?
- Does the family have a copy of the Plan of Care to give you at the first visit?
- Was a Plan of Care faxed over to you from the hospital?
- Who can you contact if you do not have a copy of the Plan of Care, and the family does not remember to bring a copy?
- How do you find out who the MCO Care Coordinator is for the infant?
- (at the end of this presentation are the key contacts for Care Coordination)

Remember…

- You may encounter situations where a Plan of Care with notification to CYFD ***and*** a referral to CYFD Protective Services are appropriate.
- CYFD Notification regarding a substance-exposed newborn does not replace your legal obligation to refer a family to CYFD if you reasonably suspect that abuse or neglect will occur in the post-partum phase.

Where the rubber meets the road…

Infant is on Monthly Birth Defects Report from Hospital with NAS and Substance Exposure Diagnosis Codes	Plan of Care Copy Received
YES	YES

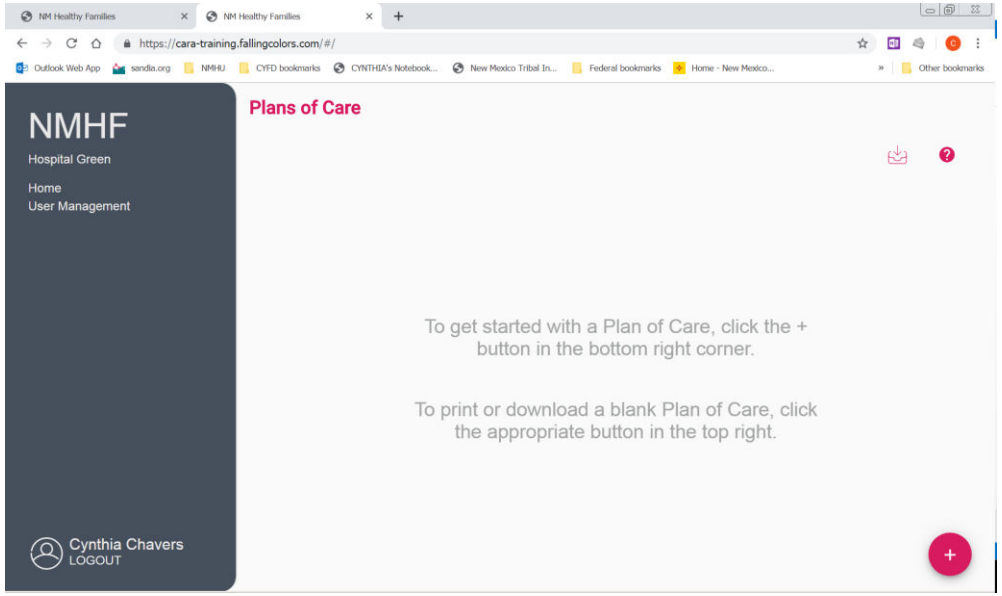
These items should match (Yes, Yes or No, No)

- NM DOH gets birth defects data up to age four from 21 birthing hospitals in the State of New Mexico, which now includes the diagnosis codes associated with NAS and substance exposure.
- If you're having trouble deciding whether a family would benefit from a Plan of Care, just think about the backwards engineering that will be needed if the infant is born substance-exposed and gets discharged without a Plan of Care.

Plan of Care Resources

- **Assessment of Need:** Use the Assessment of Need for Plan of Care form if you are unsure about the need for a Plan of Care.
- **Plan of Care:** Enlist the infant's family (or caregivers) to create the Plan of Care customized to their needs and values.
- **Follow-up Priorities:** Use the Plan of Care Follow-up Priorities form to support implementation.

Reserved for introducing CYFD Notification Portal



If substance use disorder or other factors are interfering with the parents' ability to care for the infant, or if there are concerns that the family does not have adequate supports, a referral shall be made to CYFD Child Protective Services for potential child abuse/neglect. Creating a Plan of Care does not exempt the family from potential investigation by CYFD. Dial #SAFE.

Plan of Care

This 3-page document must be completed before discharge.

