# Vermont's CHARM (Children and Recovering Mothers) Team:

*A collaborative approach to supporting pregnant and parenting women with opioid use disorders and their infants*


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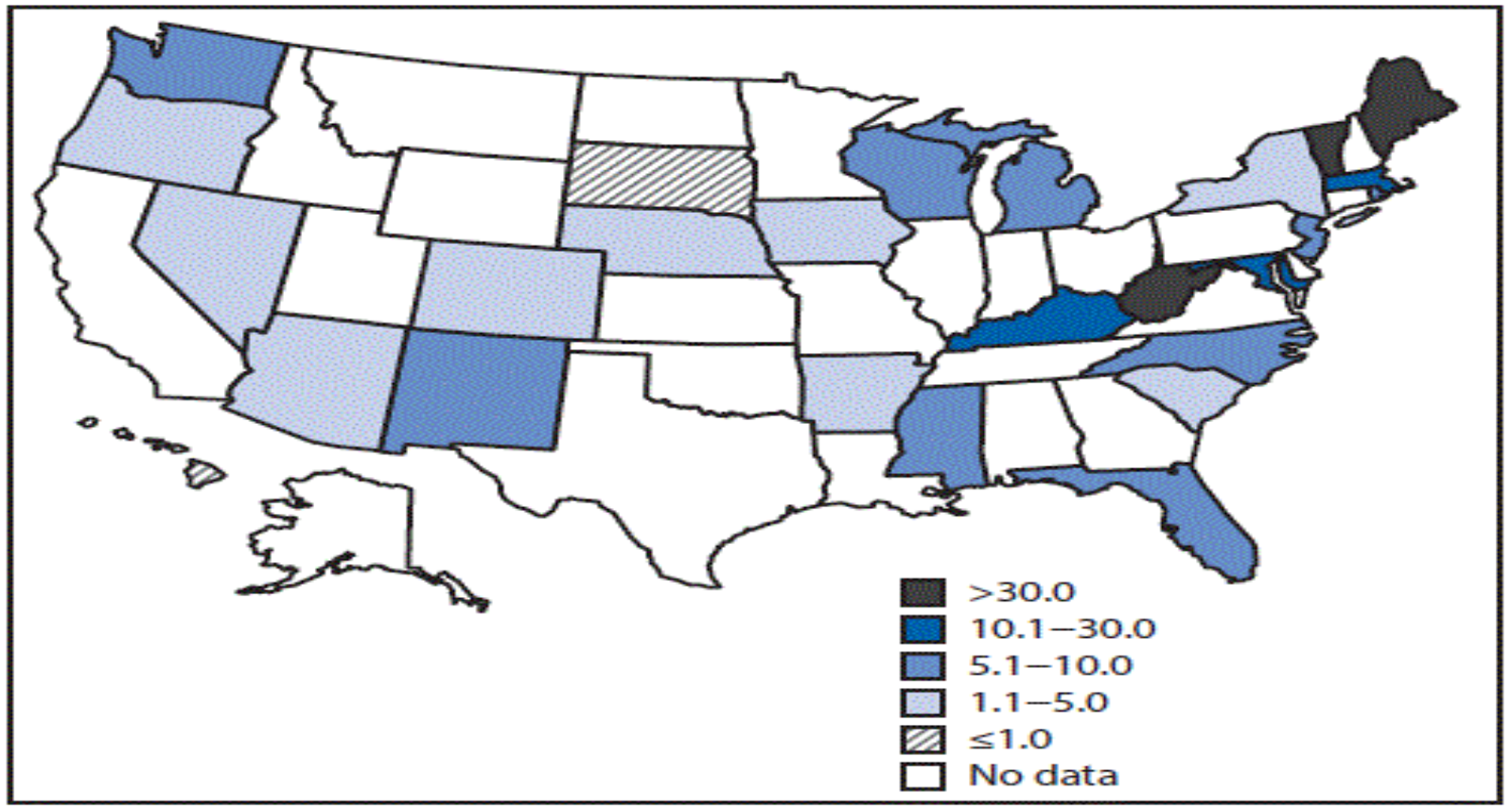
***OFA PeerTA Webinar: Opioid Use Disorder, Treatment, and Barriers to Employment Among TANF Recipients***

*March 29, 2018*

# Agenda

- Opioid dependence in pregnancy
- Opioid-exposed newborns
- The CHARM collaborative

# Neonatal Abstinence Syndrome (NAS) Incidence Rates – 25 States, 2012-2013




| | |
|---|---|
| Maine | 30.4 |
| Vermont | 33.3 |
| W Virginia | 33.4 |

Vermont had the highest annual rate increase of states surveyed

Ko JY, Patrick SW, Tong VT, Patel R, Lind JN, Barfield WD. Incidence of Neonatal Abstinence Syndrome — 28 States, 1999–2013. MMWR Morb Mortal Wkly Rep 2016;65:799–802

# INCREASE IN NAS IN VERMONT

Represents:

- Increased access to safe treatment,
  both prior to pregnancy and during pregnancy

