Innovative Care Models:
Integrated Prenatal Care and Substance Abuse Treatment

Dr. Julia Vance, MS, CNM
Telia Grant, PRM, PARC
Objectives

Review prevalence of SA in pregnancy
- National
- Oregon
- Our Clinic and Program

Discuss Policy implications, barriers and facilitators to integrated care provision
- National Child Protective Legislation
- Statewide Reporting Laws
- Organizational Policies

Provide evidence of benefits to collaboration between Child Welfare, Corrections, Recovery Support and Clinicians
- The Carrot and the Stick
- Shared Care Plans
- Accountability

Discuss Program and Outcomes
- Numbers served
- Abstinence rates
- Parenting rates
56.7% of women entering treatment are of childbearing age.
Why focus on drug treatment in pregnancy?

Pregnancy is one of few times that women of childbearing age will access health care.

All women want a healthy pregnancy.

Substance use decreases with pregnancy.

Let’s talk about the scope of the problem of substance use in pregnancy as well as gender differences in addiction.

Each episode of sobriety improves the chances that relapses will be shorter and less severe.
Scope of the Problem: Alcohol

• Alcohol is 3rd leading cause of death in US
  • 30% of men and women meet criteria for Alcohol use Disorder

• What is high risk drinking for women?
  • > 8 drinks per week or > 4 at a sitting

• FASD remains the #1 cause of preventable mental retardation in the U.S.
  • (0.5-7/1000)

• Oregon 2011: 27.3% of women drank 1-14 drinks per week in the three months prior to pregnancy
  • 20% reported binge drinking

• ETOH use declines in pregnancy
  • Alcohol use = 8.5%  Binge use = 2.7%
  • First trimester: 17.9% / 6.6%
  • 2nd trimester: 4.2% / 1.1%
  • 3rd trimester: 3.7% / 0.4%
Scope of the Problem: Illicit Substance use

- Illicit Drug Use in pregnancy has remained stable from 2009-2014
  - What is considered illicit?
  - Legal? Known harm?

- Overall 2.9% of women aged 15-44 use substances during pregnancy, differences by age
  - 15-17 years olds = 18.3%
  - 18-25 year olds = 9%
  - 26-44 year olds = 3.4%
Gender Differences

• **Methamphetamine use**
  • 18-24 yo women use at more than double the rate of men
  • Women start using at an earlier age.
  • Emerging research suggests that women are more physiologically susceptible to methamphetamine dependence

• **Alcohol**
  • Women become dependent faster and suffer physical damage much more quickly than men with the same amount of intake

• **Heroin**
  • Greatest increases in groups with historically low rates of use:
  • Women who are insured and middle to upper income
“The Opiate Epidemic”

- > 50% Rx or street sourced pills
- 2 people per hour die from opiate OD
  - more than cocaine and heroin combined
  - Multnomah County Oregon 9 ODs per week, 2 deaths per week
- NIH: 4.2 million people > 12 yo have used heroin at some point during their lifetimes.
- 25% will become addicted
  - 900,000 chronic heroin users in the US
- 2013-2014:
  - OD deaths increased by 26%
  - > 10,500 per year
- Non-Hispanic whites 18-44yo had the highest rate for heroin overdose death
  - 7.0 per 100,000
Heroin Use Has INCREASED Among Most Demographic Groups