Infant Name:	Admission Date:
D.O.B.:	Discharge Date:
Discharge Address (Street, City, Zip Code):	Discharge Phone:

Infant's Discharge Housing Status (Circle one):

Parental Home Designated Caregiver Home Facility/Shelter Precariously Housed

Assessment of Need for Plan of Care

Mark the boxes "M," "F," or "M&F" for substances used before or during pregnancy.

Assessment of Need for Plan of Care and Potential CYFD Referral*

**If substance use disorder or other factors are interfering with the parents' ability to care for the infant, or if there are concerns that the family does not have adequate supports, a referral shall be made to CYFD for potential child abuse/neglect. Creating a Plan of Care does not exempt the family from potential investigation by CYFD. Dial #Safe.*

This is a needs assessment tool to help you determine the need for a CARA-mandated Plan of Care. Please do not include patient identifiers. Please do not forward.

Applicable Criteria: Use "M" to indicate birth mother, "F" to indicate birth father, or "M&F" to indicate both birth mother and birth father.

Criterion	Before Pregnancy	During Pregnancy	Current/Ongoing
Alcohol			
Benzodiazepines			
Buprenorphine			
Marijuana			
Methadone			
Methamphetamine			
Opioids			
Tobacco			
Cocaine			
Heroin			

☐ Newborn was treated pharmacologically for withdrawal symptoms.

Assessment of Need for Plan of Care

Where will the family go at time of discharge?

Birth Parents' Housing Status: Where will the family go at time of discharge?

☐ Home owned or rented by birth parent(s), adoptive or foster parent(s), or caregivers
☐ Precariously Housed
☐ Shelter (Specify type: _____)
☐ Treatment Facility
☐ Correctional Facility

☐ Newborn will be discharged to location other than birth parent's discharge loca
☐ Assessed for referral to Statewide Central Intake (SCI), CYFD.

Support Services: Place a checkmark to indicate status of birth parents or designat regarding support services. Support services include items such as counseling, treatme classes, but need not be specified.

You may determine need for a Plan of Care *and* a CYFD referral.

Support Services	During Pregnancy	Referred Since Delivery	Referred Sinc Delivery and Declined
Parent 1			
Parent 2			
Caregiver(s)			

Services used or referred do not need to be specified.

Plan of Care: ☐Needed/Required; ☐Completed and signed; ☐Provided to newborn's Primary Care Provider for ongoing monitoring; ☐Submitted notification and Plan of Care through the Portal

Note your decision regarding follow-through at the bottom of the Assessment Tool.

Plan of Care

Provide key identifying information for infant and note discharge housing arrangement.

If substance use disorder or other factors are interfering with the parents' ability to care for the infant, or if there are concerns that the family does not have adequate supports, a referral shall be made to CYFD Child Protective Services for potential child abuse/neglect. Creating a Plan of Care does not exempt the family from potential investigation by CYFD. Dial #SAFE.

Plan of Care

This 3-page document must be completed before discharge.

Infant Name:	Admission Date:
D.O.B.:	Discharge Date:
Discharge Address (Street, City, Zip Code):	Discharge Phone:

Infant's Discharge Housing Status (Circle one):

Parental Home Designated Caregiver Home Facility/Shelter Precariously Housed

Plan of Care

Identify ICC and PCP as well as key household members.

Infant's Insurance Care Coordinator (ICC):	Infant's Primary Care Provider (PCP):
ICC Phone:	PCP Phone:
ICC Fax:	PCP Fax:
Health Insurance Company: _____ Health Insurance Plan: _____	First Appointment Following Discharge: ____/____/____ ____:____ AM/PM

Key Household Members: Birth parent(s), adoptive or foster parent(s), or designated caregiver(s).

Name	Age	Relationship to Infant	Contact Information
1.			
2.			
3.			

Plan of Care

Indicate in utero exposures.

Review and select appropriate services.

Applicable Criteria for Plan of Care: Check all substances to which infant was exposed in utero.

