Please note:

Due to the volume of participants, conference-line capabilities are limited. Please use the audio settings through your computer to listen to the webinar.
Public Health Approaches to Address the Opioid Epidemic: Cross-sector Collaboration in Maternal and Child Health
Reminders

• Today’s call will be recorded
• Please do not unmute your phone lines throughout the presentation.
• If you need to step away from the phone, please do not put the call on hold
• Submit questions throughout the call by using the chat box
• Please fill out the evaluation at the conclusion of the webinar
• Follow up materials will be sent in mid-May
Welcome

Lori Tremmel Freeman, MBA
Chief Executive Officer, AMCHP

Michael D. Warren, MD MPH, FAAP
President (2017-2018), AMCHP Board of Directors
Deputy Commissioner for Population Health, Tennessee Department of Health
Objectives

• Develop an understanding of state-level public health approaches to address the opioid crisis, particularly for programs that serve women, children, and families.

• Identify prevention strategies to mitigate the opioid crisis’ effect on maternal and child health populations.

• Discuss opportunities for cross-sector collaboration at the state level to address the opioid crisis.
Panelists

Jay Butler, MD
- President, Board of Directors, Association of State and Territorial Health Officials Director of Public Health, Alaska Department of Health and Social Services

Dina Lieser, MD, FAAP
- Senior Advisor at HRSA’s Maternal and Child Health Bureau’s Division of Home Visiting and Early Childhood Systems

Patricia M. Tilley, MS Ed
- Chief, Bureau of Population Health & Community Services, Division of Public Health Services, New Hampshire Department of Health & Human Services

Christina Mullins, MA
- Director, Office of Maternal, Child and Family Health, West Virginia
2017 Challenge:
Public Health Approaches to Preventing Substance Misuse and Addictions
Maternal Opioid Use and NAS, US, 2004-2013 by Location of Residence

Data from National Inpatient Sample, a nationally representative all-payer sample of hospital discharges

Scope of Substance Misuse and Addictions

- **Legal Substances**: Alcohol, Marijuana
- **Illicit Substances**: Heroin, Methamphetamines, Synthetic Cannabinoids, Cathinones
- **Therapeutic Substances and Prescription Drugs**: Opioids, Amphetamines, Benzodiazepines
- **Emerging Technologies**: Powdered Alcohol, Vaping Devices, Designer Psychoactives
Substance Misuse and Addictions: Prevention Framework

Public Health Practice Paradigms

Acute Health Event Control and Prevention
- Prevent life-threatening adverse outcomes
- SNEPs
- Naloxone
- Ignition Interlock

Chronic Disease Screening and Management
- Diagnose and treat addictions and substance use disorders
- Screening and Treatment
  - Remove Stigma
  - Understanding of Addiction as a Chronic Condition of the Brain

Environmental Controls and Social Determinants
- Reduce the need to self-medicate, control access to addictive substances, and promote protective factors
- Taxation
- Age Restrictions
- Limited Advertising
- Prevention of ACEs
- Personal and Community Resiliency
- Adolescent Risk Reduction
- Promote Mental Wellness
- Effective PDMPs and Use of Data
- Rational Pain Management
- Judicious Prescribing

Strategic Priorities
2016 - 2019 Strategic Map

Develop and Leverage Public Health Approaches to Prevent Substance Misuse, Addictions, and Related Consequences

Reduce Stigma and Change Social Norms
Increase Protective Factors and Reduce Risk Factors in Communities
Strengthen Multi-Sectoral Collaboration
Strengthen Prevention Infrastructure
Optimize the Use of Cross-Sector Data for Decisionmaking

Foster Cultural Competence and Relevance
Cross-Sectoral Collaboration is Key

- Public Health Agencies
- Attorneys General Offices
- Justice and Corrections
- Medical Boards

- Healthcare Providers
- Hospitals and Clinics
- Community Coalitions
- Businesses and Labor

- Media
- Emergency Medical Services
- Social Services Agencies
- Faith Communities

- Pharmaceutical Industry
- Educators
- Third-Party Payers
- Others
Alaska Opioid Response Incident Command System

- State Disaster Declaration
  - February 15, 2017
- Administrative Order 287
  - Multi-agency approach
  - Local, Tribal, State, Federal, and Non-Governmental Agencies
- Multi-Agency Coordination (MAC) Group
- Incident Command System
- Alaska Criminal Information and Analysis Center
- Joint Information System
What Can We Do?