<table>
<thead>
<tr>
<th>SEX</th>
<th>2002-2004*</th>
<th>2011-2013*</th>
<th>% CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>2.4</td>
<td>3.6</td>
<td>50%</td>
</tr>
<tr>
<td>Female</td>
<td>0.8</td>
<td>1.6</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AGE, YEARS</th>
<th>2002-2004*</th>
<th>2011-2013*</th>
<th>% CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-17</td>
<td>1.8</td>
<td>1.6</td>
<td>--</td>
</tr>
<tr>
<td>18-25</td>
<td>3.5</td>
<td>7.3</td>
<td>109%</td>
</tr>
<tr>
<td>26 or older</td>
<td>1.2</td>
<td>1.9</td>
<td>58%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RACE/ETHNICITY</th>
<th>2002-2004*</th>
<th>2011-2013*</th>
<th>% CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Hispanic white</td>
<td>1.4</td>
<td>3</td>
<td>114%</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>1.7</td>
<td>--</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ANNUAL HOUSEHOLD INCOME</th>
<th>2002-2004*</th>
<th>2011-2013*</th>
<th>% CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $20,000</td>
<td>3.4</td>
<td>5.5</td>
<td>62%</td>
</tr>
<tr>
<td>$20,000–$49,999</td>
<td>1.3</td>
<td>2.3</td>
<td>77%</td>
</tr>
<tr>
<td>$50,000 or more</td>
<td>1</td>
<td>1.6</td>
<td>60%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HEALTH INSURANCE COVERAGE</th>
<th>2002-2004*</th>
<th>2011-2013*</th>
<th>% CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>4.2</td>
<td>6.7</td>
<td>60%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>4.3</td>
<td>4.7</td>
<td>--</td>
</tr>
<tr>
<td>Private or other</td>
<td>0.8</td>
<td>1.3</td>
<td>63%</td>
</tr>
</tbody>
</table>

Heroin Addiction and Overdose Deaths are Climbing

Heroin-Related Overdose Deaths (per 100,000 people)

Heroin Addiction (per 1,000 people)

Heroin use is part of a larger substance abuse problem.

Nearly all people who used heroin also used at least 1 other drug.

Most used at least 3 other drugs.

Heroin is a highly addictive opioid drug with a high risk of overdose and death for users.

People who are addicted to...

- Alcohol: 2x more likely
- Marijuana: 3x more likely
- Cocaine: 15x more likely
- Rx Opioid Painkillers: 40x more likely

...more likely to be addicted to heroin.

Responding to the Heroin Epidemic

**PREVENT**
People From Starting Heroin
- Reduce prescription opioid painkiller abuse.
- Improve opioid painkiller prescribing practices and identify high-risk individuals early.

**REDUCE**
Heroin Addiction
- Ensure access to Medication-Assisted Treatment (MAT).
- Treat people addicted to heroin or prescription opioid painkillers with MAT which combines the use of medications (methadone, buprenorphine, or naltrexone) with counseling and behavioral therapies.

**REVERSE**
Heroin Overdose
- Expand the use of naloxone.
- Use naloxone, a life-saving drug that can reverse the effects of an opioid overdose when administered in time.
What about Marijuana?

• Legal status is changing
• Medical vs recreational
• Newest information related to behavioral and cognitive difficulties in school age children
• Teen brains are particularly sensitive
• What do you say to pregnant women?

**TREAT MARIJUANA THE SAME AS ALCOHOL!**

• No safe level of use
• There are safe medication alternatives that can be used to manage sx of pregnancy
• Why take the chance?
Impacts of fetal exposure to substances
Physical Effects
Costs of Infants Exposed in Utero

- **Increased use of health care, psychiatric and behavioral treatment**
- **Early Intervention and Special Education services and residential or other institutional care.**
- **Increased rate of foster care, juvenile and criminal justice involvement**
- **Social Security Disability Insurance payments, lost employment productivity and personal rates of substance abuse.**

**Millions of dollars that Medicaid spent in 8 states on FASD in one year**
9 times the cost of controls, 2.8 x more than ID alone without FASD

**The daily cost of one day in the NICU, not including medications, labs, physician fees**

**A Substance Affected Infant is born every 19 Minutes**
28,000 per year

**EI**

**$6897**

**19**
Foster Care

• Substance use and foster care placement
  • It is estimated that between 60-70% of all substantiated child protective service cases and over 80% of parents with children in foster care involve substance abuse disorders

• Oregon:
  • 2,324, or 56.4% of Oregon children placed in foster care in 2012 were removed due to parental alcohol or substance abuse
  • 2014-2015 cost of $31,367 per child per year.

- 51% are reunified with their families
- 21% exit to adoption
- 16% exit to live with relatives or guardians
- 10% age out
- 2% other
Federal Law regarding CPS Reporting of Substance Exposed Infants

• 2003: Keeping Children and Families Safe Act
  • Requires reporting of SE infants to child protection
  • 36 states have laws or policies that relieve providers of reporting requirements
  • 9 states plus D.C. appear to conform
  • Remaining 5 are too confusing to interpret
Family First Act: Wyden/Hatch

• “A parent’s drug addiction is becoming a growing reason for removing children from their homes and placing them in foster care,” Wyden said.

