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
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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.

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<thead>
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<tbody>
<tr>
<td>8:00 – 8:30am</td>
<td>Registration and Breakfast</td>
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<tr>
<td>8:30 – 8:45am</td>
<td>Welcome</td>
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<td>Speaker:</td>
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<td></td>
<td>Karen VanLandeghem, Senior Program Director, National Academy for State Health Policy</td>
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<tr>
<td>8:45 – 9:30am</td>
<td>Understanding the Impact of Substance Use Disorder on Families</td>
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<td>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.</td>
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<td>Speaker:</td>
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<td>Jill Gresham, Senior Program Associate, Children and Family Futures</td>
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<td>Moderator:</td>
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<td>Donna Bradbury, Associate Commissioner, Division of Integrated Community Services for Children &amp; Families, New York State Office of Mental Health</td>
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| 9:30-10:45am | State Strategies for Ensuring Access to Continuous Care for Women with Substance Use Disorder | • 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 | 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 | • 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 | 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                                                              |                                                                          |                                                                          |

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| 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                  | Supported by the Health Resources and Services Administration
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

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6
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

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

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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

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

- Parental Substance Use in Child Welfare Services
- Treatment for Substance Use Disorders

Number of Children in Out of Home Care at End of Fiscal Year in the United States, 2000 to 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

N = 273,506

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

Number of Children in Out of Home Care in 2016 = 687,721

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

Source: AFCARS Data, 2000-2016

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Extended families are particularly affected by the opioid epidemic...

About a third of children placed in out of home care associated with parental alcohol and drug use are placed with relatives.

The number of children with relatives associated with their parents substance use rose from 34% in 2008 to more than 40% in 2014.

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

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

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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.

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.
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)

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

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Quantitative Study Findings

**Graph 1:**

- **Y-axis:** Foster Care Entries (thousands)
- **X-axis:** Overdose Deaths (thousands)
- **Legend:**
  - Foster Care Entries
  - Overdose Deaths

**Sources:**

---

Study Findings:
Relationship of Substance Use and Child Welfare Indicators

**Graph 2:**

- **Legend:**
  - 10% increase in the overdose death rate
  - 2.3%
  - 2.6%
  - 4.5%

**Sources:**

---

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

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)
Addressing Prenatal Exposure

Multiple Intervention Points
Family-Centered Approach

Policy and Practice Framework:
5 Points of Intervention

1. Pre-Pregnancy
   Awareness of substance use effects

2. Prenatal Screening and Assessment
   Initiate enhanced prenatal services

3. Child Identification at Birth
   Parent

4. Post-Partum
   Ensure infant’s safety and respond to infant’s needs

5. Infancy & Beyond
   Identify and respond to the needs of the infant, toddler, preschooeler, child and adolescent

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Young, Gardner, et al., 2009
Pre-Pregnancy

Public awareness campaigns on the risk of substance use while pregnant, the impact of opioid use and the disease model of substance use disorder are implemented.

Physicians screen all women of child bearing age for substance use disorders?

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

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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


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.


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• 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

Supporting the Mother-Infant Dyad

• The neonatal period is an optimal time to begin interventions to optimize dyadic interaction
• Improving clinician attitudes positively impact dyadic interactions
• Nurses who demonstrated caring behaviors towards mothers were better able to help them recognize and interpret infant cues, thus enhancing mother-infant interactions

(Velez & Jansson, 2008; Velez & Jansson, 2014)
Promising Practice:

A Revised Approach to NAS Treatment from a Multi-Year Improvement Effort at Yale New Haven Children’s Hospital

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

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

*Supported by the Health Resources and Services Administration*
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

Promising Practice:

Many hospitals across the country are implementing these practice changes for non-pharmacological approaches

There remains a critical need for additional research to understand:
- Implementation challenges and lessons
- Operational definitions of assessment of eat, sleep, console
- Criteria for the use of medications
- Longer-term outcomes for infants and families beyond length of stays in hospitals

Supported by the Health Resources and Services Administration
4 Neonatal

- 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
Effects of Substance Exposure