Substance	✓	Substance	✓
Alcohol		Methamphetamine	
Benzodiazepines		Nicotine	
Buprenorphine (Subutex, Suboxone)		Opioids	
Marijuana		Other (Specify):	
Methadone		Other (Specify):	

Support Services (continues on page 3):

Service	Name of Organization / Contact	Current ✓	Referred ✓	Declined ✓	Unavail-able ✓
12-Step Program					
Childcare					
Children's Medical Services					
Domestic Violence Services					
Early Intervention					
Family Wrap-Around Services to 3 years					

Plan of Care

Note referral to Protective Services (if applicable).

Share the Plan with all key stakeholders.

◯ Family has been reported to CYFD Child Protective Services Division.

Name of CYFD Caseworker (if applicable): _____

_____ _____

Parent/Caregiver Name | Staff Person Name

_____ _____

Parent/Caregiver Signature | Staff Person Signature

___ Submitted Notification and Plan of Care through CYFD Portal

___ Fax to NM DOH Children's Medical Services
Phone: 505-476-8868
Fax: 505-476-8996 or 505-827-5995

___ Copy to Family/Caregivers

___ Copy to Primary Care Provider

___ Copy to Insurance Care Coordinator

___ Copy to CYFD Caseworker (if applicable)

Follow-up Priorities

A Plan of Care is only as good as the follow-up that results. Use this tool to establish follow-up priorities.

Plan of Care Follow-up Priorities

This is a worksheet for planning and documenting implementation of the CARA*-mandated Plan of Care for substance-exposed infants and their affected family members/caregivers. Please do not forward to NMDOH. Please do forward (along with the Plan of Care) to the family and/or caregiver, the Insurance Care Coordinator, and the Primary Care Provider.

Infant Name:	Parent/Caretaker Name:	Primary Care Provider:	Insurance Care Coordinator:
	Contact:	Contact:	Contact:

Follow-up Priorities:

Action Step	Target Date	Barriers	Supports	Outcome

Who gets copies of the Plan of Care, and why

Infant's Family or Caregivers	Infant's Primary Care Provider (PCP)	Insurance Care Coordinator (ICC)	NM DOH	NM CYFD
Parents/Caregivers are expected to participate in Plan of Care development and implementation.	PCP must be aware of contents of Plan of Care to support implementation	ICC assists family/ caregivers in accessing support services identified in the Plan of Care and other supports the family may need.	NM DOH matches Plan copies to newborn data supplied by hospitals and other birthing facilities.	Plan copies go to NM CYFD per state law. NM CYFD reports de-identified data to the federal government.
			NM DOH assists families/caregivers in accessing services if infant is uninsured or insured without care coordination.	If there is a report to NM CYFD Protective Services, the caseworker will need a copy of the Plan to monitor implementation.

So many plans…

Plan Type	Purpose	How Plan of Care Differs
CYFD Safety Plan	Immediate safety of infant	Addresses health and SUD needs of infant and parents/caregivers
Substance-Use Treatment Plans	Treatment of SUD in parent/caregiver	Comprehensive plan for infant and parents /caregivers
Hospital Discharge Plans	Health and wellbeing of substance-exposed infant at time of discharge	Addresses ongoing health and development needs of infant as well as parents/caregivers

Safety Plan/Plan of Care Dovetail

A well-developed and effectively implemented Plan of Care may prevent removal of an infant from his/her family or provide an opportunity for quick reunification if initial placement is away from the birth mother or father.

A strong Plan of Care benefits an infant and his/her caregivers by addressing their treatment needs, regardless of immediate child placement decisions.*

*National Center on Substance Abuse and Child Welfare (2018). *A planning guide: Steps to support a comprehensive approach to Plans of Safe Care; March 2018 Draft*.

Best Practices: Timing

- The best time to consider the need for a Plan of Care is in the prenatal phase. Initiate a plan that supports formal creation of a Plan of Care at the time of delivery.
- Birth parents and their families have a natural interest in positive outcomes for their newborns.
- Pregnant women struggling with substance use may be most amenable to treatment when they understand that their choices during pregnancy may have lasting effects on their offspring.
- The new state law clarifies that substance abuse on the part of a pregnant woman is not, in and of itself, grounds for a report to CYFD Protective Services. This should reduce inhibition regarding uptake of prenatal care.

