

SERVICE PARTNERSHIP



SUBGROUP MISSION

To explore the substance use disorder-related service needs of the HBCD participant population and the strategies by which our projects can uniformly support local efforts to meet them



DEFINITION OF STAKEHOLDERS

- Pregnant women
- Infants/children
- Caregivers - inclusive of mothers, fathers, and/or legal custodians
- Health care providers
- Community services providers

Recommendation Build bridges within the community to support participants and to support the project.



SERVICE PARTNERSHIP

DEFINITION OF NEEDS

Environmental scan of vetted services available to pregnant women, parents, and caretakers

Sharing audience-appropriate resources with our stakeholders

Providing aggregate, deidentified information regarding exposures to regional health care providers and community service providers

QUESTIONS TO OUR CABS

What actionable findings should be specified for sharing with participants?

When and how should we share information on evidence-based interventions to mitigate the effects of identified exposures?

[Review list]; What other services might be helpful, and to whom?

Recommendation Build bridges within the community to support participants and to support the project.



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SUD/ODU POPULATION

- Addiction Medicine
- Medication Assisted Treatment (MAT) Clinics/Providers
- Inpatient Treatment Providers
- Community Rehabilitation
- Peer Support/Recovery Programs

HIGH RISK POPULATION

- Perinatal Medicine
- Emergency Medicine
- Pediatric Specialists
- Mental Health Clinicians
- Preventative Services
- Early Intervention
- Social Services

GENERAL POPULATION

- Primary Care
- OBGYN/Labor & Delivery
- Pediatrics
- Family/Caregivers
- Childcare Programs/Providers
- School Teachers/Counselors

PROPOSED NEEDS AND SERVICES

Developing and providing an *environmental scan* of local programs services

Providing childcare, transportation, and other services to foster *engagement and retention*

Sharing *evidenced-based recommendations* to inform programs in our local communities

Sharing *individual-level exposure data* where appropriate

Providing *referrals* to treatment services and interventions

Providing *aggregate-level exposure data* with the local community

Hiring a *case manager* to navigate services and resources

Coordinating mentorship and *support groups*

PROPOSED TABLE OF NEEDS/STAKEHOLDERS

	Pregnant Women	Infants and Children	Caregivers	Health Care Providers	Community Providers
Environmental Scan					
Engagement and Retention					
Recommendations					
Exposure Data (individual)					
Referrals					
Exposure Data (aggregate)					
Case Manager					
Support Groups					

POPULATED SERVICE NEEDS BY STAKEHOLDER

	Pregnant Women	Infants and Children	Caregivers	Health Care Providers	Community Providers
Environmental Scan	X	X	X		
Engagement and Retention	X	X	X		
Recommendations				X	X
Exposure Data (individual)			X	X	
Referrals	X	X	X		
Exposure Data (aggregate)			X	X	X
Case Manager	X	X	X		
Support Groups	X	X	X	X	X

ADDITIONAL NEEDS

- This is a groundbreaking study for public education and the impact of substance abuse. I cannot express the value it will bring to us. The services that will be helpful will evolve as the study grows.
- Peer supports, treatment, ongoing interventions and tracking of parental and child progress, including school enrollment and development.
- In my experience as a provider, the peer recovery specialists are **IMPERATIVE** to success in recovery. They are able to relate in ways I could never imagine, and have the ability of forming a faster and stronger rapport for some patients. Also- I would involve **PHARMACISTS**. They provide a critical touch point for our patients and have the ability to provide **NARCAN** training, smoking cessation, and another face to face opportunity for this vulnerable population.
- Follow up tracking of outcomes of subsequent births in terms of exposure, maternal outreach/barriers, service acquisition, etc...
- Community education, updated resource tracking and listings, data resources, ongoing coalition work for continued collaboration and problem-solving.

ADDITIONAL NEEDS

- A case manager/navigator would be hugely beneficial. In particular, a peer in this role would be ideal- a mother in recovery. There are many services and resources that exist but great barriers to access that someone such as a case manager could educate and assist the patient and their family with overcoming or addressing- this is also where I think you could track engagement/compliance.
- A care coordinator is always beneficial. I couldn't do my job without mine. A peer is also an imperative addition to a care coordination team.
- Housing stability is a concern that faces substance addicted populations. As a result of our nation's medical model, the timeline for residential treatment often does not meet the needs of individual's battling a life long addiction. In the NY/Metropolitan area, substance exposed perinatal populations typically have to navigate the housing/shelter systems upon discharge from treatment which imposes additional challenges to rehabilitation.