- Increased identification

**This is a good thing!**

# Myth #1: Opioids during pregnancy ➔ "damaged baby"

- There is no evidence that opioid exposure, in and of itself, results in developmental delay or any other lasting effects on the exposed child
- On the other hand, alcohol exposure can result in profound physical/developmental/behavioral effects

# Myth #2: Every baby born to a mother on opioids is born "addicted"

- Opioid-exposed: exposure to opioids – either prescribed or illicit
- Opioid-dependent: infant exhibits signs of withdrawal severe enough to need medication
- Opioid-addicted: infants cannot be addicts; the disease of addiction requires obsession and compulsion, loss of control, "breaking the rules"
- Vermont data show that only 20% of opioid-exposed infants require treatment

"Addicted newborns"

# Myth #3: If a baby needs treatment for opioid withdrawal, it must be because the mother "used" opioids during pregnancy

- The severity of withdrawal is not associated with the dose of medication during pregnancy
- Exposure to tobacco can increase the severity of withdrawal
- Higher Neonatal Abstinence Scores do not indicate that a mother has "used" during pregnancy

# Myth #4: Opioid abuse + pregnancy = child abuse

- >1500 babies born to opioid-dependent women followed through our clinic
- Over 80% of these babies were discharged in the care of their mother +/- father (2002 – 2016)
- The majority of parents we see are actively engaged in treatment and display good parenting, many need support in order to do so
- If a parent is not adhering to treatment, does not want to receive treatment, **and** is actively using – they may NOT be ready to parent a child

# Why is medication-assisted treatment for pregnant women with opioid use disorder the standard of care?

- Decreases prematurity and low birth weight
- Improves the health of the pregnancy
- Lowers infant mortality
- Pregnant woman feels well (not “high”) and has no cravings
- Successful engagement in treatment increases the probability of good parenting
- Detoxification during pregnancy is rarely successful and dangerous to the fetus

**Concern:** anything that drives pregnant opioid-dependent women from seeking treatment results in more prematurity, higher infant mortality, less probability of successful parenting

# The **untreated** woman with opioid-use disorder who delivers a newborn

- Neonatal opioid withdrawal
- Neonatal complications:
  - Prematurity, low birth weight
  - Meconium aspiration, transient tachypnea
  - Feeding difficulty, seizures, jaundice
- If recognized that mother is opioid-dependent:
  - Child protective services involvement
  - Challenge of taking care of newborn and starting treatment for addiction
- If unrecognized and infant exhibits no withdrawal:
  - After discharge infant may be particularly irritable
  - Family's ability to cope and seek help is impeded by fear of discovery
  - Mother will probably remain active in her addiction
  - Infant may be exposed to unsafe situations
  - Mother continuously "flying under the radar" and hiding her addiction
  - Mother often unwilling to come forward for fear of losing her child/children

*www.thefix.com*

# Opioid dependence : Treatment options

- Detoxification – generally not safe nor advisable in pregnancy

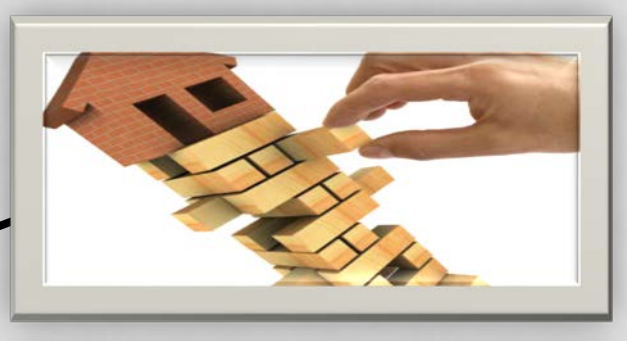
- Medication Assisted Treatment (MAT): the standard of care in pregnancy
  - Methadone