Best Practices: Prenatal Screening

Lovelace
Medical Group

Name_____Date_____

Please answer each question below.

Have you ever used drugs, alcohol or tobacco during this pregnancy?

Have you had a problem with drugs, alcohol or tobacco in the past?

Does your partner have a problem with drugs, alcohol or tobacco?

Do you consider one of your parents to be an addict, an alcoholic, or unable to stop smoking?

SCREENING QUESTIONNAIRE FOR SUBSTANCE USE IN PRENATAL CARE

1) When did you know of your pregnancy?
   a) How did you find out you are pregnant?
   b) Have you started prenatal care?
   c) How are you doing?

2) Before you knew of your pregnancy what was your use of alcohol?
   a) No use
   b) 1 to 2 drinks in a month
   c) 1 to 2 drinks in a week
   d) 1 to 2 drinks in a day
   e) 3 or more drinks in a day

3) Since learning of your pregnancy what is your use of alcohol?
   a) No use
   b) 1 to 2 drinks in a month
   c) 1 to 2 drinks in a week
   d) 1 to 2 drinks in a day
   e) 3 or more drinks in a day

4) Before you knew of your pregnancy what was your use of cigarettes/tobacco products?
   a) No smoking
   b) 1 to 2 cigarettes/tobacco products in a month
   c) 1 to 2 cigarettes/tobacco products in a week
   d) 1 to 2 cigarettes/tobacco products in a day
   e) 3 or more cigarettes/tobacco products in a day

Best Practices: Nonjudgmental Approach

- A Plan of Care is developed collaboratively with the infant's family (or caregivers) and is supportive of all family members (caregivers).
- Substance abuse is viewed as medical condition with social, economic, and cultural roots. Favor behavioral health service providers who have demonstrated a nonjudgmental approach.
- Support client/patient efforts at harm reduction.

Best Practices: Warm Hand-off

A warm hand-off is any effort you make to assure a follow-through connection between two parties.

MCOs report that as many as 50% of referrals fail when the referring entity goes no further than supplying a name and contact information.

If you are a discharge planner, be sure that your patient knows or is introduced to her Insurance Care Coordinator (ICC) - ideally before discharge - because that is the person who will assist the family in implementing the Plan of Care.

If you are an ICC, be sure that your client knows or is introduced to support service providers identified in the Plan of Care.

Best Practices: A vision for the future

- Access to prenatal care for all pregnant women in New Mexico.
- Universal screening at first visit for substance use, ACES, domestic violence, and other needs or risk factors with a validated tool.
- Expand or replicate wrap-around service programs for families that integrate SUD treatment with prenatal and early intervention services.

Evidence Based Practice

Early Start

A Cost–Beneficial Perinatal Substance Abuse Program

Nancy C. Goler, MD, Mary Anne Armstrong, MA, Veronica M. Osejo, BS, Yun-Yi Hung, PhD, Monica Haimowitz, LCSW, and Aaron B. Caughey, MD, PhD

OBJECTIVE: To conduct a cost–benefit analysis of Early Start, an integrated prenatal intervention program for stopping substance use in pregnancy.

METHODS: A retrospective cohort study was conducted of 49,261 women who had completed prenatal substance abuse screening questionnaires at obstetric clinics and who had undergone urine toxicology screening tests. Four study groups were compared: women screened and assessed positive and followed by Early Start (screened-assessed-followed, n=2,032), women screened and assessed positive without follow-up (screened-assessed, n=1,181), women screened positive only (screened-positive-only, n=149), women in the control group who screened negative (control, n=45,899). Costs associated with maternal health care (prenatal through 1 year postpartum), neonatal birth hospitalization care, and pediatric health care (through 1 year) were adjusted to 2009 dollars. Mean costs were calculated and adjusted for age, race, education, income, marital status, and amount of prenatal care.