American Academy of Pediatrics Technical Report
Comprehensive review of ~275 peer reviewed articles over 40 years (1968-2006)

Short-Term
- Birth Anomalies
- Fetal Growth
- Neurobehavioral
- Withdrawal

Long-Term
- Achievement
- Behavior
- Cognition
- Growth
- Language

(Behnke & Smith, 2013)

Supported by the Health Resources and Services Administration
## Short-Term Effects of Prenatal Exposure

<table>
<thead>
<tr>
<th>Substance</th>
<th>Growth</th>
<th>Anomalies</th>
<th>Withdrawal</th>
<th>Neurobehavioral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>Strong Effect</td>
<td>Strong Effect</td>
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<td>Effect</td>
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<tr>
<td>Nicotine</td>
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<tr>
<td>Marijuana</td>
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<td>No Effect</td>
<td>No Effect</td>
<td>Effect</td>
</tr>
<tr>
<td>Opiates</td>
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<td>Strong Effect</td>
<td>Effect</td>
</tr>
<tr>
<td>Cocaine</td>
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<td>No Effect</td>
<td>Effect</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>Effect</td>
<td>No Effect</td>
<td>Lack of Data</td>
<td>Effect</td>
</tr>
</tbody>
</table>

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

## Long-Term Effects of Prenatal Exposure

<table>
<thead>
<tr>
<th>Substance</th>
<th>Growth</th>
<th>Behavior</th>
<th>Cognition</th>
<th>Language</th>
<th>Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>Strong Effect</td>
<td>Strong Effect</td>
<td>Strong Effect</td>
<td>Effect</td>
<td>Strong Effect</td>
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<td>Nicotine</td>
<td>No consensus</td>
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<td>Effect</td>
<td>Effect</td>
<td>Effect</td>
</tr>
<tr>
<td>Marijuana</td>
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<td>No Effect</td>
<td>Effect</td>
</tr>
<tr>
<td>Opiates</td>
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<td>Effect</td>
<td>No consensus</td>
<td>Lack of Data</td>
<td>Lack of Data</td>
</tr>
<tr>
<td>Cocaine</td>
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<td>Effect</td>
<td>Effect</td>
<td>Effect</td>
<td>No consensus</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>Lack of Data</td>
<td>Lack of Data</td>
<td>Lack of Data</td>
<td>Lack of Data</td>
<td>Lack of Data</td>
</tr>
</tbody>
</table>

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

Supported by the Health Resources and Services Administration
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.

Questions to Ask

• What collaboratives currently exist in your state?
• Are current efforts treating the parent-infant dyad? Or focusing only on one?
• How are women with SUDs identified and engaged by healthcare professionals in your state?
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
- Services for parent(s) with substance use disorders. Treatment plan includes family issues, family involvement
- Goal: improved outcomes for parent(s)

Parent’s Treatment With Children Present
- Children accompany parent(s) to treatment. Children participate in child care but receive no therapeutic services. Only parent(s) have treatment plans
- Goal: improved outcomes for parent(s)

Parent’s and Children’s Services
- Children accompany parent(s) to treatment. Parent(s) and attending children have treatment plans and receive appropriate services.
- Goals: improved outcomes for parent(s) and children, better parenting

Family Services
- Children accompany parent(s) to treatment; parent(s) and children have treatment plans. Some services provided to other family members
- Goals: improved outcomes for parent(s), children, and other family members; better parenting and family functioning

Family-Centered Treatment
- Each family member has a treatment plan and receives individual and family services.
• The parenting role is complex and **cannot be separated from treatment**

• Addressing the needs of **both parents and children** contributes to successful family outcomes

• **Parents do better in treatment when their children remain with them**

• Two generation interventions may **save money**

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**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 + Recovery Coach = 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)

Supported by the Health Resources and Services Administration
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

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)
Focuses on opioid use during pregnancy

Recovery of pregnant and parenting women and their families

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.

Substance Exposed Infants In-Depth Technical Assistance (SEI-IDTA, 2014-Present)

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

Supported by the Health Resources and Services Administration
• 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.