• Allows states to use federal foster care funds to provide prevention and treatment services to addicted parents
  • Goal is to keep kids with parents
  • increased prevention, treatment and law enforcement.

• Shifting foster care funds to help parents cope with addiction will reduce costs

Family First Prevention Services Act of 2016
Strengthen families by providing evidence-based prevention services to keep children out of foster care and reduce inappropriate group home placements
State Legislation: Substance use in Pregnancy

Child Abuse under CW law

Civil Commitment

Assault

Women specific tx; 10 give women priority
4 outlaw discrimination based on pregnancy

Mandate HCP reporting in pregnancy
Mandate testing if use is suspected
Policies: Mixed messages

- State Mandatory Reporting laws
- CPS Reporting Laws
- Labor & Delivery Postpartum Lactation Peds
- 42 CFR
- Carrot and Stick
Why do women avoid prenatal care?

- Stigma
- Judgmental Providers
- Fear of CPS Involvement
- Lack of Care for older kids
- Fear of SA treatment
Other Barriers to Health Care Access

• Poverty
  • At risk for homelessness
  • Transportation
  • Long term lack of Health care coverage
    • May be first time that women are eligible for Medicaid
      • First opportunity to address dental needs
      • High risk for HIV, Hep C
      • Preexisting medical conditions: HTN, DM
  • ACA and Mental Health Coverage
    • Untreated PTSD, CPMI, MH DOs
What does research show the ideal women’s treatment should include?

• SA treatment for up to 12-18 months.
• On-site child care
• Women centered treatment
  • Education around self-sufficiency, parenting, trauma/sexual abuse, nutrition and health education.

• Results for women who complete treatment:
  • Lower rates of use, fewer arrests and parole violations, less unemployment and less use of government assistance.
  • Earlier placement of infants with their mothers in treatment resulted in longer lengths of stay, lower rates of maternal depression and higher self-esteem.
How does an integrated model address barriers

• Non-judgmental welcoming environment
  • Peer Recovery Mentor outreach
• Personal Support
  • Collaboration and Advocacy with CW and Corrections
• Family Support services
  • PRM- family outreach
  • Primary role to connect with Recovery Community
• Access to support services on site from SW / A&D
  • Medical Home
  • Collaboration with CPS, Treatment and Corrections
Why Co-location?

• Albrecht et al. (2011) used a retrospective cohort survey design to evaluate 10,661 pregnant treatment admissions during 2006.

• The effect of wait times to treatment entry impacted completions rates

• Women qualifying for OP tx that was immediately available (same day) were most likely to complete treatment.

• Even delaying admission by one day reduced completion by 31%
  • Women had more time to recognize barriers related to child care, employment or relationship conflict.

• Other things associated with treatment completion:
  • Employment
  • Referral to treatment by the court
  • High school education

• Therefore, recommendation is to coordinate services and modify policies to facilitate immediate entry into care.

• Both of these recommendations are met by the co-location of prenatal and substance abuse assessment and treatment services.
Two Original Clinical Sites: Integrated & Co-located Care

**WHO WE ARE?**
CNMs, MD, CADC, PRM, Doulas, SW

**WHAT WE DO?**
- Substance Use Tx and Health Care HOME
- Prenatal Care and Doula services
- Social Work interventions
  - IPV, housing, transportation, Trauma informed care
- Drug and Alcohol Assessment and Treatment
  - Referral to higher level of care if needed
  - Coordination of Medication Assisted Therapy (MAT)
  - Collaboration with inpatient tx providers

**HOW WE ARE DIFFERENT?**
CADC within CNM Clinic
FP within MAT Clinic
Project Nurture: Legacy Midwifery
Meet Our Team

Julia Vance, CNM
(Original Lead Clinician, Data Management, Program Design)