RESULTS: Screened-positive-only group adjusted mean maternal total costs ($10,869) were significantly higher than screened-assessed-followed, screened-assessed, and control groups ($9,430; $9,230; $8,282; all $P<.001$). Screened-positive-only group adjusted mean infant total costs ($16,943) were significantly higher than screened-assessed-followed, screened-assessed, and control groups ($11,214; $11,304; $10,416; all $P<.001$). Screened-positive-only group adjusted mean overall total costs ($27,812) were significantly higher than screened-assessed-followed, screened-assessed, and control groups ($20,644; $20,534; $18,698; all $P<.001$). Early Start implementation costs were $670,600 annually. Cost–benefit analysis showed that the net cost benefit averaged $5,946,741 per year.

CONCLUSION: Early Start is a cost-beneficial intervention for substance use in pregnancy that improves maternal–infant outcomes and leads to lower overall costs by an amount significantly greater than the costs of the program.

(Obstet Gynecol 2012;119:102–10)
DOI: 10.1097/AOG.0b013e31823d427d

LEVEL OF EVIDENCE: II

Alcohol, tobacco, and other drug use remains a paramount problem in pregnancy leading to preventable morbidity and mortality in more than 400,000 pregnancies annually.[1–3] Exposure to alcohol, tobacco, and other drugs in pregnancy leads to increased rates of placental abruption, intrauterine fetal demise, low-birth-weight neonates, neonatal abstinence syndrome, and preterm labor and birth.[1,2,4] In turn, preterm birth, associated with short-term and long-term morbidity, adds significant costs.[5] Despite multiple educational advertising campaigns, substance use during pregnancy continues to be significant. Data from the Substance Abuse and Mental Health Services Administration in 2008 revealed no significant decrease in pregnancy usage (5.1% up from 4% in 2005–2006).[6]

In 1990, Kaiser Permanente Northern California developed Early Start, an integrated prenatal intervention program for stopping alcohol, tobacco, and other drug use.[7] The program created the Early Start specialist position, a licensed clinical social worker or marriage and family therapist with expertise in substance use and pregnancy who is located within the obstetrics and gynecology department. Appointments for substance use are linked to routine prenatal care

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2007 James A Vohs Award for Quality Second-Place Selection

Early Start: An Integrated Model of Substance Abuse Intervention for Pregnant Women

By Cosette Taillac, LCSW, BCD
Nancy Goler, MD
Mary Anne Armstrong, MA
Kathleen Haley, MS
Veronica Osejo

Abstract

Untreated perinatal substance abuse is associated with serious adverse maternal and neonatal outcomes. Historically, many barriers have prevented pregnant women from seeking treatment. Early Start (ES) breaks new ground by sidestepping these barriers with a fully integrated service delivery model.

ES is the largest HMO-based prenatal substance-abuse program in the United States targeting all pregnant women seen at Kaiser Permanente Northern California (KPNC) prenatal clinics, currently screening more than 39,000 women each year. The program is based on the premise that substance abuse is a treatable disease and addresses it in a nonjudgmental, accepting manner. A substance-abuse counselor is located in each obstetrics clinic providing accessible one-to-one counseling to pregnant women screened at risk for alcohol, tobacco, or drug use as part of the routine prenatal care package offered to all patients.

A 2006 ES study, sponsored by the Kaiser Foundation Research Institute, evaluated program effectiveness in terms of its impact on neonatal and maternal outcomes. Preliminary results that included 49,986 KPNC patients indicate that compared with pregnant women whose results on screening for substance use were positive but who were untreated, ES-treated women had significantly lower rates on a number of outcome measures.

The originality and transferability of ES has led to both local and national recognition. Universal screening of all pregnant women with access to an integrated model of substance-abuse treatment should be the standard of care for every prenatal patient because of the significant benefits for mothers and their babies.