PROPOSED DISCUSSION QUESTIONS

1. What actionable findings should be specified for sharing with participants?
When and how should we share perinatal case exposure data, including to opioids, with caregivers and guardians?...
Health care providers?...
Community service providers?
2. Is it ever acceptable to share regional exposure data even if the cases are not randomly distributed and in a low-density population (privacy concerns)?...
To whom and how?
3. When and how should we share information on evidence-based interventions to mitigate the effects of identified exposures?
4. What other services might be helpful, and to whom? [populate table]

DATA SHARING: CAREGIVERS AND COUNSELORS

- We want to share with the participants that they are not being singled out or alone in this process but would be a part of the solution and prevention for themselves and their children. They would be accessing the best care possible and work towards best treatment, prevention and hopefully an end to generational addiction.
- Once case exposure for that individual has been identified in order to initiate immediate treatment, and awareness to all stakeholders involved caregivers, guardians, health care providers, and (c)ommunity service providers should all be informed of case exposure data.
- It is important for this data to be shared to all stakeholders and caregivers to provide prevention, and intervention for current and future children born under this diagnosis. If we aren't sharing data and advocating for the child, then who is their voice? When and how does change occur?

DATA SHARING: COMMUNITY SERVICES PROVIDERS

- The when is more difficult to answer than the how. I fear sharing the information too early may have the participants pulling their child out of the study.
- I would say yes to all, primarily from a prevention perspective, which will also serve to help overcome stigma and normalize it to a degree that you may have an increase in pregnant women willing to seek/accept intervention prenatally. Secondarily, it would serve as a community “benchmark” for tracking of progress or spikes in need of additional or alternative intervention.
- (Y)ou could de-identify the localities for what is publicly shared and only keep the identification of Locality A, B, C, D, etc... in-house for consistency of reporting and data integrity. This would publicly reduce as much identifying information as possible without sacrificing valuable data.
- I don't know how easy it actually would be to sleuth out identities, especially without identification of a locality or a sub-group.

DATA SHARING: HEALTH CARE PROVIDERS (1)

- Yes, it is acceptable to share this information. I would limit the information sharing to those who had direct care at any point with any of the individuals.
- Yes...I would be interested in prenatal information, use at delivery, 1 mo postpartum, 3-4 mo postpartum, 6 mo postpartum, and 1 year.
- Yes, this allows the health care provider to make more informed decisions regarding the patient's care, not only in a diagnostic/clinical manner but also when considering the complexities associated with the social implications of substance use in the home. This should be disclosed prior to the patient's visit.
- Sharing aggregate exposure data with healthcare providers would be beneficial to provide education around the treatment and care of a stigmatized population. Doing so more granularly at the individual level would raise ethical concerns here in New York.

DATA SHARING: HEALTH CARE PROVIDERS (2)

- If the question is asking whether sharing data related to opioid/substance exposure as it relates to THEIR child's health and development – YES.
- As a larger region, it would be not only acceptable but very beneficial to share exposure data by zip code in New York City (not just by borough or county).
- We should obtain a consent from the patient's legal guardian to share the information with any of the patient's caregivers or service providers. This could be accomplished similarly to the CHARM model in Vermont- where there is a collaborative formed, and any service provider/agency within that collaborative are able to openly share information regarding the patient's care- as the patient and/or legal guardian sign consent to share with the coalition as an entity.



A COLLABORATIVE APPROACH TO THE TREATMENT OF PREGNANT WOMEN WITH OPIOID USE DISORDERS



Practice and Policy Considerations for Child Welfare,
Collaborating Medical, and Service Providers

- U.S. Department of Health and Human Services
- Substance Abuse and Mental Health Services Administration
- Center for Substance Abuse Treatment
- Administration for Children and Families
- Administration on Children, Youth and Families Children's Bureau

Source:

https://ncsacw.samhsa.gov/files/Collaborative_Approach_508.pdf

Appendix 5: Children and Recovering Mothers (CHARM) Collaborative in Burlington, Vermont: A Case Study

Disclaimer: The views, opinions, and content of this publication are those of the authors and do not necessarily reflect the views, opinions, or policies of the Substance Abuse and Mental Health Services Administration (SAMHSA) or of the U.S. Department of Health and Human Services (HHS). Resources listed in this document are not all-inclusive and inclusion in this list does not constitute an endorsement by SAMHSA or HHS.