• **Increase access to naloxone**
  • Provide public and professional education on administering naloxone and managing overdose
  • Eliminate liability and financial barriers
  • Authorize standing orders, third-party prescribing, and pharmacist independent dispensing

• **Support clean needle use**
  • End “drug paraphernalia laws” that restrict access
  • Support syringe and needle sales and exchange programs

• **Reduce impaired driving**
  • Support widespread and sustained use of ignition interlocks
  • Implement sobriety checkpoints
Volunteers assemble 'rescue kits' in hopes of preventing overdose deaths

About 35 volunteers helped package Heroin/Opioid Overdose Rescue Kits in a storage room at MyHouse, a homeless youth center in Wasilla on February 9, 2017. (Marc Lester / Alaska Dispatch News)
What Can We Do?

- Reframe “addictions”
  - Increase awareness of addictions as chronic health conditions

- Improve access to preconception care

- Increase screening and diagnosis
  - Incorporate Screening, Brief Intervention and Referral to Treatment (SBIRT) into healthcare and social services

- Improve access to withdrawal symptom management and support for recovery
  - Standardization of assessment and treatment of NAS
  - Remove barriers to access to therapy for withdrawal symptom management and maintenance of recovery
  - Train prescribers and dispensers on identifying and managing addictions
  - Increase facilities and providers
  - Encourage third-party payer coverage
“We have to stop treating addiction as a moral failing, and start seeing it for what it is: a chronic disease that must be treated with urgency and compassion.”

— Dr. Vivek H. Murthy, United States Surgeon General
Can a 'miracle shot' called Vivitrol break the prison-heroin cycle in Alaska?

Arielle Holmes, 28, is one of three Alaska inmates in Alaska to be the first to receive Vivitrol before her release as part of a pilot project of the state Department of Corrections. (Marc Lester / Alaska Dispatch News)
What Can We Do?

• Promote healthy families and increase resiliency
  • Promote maternal and early childhood health programs
  • Prioritize pregnant women for screening and access to treatment
  • Utilize tools outlined in CDC’s 2016 technical package, “Preventing Child Abuse and Neglect”
  • Support post-partum social support

• Reduce the prescription supply of opioids in communities
  • Develop and utilize user-friendly, robust PDMPs

• Support safer pain management and judicious prescribing
  • Expand public and professional education, including evidence-based pain management guidelines and non-opioid pain management strategies
  • Encourage providers to take the Surgeon General’s pledge
  • Develop and promote safe medication storage practices and drug return programs
What Can We Do?

Use data for assessing the problem and measuring progress

- Standardize and enhance **post-mortem toxicological testing** in investigation of suspected overdose and suicide deaths (e.g., testing for fentanyl)
- Leverage **Violent Deaths Reporting System** to increase timeliness and accuracy of data collection and analysis
- Develop **syndromic surveillance** methodology to identify clusters of overdose and substance toxicity
- Increase capacity to determine risk factors for **HCV infection**
- Establish access to and capacity to **analyze PDMP data**
- Utilize **BRFSS module assessing ACEs**
- Create **lines of communication** to assure cross-sectoral data sharing
What Will Success Look Like?