Introduction

In the early 1990s, two prevalence studies confirmed that prenatal substance abuse was a significant problem among Kaiser Permanente Northern California (KPNC) patients. An internal prevalence study conducted by neonatologist Marc Usatin, MD (Walnut Creek), from 1989 to 1990 tested newborn meconium for prenatal exposure to street drugs but not alcohol. An overall exposure rate of 3.2% was found for all KPNC birthing facilities. Shortly thereafter, the California Department of Alcohol and Drug Programs conducted a study that included five KPNC hospitals and found rates of perinatal alcohol and drug exposure ranging from 10% to 18% of all births (two KPNC sites had rates higher than the statewide average of 11.35%).[1] This information, coupled with a body of literature documenting adverse neonatal outcomes such as placental abruption, fetal death, premature delivery, and babies born small for gestational age,[2–7] prompted the development of a new approach to treating this population.

Historically, pregnant women at KPNC who were identified as having substance abuse problems were referred by their prenatal clinician to existing internal or community-based treatment programs. These efforts were largely unsuccessful; only a fraction of the women referred to these programs attended them. Several clinicians, concerned about the poor outcomes and poor intervention record with this approach, explored other successful prenatal substance abuse intervention models, all of which were in the public sector at that time. To capitalize on KPNC's strength and history as a vertically integrated program, the clinicians identified models that would further integrate services. Experts from Born Free, a program in Contra Costa County that routinely screened

Historically, pregnant women at KPNC who were identified as having substance abuse problems were referred by their prenatal clinician to existing internal or community-based treatment programs. These efforts were largely unsuccessful …

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Current Publications and Information

Public Health Surveillance of Prenatal Opioid Exposure in Mothers and Infants

Margaret A. Honein, PhD, MPH, Coleen Boyle, PhD, MS hyg, Robert R. Redfield, MD

INFORMING CLINICAL CARE AND LINKAGE TO SERVICES FOR PREGNANT WOMEN AND INFANTS

Because prevention and treatment of opioid use disorder in pregnancy is important to both maternal and infant health, there is an urgent need to expand prevention efforts and reduce barriers for medication-assisted treatment before, during, and after pregnancy. The stigma of substance exposure during pregnancy and fears of punitive consequences can be obstacles to women receiving the treatment and care they need, and studies with inadequate control of cofactors can exaggerate the specific effects of an individual substance as occurred with prenatal cocaine exposure.[4] Opioid use disorder during pregnancy is a medical condition that requires care and treatment and can have adverse consequences for the infant, much like pregestational diabetes, which increases the risk of birth defects and other adverse pregnancy outcomes.[5] Current recommendations for pregnant women with opioid use disorder are to avoid withdrawal during pregnancy and be provided appropriate opioid agonist treatment.[6] Increasing and targeting prevention efforts and providing appropriate treatment and adequate access to care could improve both maternal and infant health in the midst of this public health crisis.

Public health surveillance is needed to fill critical knowledge gaps and inform clinical guidance for the care of pregnant women with a treated or untreated opioid use disorder and their infants. Updated, evidence-based clinical guidance might help mitigate adverse infant and childhood outcomes by providing treatment that is tailored to the specific prenatal exposures, including both pharmacologic and nonpharmacologic treatments for infants who are exposed. Progress could be monitored by using a cascade of care model (Table 1) with metrics obtained from longitudinal linked public health surveillance.

Current Publications and Information Continued

Obstetrics

Clinical care for opioid-using pregnant and postpartum women: the role of obstetric providers

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We review clinical care issues that are related to illicit and therapeutic opioid use among pregnant women and women in the postpartum period and outline the major responsibilities of obstetrics providers who care for these patients during the antepartum, intrapartum, and postpartum periods. Selected patient treatment issues are highlighted, and case examples are provided. Securing a strong rapport and trust with these patients is crucial for success in delivering high-quality obstetric care and in coordinating services with other specialists as needed. Obstetrics providers have an ethical obligation to screen, assess, and provide brief interventions and referral to specialized treatment for patients with drug use disorders. Opioid-dependent pregnant women often can be treated effectively with methadone or buprenorphine. These medications are classified as pregnancy category C medications by the Food and Drug Administration, and their use in the treatment of opioid-dependent pregnant patients should not be considered "off-label." Except in rare special circumstances, medication-assisted withdrawal during pregnancy should be discouraged because of a high relapse rate. Acute pain management in this population deserves special consideration because patients who use opioids can be hypersensitive to pain and because the use of mixed opioid-agonist/antagonists can precipitate opioid withdrawal. In the absence of other indications, pregnant women who use opioids do not require more intense medical care than other pregnant patients to ensure adequate treatment and the best possible outcomes. Together with specialists in pain and addiction medicine, obstetricians can coordinate comprehensive care for pregnant women who use opioids and women who use opioids in the postpartum period.