  - Buprenorphine


- Harm Reduction
  - Needle exchange

# Issues facing substance-using pregnant women and their children

- **Generational substance use**
- **Untreated mental health problems**

- **Legal involvement**
- **Unstable housing**
- **Unstable transportation**

- **Limited parenting skills and resources**
- **Exposure to trauma**

- **Lack of positive and supportive relationships**

*Slide courtesy of H Jones*

# Shame

# Focus on the mother's health to have better outcomes

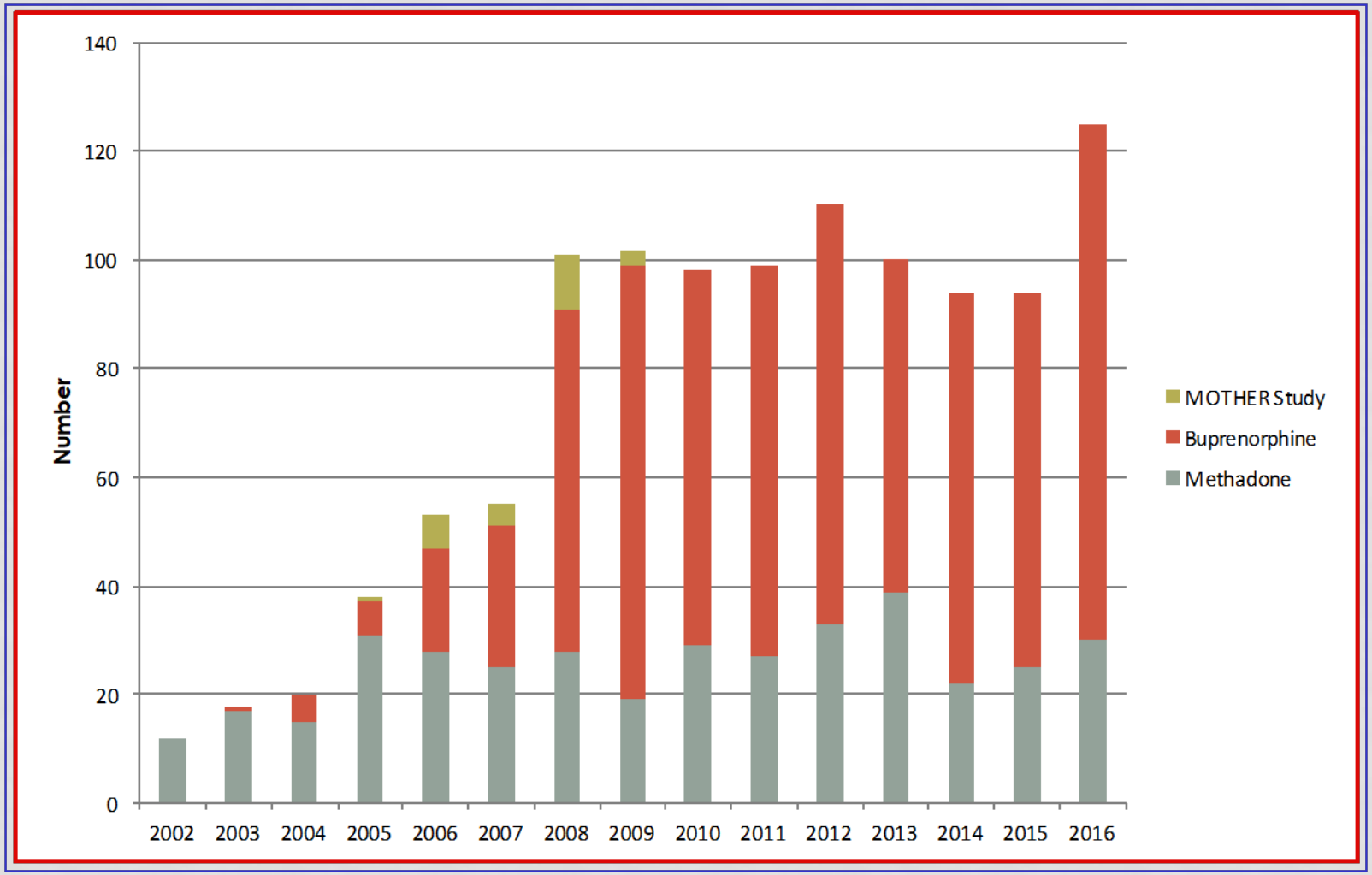
- Build trust
- Focus on respect and strengths
- Decrease fear and shame
- **Promote breastfeeding**

# UVM CHILDREN'S HOSPITAL: EVALUATION AND MANAGEMENT OF NAS

- NAS scoring using modified Finnegan, transitioning to ESC; maximize non-pharmacologic care
- Inpatient methadone for newborns requiring medication
- Once infants are stable on methadone for 72 hours, they are discharged home
- Importance of assessing home and safety concerns
- Importance of caregiver education regarding methadone
- NeoMed Clinic visits within 1 week and then every 2 weeks for weaning of methadone, monitoring of growth and development, monitoring of parent(s) recovery