• 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
Questions to Ask

• Is family centered treatment available in your community?
• What recovery supports are in your community?
• Do community members share common values about SUDs and recovery?

Medications used to Treat Opioid Use Disorders

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

Comprehensive Addiction and Recovery Act (CARA) amendments to the Child Abuse Prevention and Treatment Act (CAPTA)

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.”

Supported by the Health Resources and Services Administration
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

1974 Child Abuse Prevention and Treatment Act (CAPTA)

2003 The Keeping Children and Families Safe Act

2010 The CAPTA Reauthorization Act

2016 Comprehensive Addiction and Recovery Act (CARA)

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”

Supported by the Health Resources and Services Administration
• 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

A COLLABORATIVE APPROACH

Women with substance use disorders are identified during pregnancy... engaged into prenatal care, medical care, substance use treatment, and other needed services...

A Plan of Safe Care for an infant and their parents or caregivers is developed reducing the number of crises at birth for women, babies, and systems!

Supported by the Health Resources and Services Administration
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**
Preparing for baby’s safe arrival and beyond

- **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**

Plans of Safe Care benefit from being...

---

**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

---

Supported by the Health Resources and Services Administration
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)
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

$40 million
Regional Partnership Grants
Kinship Navigator Programs

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

$70 million
SAMHSA Drug Courts

$1 billion
35%
Treatment funds to SAMHSA for states
SAMHSA budget increase

Supported by the Health Resources and Services Administration
$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

$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

Supported by the Health Resources and Services Administration
$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

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

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Taking Next Steps
What will you do?

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?
Jill Gresham, MA
Senior Associate
National Center on Substance Abuse and Child Welfare
Jgresham@cffutures.org
(714) 505-3525

RESOURCES

Supported by the Health Resources and Services Administration
51
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


NCSACW Resources

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

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

Supported by the Health Resources and Services Administration
Resources To Help Address The Opioid Crisis
For Families Involved in the Child Welfare System

In-Depth Technical Assistance

- 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

- 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
References


• Center for Behavioral Health Statistics and Quality. (2017). 2016 National Survey on Drug Use and Health: Detailed Tables. Substance Abuse and Mental Health Services Administration, Rockville, MD.


Supported by the Health Resources and Services Administration
References Cont.

References Cont.


References Cont.

References Cont.


Supported by the Health Resources and Services Administration
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

Supported by the Health Resources and Services Administration
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

Supported by the Health Resources and Services Administration
ARTS Program: Transforming the Delivery System of Medicaid SUD Services

All ARTS Services are Covered by Managed Care Plans
A fully integrated Physical and Behavioral Health Continuum of Care

Magellan will continue to cover community-based substance use disorder treatment services for fee-for-service members

ARTS
4/1/17

Inpatient Detox
Partial Hospitalization
Residential Treatment

Intensive Outpatient Programs
Opioid Treatment Program
Office-Based Opioid Treatment

Case Management
Peer Recovery Supports

ARTS 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

Supported by the Health Resources and Services Administration
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.

**Increases in Addiction Providers Due to ARTS**

---

**Over 350 new Addiction Treatment Provider Organizations in Medicaid**

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

*Supported by the Health Resources and Services Administration*
### VCU Evaluation: Outcomes From First Year of ARTS

**Increase in total number of Substance Use Disorder Outpatient Providers**

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of SUD Outpatient Providers</td>
<td>1,087</td>
<td>2,965</td>
<td><strong>↑173%</strong></td>
</tr>
<tr>
<td>Physicians</td>
<td>261</td>
<td>1,571</td>
<td><strong>↑502%</strong></td>
</tr>
<tr>
<td>NP</td>
<td>25</td>
<td>188</td>
<td><strong>↑652%</strong></td>
</tr>
<tr>
<td>Counselors and SW</td>
<td>300</td>
<td>457</td>
<td><strong>↑52%</strong></td>
</tr>
<tr>
<td>Other</td>
<td>501</td>
<td>749</td>
<td><strong>↑50%</strong></td>
</tr>
</tbody>
</table>