Telia Grant
Peer Recovery Mentor & Doula

Diana Smith, CNM, Data Management

Chelsea Barbour, MSW, Project Lead, Parenting Group

Annie Johnson, CNM Clinician

Susan CADC, PN and PP Groups, Assessments
Tenets of Practice Change

- History of SA identification process at our site
- SW Self-report 10%
- Chart review 22.3%
- Screening with 5 Ps Plus 31.58%
- Identification of SA in pregnancy
- Implementation of universal screening
- 5Ps Plus
  - Only validated tool for pregnancy
  - Parents, Peers, Partner, Past, Present, Smoking, Emotional and IPV
- Point of care identification
- Immediate access to assessment & treatment
**Peer Recovery Mentor Model**

- **Definition:**
  - Person who has progressed in their own recovery (at least 2 years)
  - Alcohol, drug abuse or mental health disorder

- **Role:**
  - To assist others with chemical dependency or mental disorder from peer perspective

- **Unique Perspective that training cannot replicate**

- **Traditional Health Worker Program**
  - OHP billing for both PRM (and doula) services

- **Certification (differs by state)**
  - Training: 40 hours
Peer Addictions Recovery Support Counselor

- 500 hours supervised internship
  - 25 hours supervision by CADC
- Additional 40 hours education
  - HIPAA / 42 CFR
  - Fair housing
  - Mandatory Reporting
  - Civil Rights
  - Informed Consent
  - OAR and Medicaid Fraud
PMR Recovery Support

• Keeping Recovery First
  • Recovery role model
  • Relapse prevention and intervention services

• Outreach and Case management
  • Parenting, recovery, housing ……EVERYTHING!

• Life skills training
  • Self-sufficiency in accessing resources
  • Self Care
  • Accessing Recovery Support

• Self advocacy
  • health care, treatment, parenting and mental health

• Focus on strengths

• Diversity and inclusion

• Self-direction, empowerment and choice

• Supportive rather than Directive
And……..She even helps women birth!

**Doula services**

- Care and support for mother and family during and after labor
- Breastfeeding education and support
- Care delivered during group/individual sessions and during hospital stay
Stories of Success

• Jeanine
  • Reunification / custody retained

• Nickie
  • Family relinquishment / recovery / parenting

• Tasha
  • Relapse reentry into tx x4 / parented/removed/parented
  • Other child with father / engaging
What have we seen thus far............?

130 women eligible for Project Nurture, majority decline

Engaged Prenatally: 47
Parenting: 34/39
Relapsed: 9
Women with 9 other kids in termination proceedings had all kids returned:

- Engaged Prenatally: 47
- Parenting: 34/39
- Relapsed: 9
- Women with 9 other kids in termination proceedings had all kids returned.
What about the babies...........?

39 born thus far, additional 12 currently pregnant

- **Babies with NAS.** Hospitalized from 5-48 days
- **Dyads attending Parenting Group**
- **Babies born preterm**  
  > 32 weeks
- **Current on imms and developmental assessments**  
  100%
Ongoing Barriers

• Need for tiered method of reimbursement for care provision of complex patients
  • Case Management
  • PRM and Doula
• Benzodiazepine detox while pregnant
• Housing especially with felonies or drug convictions
• Transportation and Child Care
• “Double dipping” with PN SA treatment groups and inpatient rules
• No Inpatient treatment available for women with children over 5 yo
• Lack of prescribers for MAT (OR bill would allow PA and NP Rxing)
• Continuing misinformation among medical providers, especially inpatient nursing and pediatric providers
• Data collection challenges
Collaboration is the Key!

**PRM**
- Program growth and treatment uptake increased dramatically

**Corrections**
- Building PN into court requirements
- Shared outcome goals

**IT**

**CW**
- Shared treatment goals
  - Coordination of services to decrease duplication of care

**SUD Treatment**
- Shared outcome plans
  - Billing issues, shared drug testing results and building PNC into treatment plans when inpatient
Questions?
References


Addiction Counselor Certification Board of Oregon. www.accbo.com

NIAAA, 2013
National Survey on Drug Use and Health (NSDUH,2013)
Oliveros & Kaufman, 2010
Albright &Rayburn, 2009
Goodman & Wolff, 2013
Dluzen & Liu, 2008
SAMHSA, 2014.
Albright &Rayburn, 2009
Amendah, Grosse & Bertrand, 2010
O’Brien and Phillips, 2011