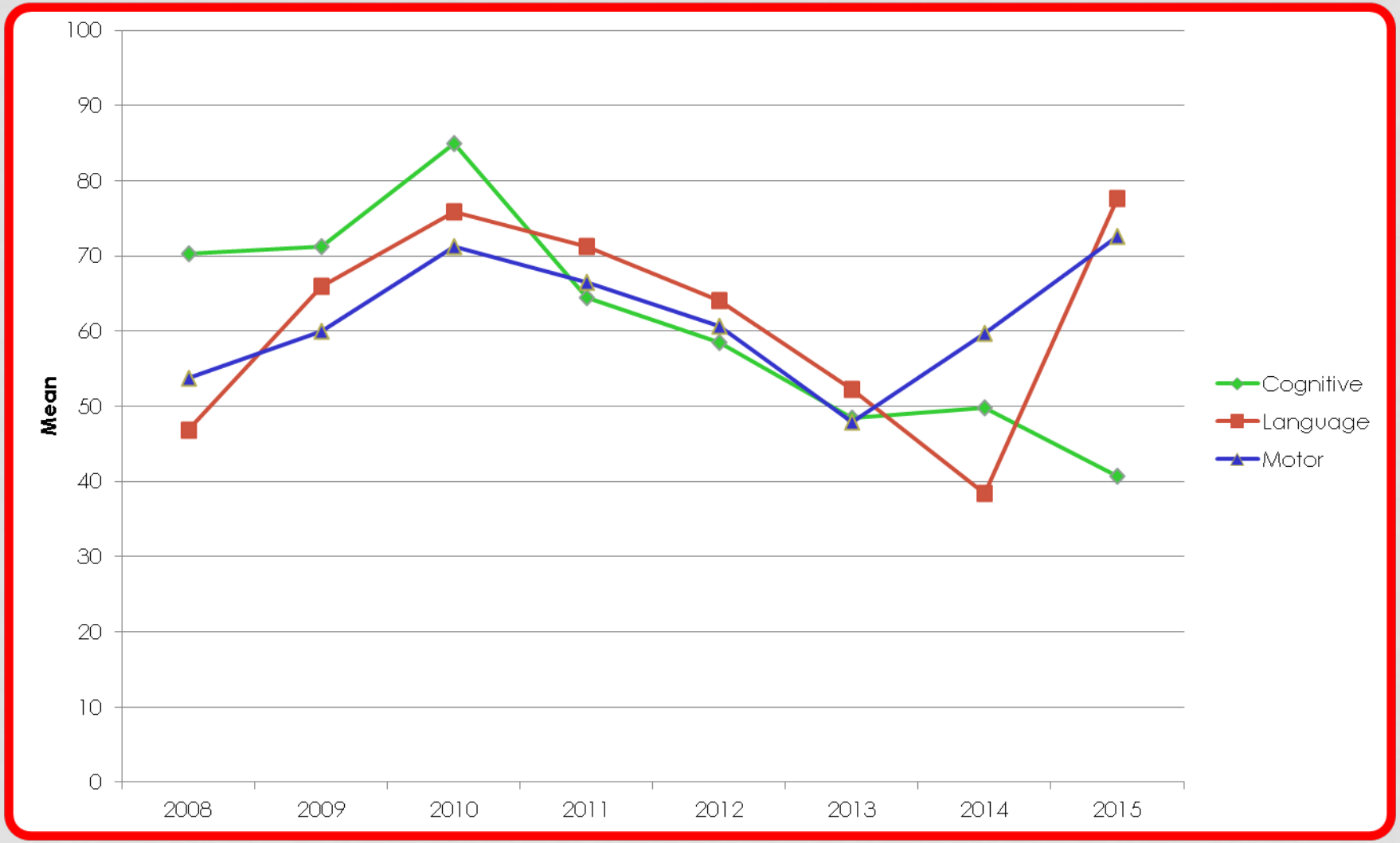
# *UVM Children's Hospital:*

Infants born (at UVM) to opioid dependent women with substance use disorder on **methadone** or **buprenorphine** at delivery (N = 1,119)



# *UVM CHILDREN'S HOSPITAL*

## BAYLEY III: MEAN PERCENTILE RANK (N=277) 7-14 MONTHS OF AGE



# Key Points

- The incidence of neonatal abstinence syndrome is increasing – does this represent increased identification of cases, increased access to care for pregnant opioid-dependent women?
- Behind every case of neonatal abstinence syndrome, there is a mother suffering from the disease of addiction – this is where efforts need to be the greatest – need to decrease judgement, increase access to trauma-informed treatment
- Developmental/behavioral outcomes are overall not affected by opioid-exposure in utero on its own, unlike alcohol exposure
- Community strategies that focus on punishment will result in increased morbidity and mortality for children and their families
- Healthy collaboration between partners working with families is essential

# CHARM: Children and Recovering Mothers

- CHARM is an **inter-disciplinary and cross-agency team** that **coordinates care** for pregnant and postpartum mothers with a history of opioid use disorder and their babies.
- **Model collaborative approach**
  (US Dept. of Health and Human Services, SAMHSA 2016)

## CHARM Goal:

To improve the **health and safety outcomes of babies** born to women with a history of opioid use disorder
by **coordinating** medical care, substance abuse treatment, child welfare, and social service supports

# Challenges for TANF Recipients

- Health Care: Prenatal and Postpartum Care
- Substance Abuse Treatment: MAT; Counseling: Level of Care
- Services and Supports: Child Care, Housing, Transportation
- “Reach Up” Requirements

