Florida Healthy Start
Florida Association of Healthy Start Coalitions
www.HealthyStartFlorida.com

Improving Outcomes for Mothers & Babies: Substance Use (Rev. 12-15-20)

In Florida, the number of women of reproductive age affected by substance use disorder is increasing. The use of licit and illicit substances such as alcohol, opioids, and other drugs has resulted in adverse outcomes both during pregnancy and for infants.

Healthy Start plays an integral role in addressing the issue of maternal substance use and Neonatal Abstinence Syndrome, or NAS. We are a critical bridge between the public and private sectors and work with hospitals, OB/GYNs, Pediatricians, Managed Care Plans, child dependency services, behavioral health, academic institutions, public health and parents to coordinate efforts and build strategies toward solution-building.

Prevalence & Impact

An estimated five percent of women — or more than 11,000 in Florida — use one or more addictive substances during pregnancy.[1] Smoking tobacco or marijuana, taking prescription pain relievers, or using illegal drugs during pregnancy is associated with poor birth outcomes, including stillbirth.[2] Drinking alcohol during pregnancy can cause miscarriage, stillbirth, and a range of lifelong physical, behavioral, and intellectual disabilities known as Fetal Alcohol Spectrum Disorders.[3] Babies whose mothers use drugs and other substances during pregnancy are at risk of experiencing Neonatal Abstinence Syndrome requiring withdrawal at birth and extended NICU stays.[4]

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Most alarming, drug-related deaths are now the leading cause of death to mothers during pregnancy or within one year after birth, accounting for 1 in 4 of these deaths in Florida.[5] There are now as many maternal drug-related deaths as deaths due to traditional causes of maternal mortality such as obstetric hemorrhage or preeclampsia. Seventy-five percent of maternal drug-related deaths occur after the baby is born and the mother has been discharged.[6] This trend in maternal mortality is attributable to a quadupling in the rate of pregnant women identified at delivery admission with opioid use from 0.5 per 1,000 deliveries in 1999 to 6.6 in 2014.[7]

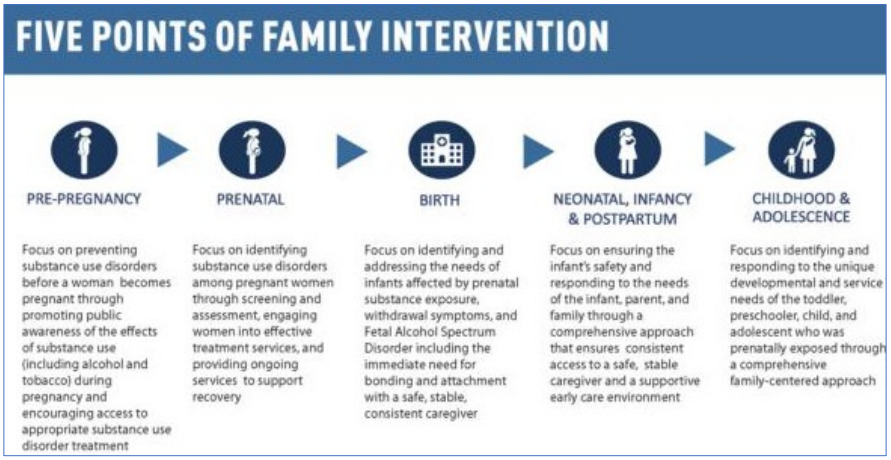
Substance Use Disorder (SUD) is a life-threatening but treatable chronic condition. Research shows that pregnancy offers a critical window of opportunity for identifying, treating and effectively managing SUD.[8] Women affected by SUD are motivated to stop or reduce illicit opioid use during pregnancy and to seek prenatal care for the best outcomes for their child, and to prevent removal by protective services.[9]

Effectively addressing the needs of families impacted by substance use requires a coordinated and comprehensive approach at the state and community level. Families are touched by multiple systems: criminal justice, child welfare, health and social services, mental health and substance abuse treatments among others. Based on an analyses of policies and practices in 10 states, the Five Points of Family Intervention identify key points in time when comprehensive cross-system efforts can help to prevent prenatal substance exposure, address the needs of pregnant and parenting women with substance use disorders, and respond to the needs of children who are affected.[10] Essential components of care for pregnant woman and their families include:

- **Identification and linkage to services:** *Screening, Brief Intervention, and Referral to Treatment* (SBIRT) is an evidence-based approach to delivering early intervention treatment services for persons with substance

use disorders, and those at risk of developing a substance use disorder. All women of childbearing age should be screened for substance use by health, social service and other community providers. Women with identified issues or risks should be counseled briefly using motivational interviewing and linked as needed with treatment and support services.[11]

- **Coodination of care across systems:** Federal legislation requires the development of a *Plan of Safe Care* for infants affected by substance abuse withdrawal symptoms or a fetal alcohol spectrum disorder. The Plan of Safe Care outlines services and supports needed by families across multiple providers and systems. Unlike a safety plan or hospital discharge plan, the Plan of Safe Care is a voluntary document developed collaboratively with the family to address their strengths and needs. Ideally, development of a Plan of Safe Care is initiated as soon as substance use by the mother or the infant's exposure is identified.[12] The Plan of Safe Care should be shared across providers, regularly monitored and updated as appropriate.