### VCU Evaluation: Outcomes From First Year of ARTS

**Increase in total number of Opioid Use Disorder Outpatient Providers**

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of OUD Outpatient Providers</td>
<td>570</td>
<td>1,352</td>
<td><strong>↑137%</strong></td>
</tr>
<tr>
<td>Physicians</td>
<td>128</td>
<td>586</td>
<td><strong>↑358%</strong></td>
</tr>
<tr>
<td>NP</td>
<td>13</td>
<td>66</td>
<td><strong>↑408%</strong></td>
</tr>
<tr>
<td>Counselors and SW</td>
<td>142</td>
<td>236</td>
<td><strong>↑66%</strong></td>
</tr>
<tr>
<td>Other</td>
<td>287</td>
<td>464</td>
<td><strong>↑62%</strong></td>
</tr>
</tbody>
</table>

*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)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Members with SUD receiving treatment</td>
<td>15,703</td>
<td>24,615</td>
<td>↑57%</td>
</tr>
<tr>
<td>Members with OUD receiving treatment</td>
<td>10,092</td>
<td>14,917</td>
<td>↑48%</td>
</tr>
</tbody>
</table>

VCU Evaluation: Outcomes From First Nine Months of ARTS

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

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Total number of prescriptions for opioid pain medication</td>
<td>549,442</td>
<td>399,678</td>
<td>↓27%</td>
</tr>
<tr>
<td>Number of prescriptions per 10,000 members</td>
<td>3,811</td>
<td>2,761</td>
<td>↓28%</td>
</tr>
</tbody>
</table>
VCU Evaluation: Outcomes From First Ten Months of ARTS

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

<table>
<thead>
<tr>
<th></th>
<th>Before ARTS (Apr 2016-Jan 2017)</th>
<th>After ARTS (Apr 2017-Jan 2018)</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Visits Related to SUD</td>
<td>24,962</td>
<td>21,445</td>
<td>↓ 14%</td>
</tr>
<tr>
<td>ED Visits Related to OUD</td>
<td>5,016</td>
<td>3,756</td>
<td>↓ 25%</td>
</tr>
</tbody>
</table>

VCU Evaluation: Outcomes From First Ten Months of ARTS

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

<table>
<thead>
<tr>
<th></th>
<th>Before ARTS (Apr 2016-Jan 2017)</th>
<th>After ARTS (Apr 2017-Jan 2018)</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalizations Related to SUD</td>
<td>13,182</td>
<td>12,650</td>
<td>↓ 4%</td>
</tr>
<tr>
<td>Hospitalizations Related to OUD</td>
<td>3,520</td>
<td>3,315</td>
<td>↓ 6%</td>
</tr>
</tbody>
</table>

Supported by the Health Resources and Services Administration
### VCU Evaluation: Outcomes for Pregnant Women

**Increase in pregnant members with Substance Use Disorder receiving treatment**

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

**Increase in pregnant members with Opioid Use Disorder receiving treatment**

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

*Supported by the Health Resources and Services Administration*
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

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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

Supported by the Health Resources and Services Administration
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
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.
Treatment

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

Kimberly Early

Pennsylvania’s Strategy

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

- Neonatal Abstinence Syndrome
  - Epi-Aid
  - CAPTA

Kimberly Early

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Strategies for Pregnant Women

- Recovery Home Model
- Opioid Prescribing Guidelines

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

Kimberly Early

Supported by the Health Resources and Services Administration
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.

Kimberly Early

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.

Kimberly Early
• 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.

Kimberly Early

• 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.