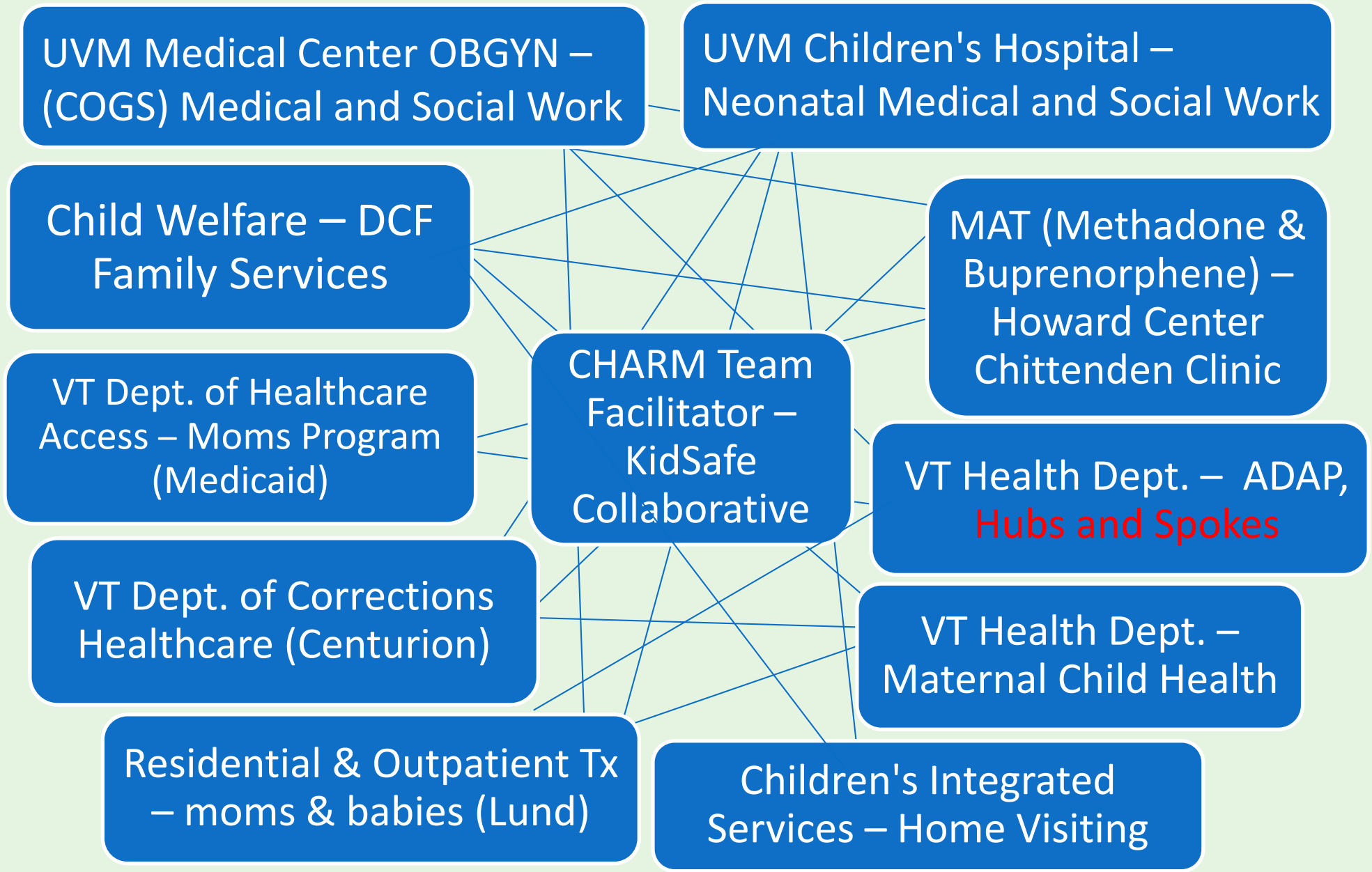
# CHARM: Promising Prevention Model

- Pregnancy: Opportunity for Change
- Early Access to Prenatal Care and Substance Abuse Treatment
- Early child welfare involvement, assessment and develop plans of safe care *prior to birth*
- Coordinated Services and Supports
- Systems for collaboration: information sharing to support health/safety of moms and infants