Overview and Purpose

The purpose of this document is to provide an in-depth case study of a community-developed, coordinated, and comprehensive approach to caring for families affected by opioid use disorders (e.g., heroin or opioid prescription medications). The Children and Recovering Mothers (CHARM) Collaborative in Burlington, Vermont, is a multidisciplinary group of agencies serving women with opioid use disorders and their families during pregnancy and infancy. This report describes and examines two aspects of the CHARM Collaborative: (1) the multiple points of intervention for families and (2) the elements of collaborative practice across systems.

There are multiple intervention opportunities for pregnant women with opioid use disorders and their newborns across service systems and professionals, beginning before pregnancy and continuing throughout a child's developmental milestones. The National Center on Substance Abuse and Child Welfare, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Administration for Children and Families, created a five-point framework that addresses screening, assessment, referral, and engagement across all stages of development for affected children (Young et al., 2009). According to the framework, interventions can reduce the potential harm of prenatal and postnatal substance exposure at five intervention points: (1) before pregnancy, (2) during pregnancy, (3) at birth, (4) during the neonatal period, and (5) throughout childhood and adolescence.

The case study narrative in this report describes the history of CHARM and the policies and practices developed across the intervention points in the five-point framework. This document also provides examples of collaborative practices implemented by CHARM. Collaborative practice can be defined as the use of 10 system linkage elements by two or more systems, agencies, or providers to improve child and family outcomes (Children and Family Futures, 2011). The 10 elements of system linkages are: (1) underlying values and principles of collaboration, (2) screening and assessment, (3) engagement and retention in care, (4) services to children of parents with substance use disorders, (5) joint accountability and shared outcomes, (6) information and data systems, (7) budgeting and program sustainability, (8) training and staff development, (9) collaboration with related agencies, and (10) collaboration with the community and supporting families. This report examines CHARM Collaborative practices across the 10 elements of system linkage. State and community collaborative groups can use this information to guide their efforts to implement collaborative practices in their own communities.

SUMMARY

A coordinated, multi-system approach best serves the needs of pregnant women with opioid use disorders and their infants.

Source:

Treating Women Who Are Pregnant and Parenting for Opioid Use Disorder and the Concurrent Care of Their Infants and Children: Literature Review to Support National Guidance. *Journal of addiction medicine*, 11(3), 178–190.

<https://doi.org/10.1097/ADM.0000000000000308>

IMPACT OF COVID-19

- Use has increased substantially and a much higher volume of enrolling individuals are presenting due to SUD or with substantial co-occurrence of SUD than pre-COVID preliminary data suggested.
- With COVID-19 much of our treatment providers have changed their operations to telehealth and also extending MAT prescriptions beyond the typical timeframe to allow the patients a longer time before needing to return to the office for an appointment. The physical distancing measures that have been put into place have greatly affected the treatment providers' day-to-day schedule and operations.
- Because of the increased laxity in prescription lengths and drug screen requirements, and overall loss of structure in the environment of unsafe housing situations and isolation, there has definitely been an uptick in return to use for my patients and overdose.

IN SUMMARY

The Services subcommittee distributed two products for review, and draft questions for discussion by our community partners, this presentation describes the responses.

Our study participants have needs for which treatments and services can reduce long term adverse health outcomes. This includes the services to which our projects can identify and direct participants.

There is a general consensus on the value of sharing data to support comprehensive care for our study participants. This accords with the national guidance.

COVID-19 is a risk amplifier for SUDs in pregnant women. There is general consensus that pandemic mitigation strategies are complicating the ability of local stakeholders to identify and offer services to our study participants.

hBCD Service Subcommittee Members

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- David Driscoll
- Tessa Vatalaro

Members:

- Gretchen Bandoli
- Felice Borisy-Rudin
- Christina Chambers
- Minki Chatterji
- Matthew Gurka
- Christine Hockett
- Chloe Jordan
- Kerry Lee
- Carla Marienfeld
- Pilar Sanjuan

Recommendation Build bridges within the community to support participants and to support the project.