Kimberly Early
Obstetrics and Gynecology

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Kimberly Early
State Efforts for Women with SUD in Colorado

Amy Cooper, LPC
Women’s Services Coordinator

Special Connections

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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/

Supported by the Health Resources and Services Administration
Special Connections

• Program Challenges:
  • Eligibility limitations
  • Capacity

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

Supported by the Health Resources and Services Administration
Next Steps for Colorado:
Efforts for the Future

Women in the Criminal Justice System

Supported by the Health Resources and Services Administration
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

Supported by the Health Resources and Services Administration
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

Supported by the Health Resources and Services Administration
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

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

Bercuvitz
**MA hospitals with highest rates of NAS in 2015**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Rate of NAS discharges per 1,000 live births</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metro</td>
<td>75.2</td>
</tr>
<tr>
<td>Covenant</td>
<td>66.5</td>
</tr>
<tr>
<td>St. Luke’s</td>
<td>53.8</td>
</tr>
<tr>
<td>BMC</td>
<td>44.7</td>
</tr>
<tr>
<td>Cape Cod</td>
<td>44.1</td>
</tr>
<tr>
<td>Brockton Memorial</td>
<td>41.5</td>
</tr>
<tr>
<td>Everett Memorial</td>
<td>41.6</td>
</tr>
<tr>
<td>Fairview</td>
<td>33.2</td>
</tr>
<tr>
<td>H. Lee Smith</td>
<td>32.2</td>
</tr>
<tr>
<td>Holyoke</td>
<td>30.4</td>
</tr>
<tr>
<td>Holyoke Hospital</td>
<td>29.9</td>
</tr>
<tr>
<td>Holyoke Hospital</td>
<td>26.2</td>
</tr>
<tr>
<td>Holyoke Hospital</td>
<td>25.0</td>
</tr>
<tr>
<td>Holyoke Hospital</td>
<td>22.7</td>
</tr>
<tr>
<td>Holyoke Hospital</td>
<td>21.9</td>
</tr>
<tr>
<td>Holyoke Hospital</td>
<td>19.8</td>
</tr>
<tr>
<td>Holyoke Hospital</td>
<td>19.5</td>
</tr>
<tr>
<td>Holyoke Hospital</td>
<td>17.6</td>
</tr>
<tr>
<td>Holyoke Hospital</td>
<td>16.8</td>
</tr>
</tbody>
</table>

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.

---

**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.)

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

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.)

Chapter 55 Data Structure

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 (NI)
- 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)


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

OEN = Opioid exposed newborn

Source: PNQIN Project Database

Sample Hospital QI Project—Preliminary

Eligible for study Matched to EI Referred to EI Intake Evaluated Eligible Enrolled Enrolled > 6 Months

Supported by the Health Resources and Services Administration
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

The data that drove the program

• Division of Children, Youth and Families (NH’s Child Welfare Agency)

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<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Age 0 – 2</td>
<td>253</td>
<td>228</td>
<td>146</td>
<td>116</td>
<td>114%</td>
</tr>
<tr>
<td>Age 3 – 5</td>
<td>188</td>
<td>109</td>
<td>98</td>
<td>99</td>
<td>167%</td>
</tr>
<tr>
<td>Age 6 – 8</td>
<td>95</td>
<td>79</td>
<td>52</td>
<td>42</td>
<td>125%</td>
</tr>
<tr>
<td>Age 9 – 11</td>
<td>87</td>
<td>54</td>
<td>51</td>
<td>26</td>
<td>158%</td>
</tr>
<tr>
<td>Age 12 – 14</td>
<td>68</td>
<td>46</td>
<td>44</td>
<td>25</td>
<td>172%</td>
</tr>
<tr>
<td>Age 15+</td>
<td>47</td>
<td>31</td>
<td>36</td>
<td>42</td>
<td>12%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>688</td>
<td>547</td>
<td>429</td>
<td>312</td>
<td>-</td>
</tr>
</tbody>
</table>

- Percent of children removed with allegations of substance abuse, drug abuse, or poisoning/homicide gases in assessment: 5% (N=355), 6% (N=329), 4% (N=208), 4% (N=137)
- Percent of children born “drug-exposed” at time of referral and allegation founded: 4% (N=49), 5% (N=328), 5% (N=228), 4% (N=149)
- Percent of children removed from their home where substance abuse was a risk factor at time of referral: 67% (N=460), 52% (N=288), 62% (N=246), 59% (N=180)


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)

![](chart.png)

### 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

- 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

### Mandatory Performance Measures

**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
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

Supported by the Health Resources and Services Administration
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


**Texas**

Presentation about the Mommies Program