- **Access to treatment, including Medication Assisted Therapy (MAT):** The use of MAT during pregnancy is a recommended best practice for the care of pregnant women with opioid use disorders.[13,14] MAT is the use of medications in combination with counseling and behavioral therapies to mitigate the physical effects of addiction. MAT during the postpartum period reduces the risk of maternal overdose deaths.
- **Community supports:** Access to safe housing, food security, legal and mental health services for co-occurring disorders are essential for pregnant and parenting women in recovery. Access to voluntary, support services, such as peer counselors and home visiting can contribute to successful recovery.
- **Overdose prevention:** Naloxone should be readily available to mothers, particularly following delivery, to prevent overdose, the leading cause of maternal mortality in and around pregnancy in Florida.

Barriers

Florida has utilized state and federal resources to take positive steps in addressing the needs of pregnant women, infants and their families impacted by substance use. Challenges remain, however, including:

- **Lack of provider screening:** Despite professional recommendations encouraging the use of universal screening, SBIRT and the availability of validated screening tools,[15] screening is not consistently offered by prenatal providers and delivering hospitals. Commonly cited reasons include lack of time, training, insurance coverage and reimbursement, and knowledge of/availability of treatment. There is also stigma and bias among providers associated with caring for pregnant women with OUD and other substance use.
- **Diffused responsibility and fragmentation of services:** The Florida Department of Children and Families assumes responsibility for the development of Plans of Safe Care (POSC) for families that become involved in the child protection system, primarily at the birth of an affected infant. Led by special task forces and

other volunteer groups, there are efforts to engage more community providers, particularly prenatally, in POSC development. These efforts have been more successful when there is a community champion or backbone organization to facilitate and coordinate inter-agency work (First 1000 Days Sarasota, for example). It remains difficult to share information across systems and agencies.

- **Shortage of MAT providers:** Prenatal care and women's health providers are reluctant to complete training and obtain a waiver to prescribe MAT due to stigma, time required to manage patients, reimbursement and related factors based on focus groups conducted by the Florida Perinatal Quality Collaborative as part of its Maternal Opioid Recovery Effort (MORE) project.
- **Medicaid eligibility and coverage:** Loss of Medicaid or other health care benefits after delivery (such as, through loss of infant custody) may result in reduced access to MAT, as well as behavioral health and related treatment services. There are also issues related to Medicaid coverage and provider reimbursement for prenatal substance abuse screening, SBIRT, developing and updating Plans of Safe Care.

Strategies

Opportunities and best practices for addressing the needs of pregnant women, infant and families impacted by Substance Use Disorders, include:

1. Enhance postpartum Medicaid coverage for pregnant women to 12 months, ensuring access to needed substance abuse treatment and services both prenatally and after delivery (See related FAHSC issue paper on Enhancing Medicaid Benefits for Pregnant Women).
2. Address the need for Medicaid reimbursement for substance abuse screening, SBIRT, the Plan of Safe Care and other critical components of care. Designate women with Substance Use Disorder as high-risk, and offer enhanced reimbursement for comprehensive care.
3. Encourage integration of SBIRT into electronic medical records and other public health data systems, including HMS.
4. Facilitate and support community planning for Plans of Safe Care by continuing to offer competitive planning grants and ongoing funding. Expand Plans of Safe Care tracking system beyond DCF-involved families.
5. Designated case management/social work/peer navigators should be immediately accessible through specialized home visiting programs (ie, CAPTA) and all MMC plans to support OB offices in caring for Substance Use Disorder patients.
6. Provide Naloxone postpartum directly to all women with Opiod Use Disorder at hospital discharge.
7. Modification of Rule 65-D to include family planning follow up for women of reproductive age in any DCF licensed treatment service.

Return on Investment and Human Benefit

- Home visiting = $3.13 saved for each $1.00 spent[16]
- Reduced NICU stay = $19.00 saved for each $1.00 spent[17]
- Expanded family planning = $7.09 saved for each $1.00 spent[18]
- Expedited MAT = $11.13 saved for each $1.00 spent[19]
- Reducing number of infants in foster care = $15,480 per child[20]
- Reduced maternal mortality

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