# CHARM Beginnings

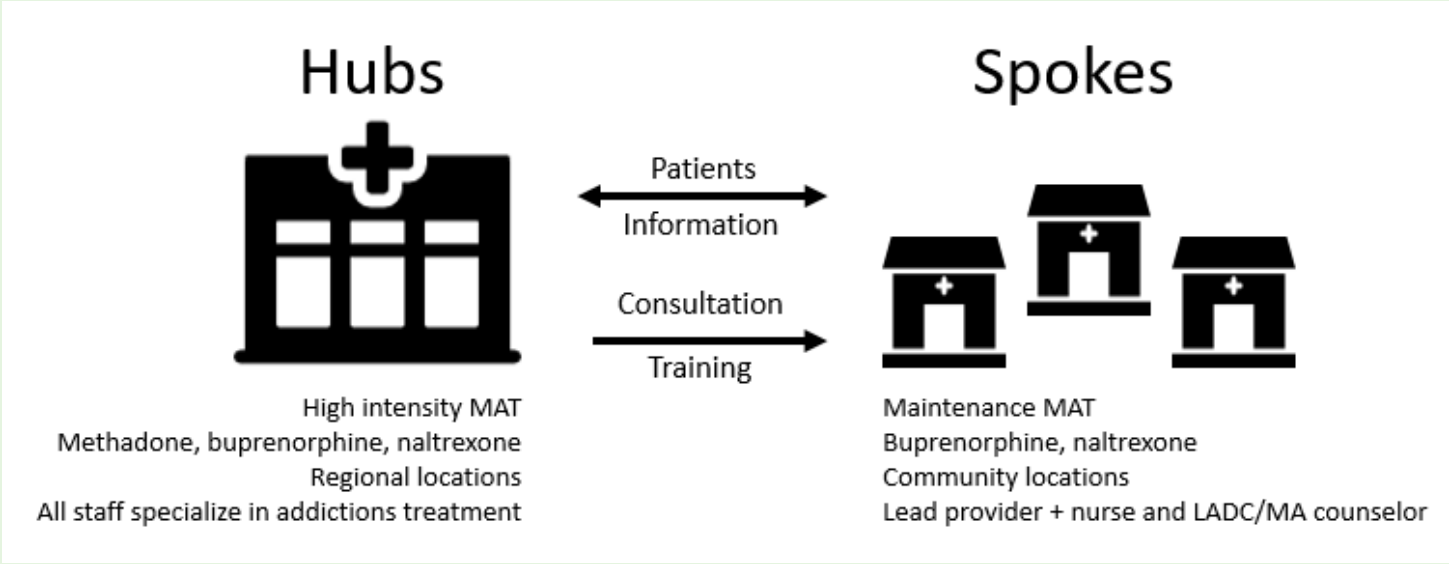
- 1998
  - No MAT available in VT for pregnant woman with opioid use disorder
  - Physician request: individual waivers from Opiate Treatment Authority
- 2002
  - Substance abuse physician, OB, and Neonatologist meet, coordinate care for pregnant women needing treatment.
  - First methadone clinic opens
- 2003
  - Additional community-based health and social services join coordination – start of multi-disciplinary approach; these efforts lead to the CHARM Team
- 2004-2006
  - KidSafe joins to facilitate team; empanelment as VT Multi-disciplinary Child Protection Team; development of MOU, release of Information; operating procedures
- Current
  - Development of “Hub & Spoke” Substance Abuse Treatment/MAT system
  - CHARM has operated continuously; MOU and ROI updated; SAMHSA recognition