Characterization of U.S. State Laws Requiring Health Care Provider Reporting of Perinatal Substance Use

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Abstract

Background

State policies pertaining to health care provider reporting of perinatal substance use have implications for provider screening and referral behavior, patients' care seeking and access to prenatal substance use disorder treatment, and pregnancy and birth outcomes.

Objectives

This study sought to characterize specific provisions enacted in state statutes pertaining to mandates that health care providers report perinatal substance use, and to determine the proportion of births occurring in states with such laws.

Methods

We conducted a systematic content analysis of statutes in all U.S. states that mentioned reporting by health care providers of substance use by pregnant women or infants exposed to substances in utero; inter-rater reliability was high. We calculated the number of states, and proportion of U.S. births occurring in states, with processes for mandatory reporting of perinatal substance use to authorities, and substance use disorder treatment provision for individuals who are reported.

Results

Twenty states (corresponding with 31% of births) had laws requiring health care providers to report perinatal substance use to child protective authorities, and four states (18% of births) had laws requiring reporting only when a health care provider believed the substance use was associated with child maltreatment. About one-half of states (13) with any reporting law had a provision promoting substance use disorder treatment in the perinatal period.

Conclusions

Findings inform the ongoing debate about how health policies may be used to reduce the population burden of perinatal substance use.

Planning and Implementation Stakeholders

- Medicaid managed care organizations
- Advocacy Groups
- NM CYFD
- NM Department of Health
- NM Human Services Department
- Hospitals
- Other Medical Providers
- Indian Health Services
- The Brindle Foundation
- Families

CARA Work Group

The CARA Work Group is co-chaired by Cynthia Chavers (CYFD) and Dr. Andy Hsi (UNM). The group, consisting of approximately 160 public- and private-sector stakeholders, has been working since 2017 to bring the State of New Mexico into compliance with federal law regarding substance-exposed newborns and their families.

Blue Cross Blue Shield of Texas (MCO)

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4411 The 25 Way NE, Suite 300
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Please send all referrals to:

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Presbyterian Health Plan (MCO and Commercial)

Lane Evans, RN, BBA, CCM

Director, Health Services

Clinical Operations

505-923-5463

Please use these numbers:

505-923-8858

866-672-1242

Notes: Response typically occurs within 48 hours, but callers may request an urgent referral to Care Coordination. This will result in same-day member contact.

Our Transition Care Team and Inpatient Utilization Management Team also interact with facilities to identify members who are appropriate for care coordination.

Western Sky Community Care (MCO)

Charlene A. Tafoya, LBSW, MSW

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Albuquerque NM 87110

1-844-543-8996, #4 for Care Coordination

CARACareCoordination@westernskycommunitycare.com

Blue Cross Blue Shield of Texas (Commercial)

Pre-Natal up to 34 Weeks

- Special Beginnings Program
- Email **all three**:

  Julie Milam
  Julie_s_milam@bcbstx.com

  Beth Boulanger

  Beth_boulanger@bcbstx.com

  Toni Allen

  Toni_allen@bcbstx.com

34 Weeks or more / Delivery

- Contact Customer Service at phone number on back of insurance card.
- Ask for referral to case manager

NM DOH: Children's Medical Services

Susan Merrill, LCSW

Community and Social Services
Coordinator for Birth Defects

susanmerrill@state.nm.us

Direct: 505-476-8918

FAX: 505-476-8996 or 505-827-5995

Children's Medical Services

Family Health Bureau

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