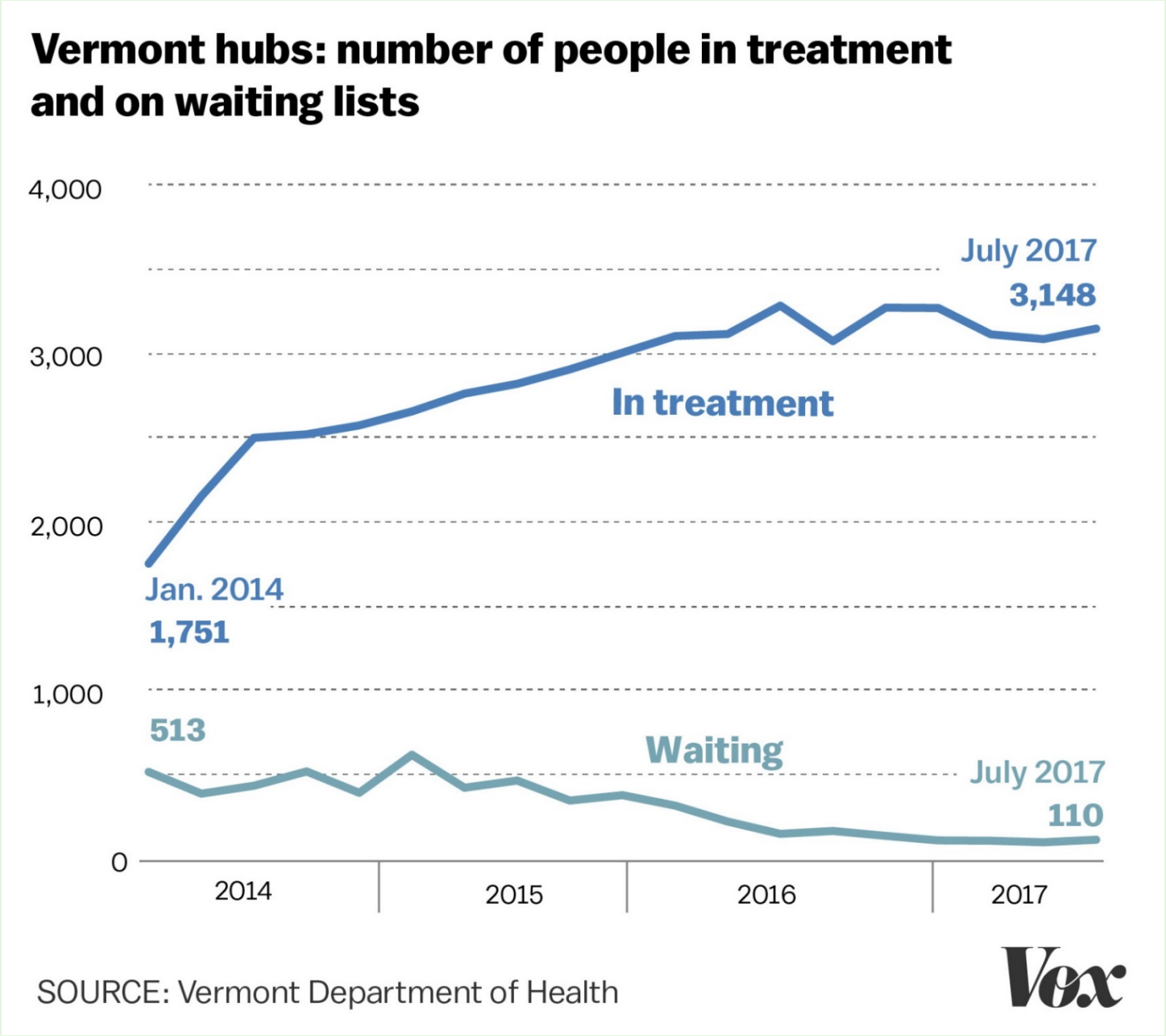
# CHARM Team – Partner Organizations



# Hub and Spoke:
## Vermont's Opioid Use Disorder Treatment System

- **Hub and Spoke** is Vermont's system of Medication-Assisted Treatment, supporting people in recovery from opioid use disorder
- **Nine Regional Hubs** offer daily support for patients with complex addictions
- Over **75 local Spokes:** doctors, nurses, and counselors offer ongoing addiction treatment fully integrated with general healthcare and wellness services
- Efficiently deploys addictions expertise and expands access to opioid user disorder treatment for Vermonters






Vermont's Blueprint for Health uses claims and clinical data to evaluate program impact and program costs.

A peer-reviewed article in *Substance Abuse Treatment* journal showed that health care costs for Vermonters in MAT were lower than for Vermonters with opioid addiction not in MAT, even when including the substantial treatment costs.

# Key Elements of CHARM Collaboration

- **A Shared Philosophy:** improving care and supports for mothers is the most important factor in helping to ensure healthy and safe infants

- **Shared Information** improves child safety and healthy outcomes

- **Memorandum of Understanding:** provides an important **framework** for sharing information and coordinating services; consent to release information

- **Vermont Law:** "Empanelled" as a **multi-disciplinary "child protection" team** under VSA Title 33 §4917

# CHARM Team Meetings: How it Works

- **Team Members**
  - Average of 11 agencies/departments represented at each CHARM team meeting
- **Meet Monthly**
  - 12- 13 participants per month
- **Systems Issues**
  - First 10-15 minutes of each meeting
- **Case Reviews**
  - Average 15-20 case reviews per meeting

# CHARM: Case Review

At each monthly meeting the CHARM team reviews a list of current cases and prioritizes cases for discussion:

- All **pregnant** patients due in upcoming month
- *Prioritized* **high-risk prenatal** patients
- All **new pregnant** patients
- All **new babies**/post-partum patients
- *Prioritized* **high-risk post-partum patients** and their babies

# Information Sharing at CHARM Meetings

- **Prenatal Care**

  ***Initial:*** Confirm pregnancy, assess for opioid dependence

  ***Ongoing:*** compliance with prenatal visits and monitoring; referrals for specialty or community services

  - **Medication-Assisted Treatment:** consistency, urine drug tests, dose adjustment, substance abuse counseling

    *Follow-up:* post-partum MAT provider plan

  - **Residential** program option for moms and babies

  - **Case Management and Referrals**: WIC, breastfeeding, nurse home visiting, social support services

    *As available: gift cards, transportation passes, baby items*

- **Post-partum and Neonatal Medical Follow-up**

# CHARM:
# Key Elements of Patient Success

- Start prenatal care early in pregnancy
- Pregnant women receive pharmacological treatment for opioid dependence early in pregnancy
- Engaged in substance abuse counseling
- Attend prenatal care appointments
- Attend Neomed Clinic appointments
- Family and social supports, stable housing
- **Plan of safe care**

**Vermont**

**CHARM Team Data -** Calendar Year 2016

| | |
|---|---|
| Number of Adult Patients | 103 |
| Number of babies | 91 |
| **Total number of individuals served** | 194 |
| **# of Case Reviews** | 276 |

# Child Protection

**DCF Policy: *Assessment* may begin one month before due date, where there is**:

- Serious threat to a child's health or safety
- Mother's substance abuse during third trimester

**Innovative approach:**

- Planning for safe environment for the infant
- Allows time for family engagement prior to birth
- Child maltreatment prevention: earlier indication of risk/parent is unable to parent safely
- Avoid unnecessary placement crisis at birth

# CHARM "System Outcomes"

- **More pregnant women are in treatment earlier with better prenatal care:**
  - Pregnancy: opportunity to engage in treatment
  - Fewer premature births; fewer small birth weight infants
- **Better care for infants:**
  - Support for moms, shorter hospital stay, attachment
  - Plans of Safe Care
- **Child safety**: Safety assessed, support services accessed, and plans of safe care initiated prior to birth
  - Fewer emergency custody orders at time of birth
  - Decisions made based on better information from project partners about safety and risks

**Improved collaboration = safer babies**

# CHARM Process Outcomes

- Time-saver
- Develop **trust**; minimize misunderstandings
- Improved understanding of patients/clients – more comprehensive view
- Improved understanding of each other's roles and perspectives
- Development of expertise among project partners: health and safety issues for opioid-exposed newborns
- Child Protection decisions made based on better information about safety and risks
- Have a "go-to" contact

# Challenges for Collaboration

- *Collaboration* – requires ongoing attention
- *Complex lives* – need high level of *ongoing* support
- *Assessing child safety* with parents with a history of opioid use disorder

  *Balancing act* – child welfare policies and practices: focus on child safety while not discouraging pregnant women from seeking prenatal care and substance abuse treatment
- *Privacy:* confidentiality, limits to information sharing

# *New:* Expanding CHARM Family Supports

- Connection to New Moms Recovery program – **peer support**
- Gift cards, gas cards, diapers, baby needs
- 2016 CARA Notification requirements/Plans of Safe Care
- Teaming with parents/families **beyond first year**
  - Collaborating with Reach Up (TANF)

Babyleavase.com

Adobe.com

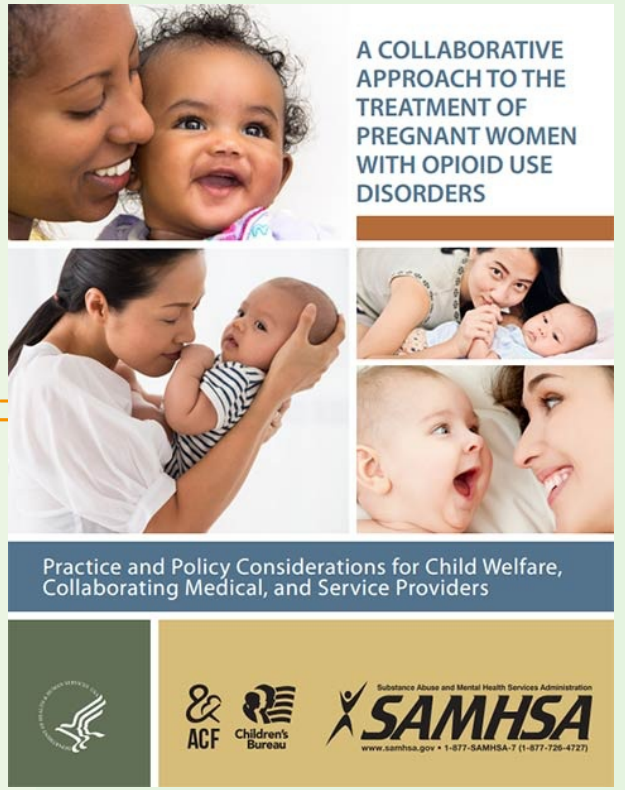
The health of the baby depends upon the mother’s health, the family’s health

- **The Children and Recovering Mothers (CHARM) Collaborative in Burlington, VT: A Case Study**

  *National Center on Substance Abuse and Child Welfare*
  http://www.ncsacw.samhsa.gov/

- Vermont Health Department – Alcohol and Drug Abuse Programs:
  **Care Alliance for Opioid Addiction**
  http://www.healthvermont.gov/response/alcohol-drugs/treating-opioid-use-disorder

- University of VT – VCHIP: **Improving Care for Opioid-Exposed Newborns (ICON)**
  http://www.uvm.edu/medicine/vchip/?Page=ICON.html



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## A collaborative approach to supporting pregnant and parenting women with opioid use disorders and their infants

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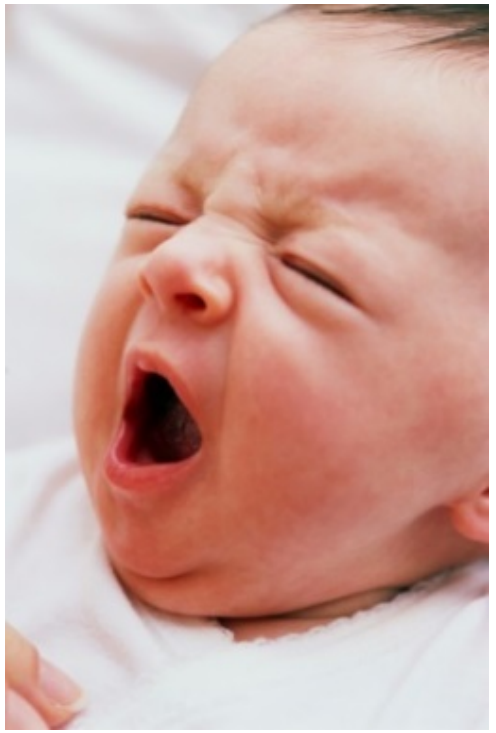

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