**Near horizon (next 3 years)**

- Reduced deaths from drug overdose
- Declines in NAS and FASD
- Fewer self-injection related HIV and HCV infections
- Less unintentional injuries and self-harm related to drugs and alcohol

**Further horizons**

- Lower rates of drug misuse and addiction, including underage use
- Reduced drug- and alcohol-related incarceration and re-incarceration of persons with addictions
- Lower rates of crime and referrals to child protective services
- Less interpersonal violence, self-harm, and child neglect
- Prevention of excessive prescriptions for controlled substances while improving wellness and function
Public Health Approaches to Address the Opioid Epidemic: Cross-sector Collaboration in Maternal and Child Health

May 9, 2017

Dina Lieser, MD
Senior Advisor
Division of Home Visiting and Early Childhood Systems (DVHECS)
Maternal and Child Health Bureau (MCHB)
Health Resources and Services Administration (HRSA)
We envision an America where all children and families are healthy and thriving, where every child and family have a fair shot at reaching their fullest potential.
Goals

• Elevate early childhood solutions as foundational to addressing the opioid epidemic

• Highlight exemplar strategies within the Maternal Infant Early Childhood Home Visiting and broader early childhood systems space

• Inspire you to take a concrete next step to amplify early childhood opportunities within your work
Substance Use Relational Impacts

Genetic factors
Developmental history
Environment
Stressors
Psychiatric disorders
Trauma history

Chronic use of drugs

Brain adaptations in different circuits
Reward
Motivation
Inhibitory control
Executive functioning

Maternal self-regulatory problems
Dyadic regulatory problems
Maladaptive maternal responses
Attachment difficulties
Infant developmental concerns

Loss of control over drug intake
Compulsive drug seeking
Poor decision-making
Withdrawal/tolerance

Maternal & Child Health
Principles of Substance Abuse Prevention for Early Childhood, A Research Based Guide, NIH
CHANGING TRAJECTORIES

"OUR EVIDENCE SHOWS THE POTENTIAL OF EARLY LIFE INTERVENTIONS FOR PREVENTING DISEASE and PROMOTING HEALTH."

James Heckman
Nobel Laureate in Economics
“Early Childhood Investments Substantially Boost Adult Health,” Science

Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan
AN AMERICA IN WHICH A LEGACY OF ECONOMIC SECURITY AND EDUCATIONAL SUCCESS PASSES FROM ONE GENERATION TO THE NEXT.

TWO-GENERATION PLAYBOOK
FOUNDATIONS OF HEALTH
## Benchmark Areas

<table>
<thead>
<tr>
<th>I. Maternal and Newborn Health</th>
<th>Preterm Birth; Breastfeeding; Depression Screening; Well-Child Visit; Postpartum Care; Tobacco Cessation Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>II. Child Injuries, Maltreatment, and Reduction of ED Visits</td>
<td>Safe Sleep; Child Injury; Child Maltreatment</td>
</tr>
<tr>
<td>III. School Readiness and Achievement</td>
<td>Parent-Child Interaction; Early Language and Literacy Activities; Developmental Screening; Behavioral Concerns</td>
</tr>
<tr>
<td>IV. Crime or Domestic Violence</td>
<td>Intimate Partner Violence Screening</td>
</tr>
<tr>
<td>V. Family Economic Self-Sufficiency</td>
<td>Primary Caregiver Education;</td>
</tr>
<tr>
<td>VI. Coordination and Referrals</td>
<td>Completed Depression Referrals; Completed Developmental Referrals; Intimate Partner Violence Referrals</td>
</tr>
</tbody>
</table>
Maternal, Infant, and Early Childhood Home Visiting

Number of Participants

FY2012: 34,180
FY2013: 75,970
FY2014: 115,545
FY2015: 145,561
FY2016: 160,374

Number of Home Visits

FY2012: 174,257
FY2013: 489,363
FY2014: 746,303
FY2015: 894,347
FY2016: 979,521
## MIECHV Families

### MIECHV Priority Populations
- Low-income families
- Pregnant women under age 21
- Families with a history of child abuse or neglect
- Families with a history of substance abuse
- Families that have users of tobacco in the home
- Families with children w/low student achievement
- Families with children w/ DD or disabilities
- Families with individuals who are serving or have served in the Armed Forces, including those with multiple deployments

### Populations Served in 2016
- 74% of families < 100% federal poverty
- 44% of families < 50% federal poverty
- 66% did not go to college
- 68% minority
- 22% of newly enrolled pregnant teens
- 14% of newly enrolled with history of child abuse and neglect
- 13% of newly enrolled with history of substance abuse
Evidence shows that when families receive home-based support:

- Children are healthier
- Parent-child bonds are stronger
- Abuse & neglect are less likely
- Children are better prepared for school
Enhancements, Innovations and Opportunities
Early Childhood Comprehensive Systems
Improve Developmental Skills of 3 year olds by 25% over a 5 year period

- Developmental/Relational Health Promotion
- Early Identification and Intervention
- Address Social Determinants of Health (including ACES)
- Coordinated and Aligned Systems
- Policy
- STATE IMPACT GRANTEE
- COLLECTIVE IMPACT APPROACH
- PLACE BASED COMMUNITIES

40
Healthy Start Approaches

- Improve Women’s Health
- Promote Quality Services
- Strengthen Family Resilience
- Achieve Collective Impact
- Increase Accountability
All roads lead to Resilience

Healthy family

Center for the Study of Social Policy’s Strengthening Families™, a Protective Factors Framework.
We envision an America where all children and families are healthy and thriving, where every child and family have a fair shot at reaching their fullest potential.
RESOURCES

• **Surgeon General’s Report on Alcohol, Drugs and Health (2016)**
• **Principles of Substance Use for Early Childhood: A research Based Guide (NIH) A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders (SAMHSA 2016)**
• **Advancing the Care of Pregnant and Parenting Women with Opioid Use Disorder and Their Infants: A Foundation for Clinical Guidance (SAMHSA 2016)**
• **Protecting Our Infants Act: Report to Congress**
• **Statement to Support the Coordination and Alignment of Health and Early Learning Systems (HHS 2017)**
Contact Information

Dina Lieser, MD
Senior Advisor
Division of Home Visiting and Early Childhood Systems (DVHECS)
Maternal and Child Health Bureau (MCHB)
Health Resources and Services Administration (HRSA)
Web: mchb.hrsa.gov/programs/homevisiting
Twitter: twitter.com/HRSAgov
Facebook: facebook.com/HHS.HRSA
Infant Safe Plan of Care: Protecting Infants and Families (a work in progress)

Patricia M. Tilley, MS Ed
Chief of Population Health and Community Services
NH Department of Health and Human Services
Carfentanil Kills 3 In NH

Carfentanil, an elephant tranquilizer, was detected for the first time in New Hampshire this week. It's 100 times deadlier than fentanyl.

Nearly 470 Babies Were Born Exposed to Drugs in 2016, DCYF Says

DCYF chief laments 'perfect storm,' explosion of NH cases

By DAVE SOLOMON

Neglecting children: DCYF report shocks NH

EDITORIAL

"Why has this been allowed to go on for so long?"

That's the question Sen. Sharon Carson asked after reading a shocking report about New Hampshire's Division of Child, Youth and Families.

Children of drug users are growing victims in opioid epidemic
Comprehensive Addiction and Recovery Act

In August 2016, “CARA” legislation amended the Child Abuse Prevention and Treatment Act (CAPTA) providing further detail about \textbf{plans of safe care} for infants exposed to substances

- Health care providers must notify state Child Protective Services of all infants \textit{born and identified as affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure}, or a Fetal Alcohol Spectrum Disorder.
Plans of Safe Care

- Early identification, screening and engagement of pregnant women who are using substances.

- Appropriate treatment for pregnant women, including timely access, comprehensive medication and guidelines and standards for treatment

- Consistent hospital screening pregnant women, postpartum women and their infants

- **Consistent hospital notifications to Child Protective Services (CPS), including questions and responses that will help CPS hotline workers assess risk and protective factors and safety concerns**

- Memoranda of Agreement for information sharing and monitoring infants and families across systems

- Ongoing care plans for mothers and their infants that include home visitation, early intervention services and recovery supports; and plans of safe care that are of sufficient duration
The Question of Protective Custody

• Reasons for placing an infant in protective custody would be based on immediate risk and safety concerns that are present and not mitigated by sufficient familial protective factors to provide for the infant’s safety.

• Regardless of whether an infant is “screened in” or “screened out”, the Plan of Safe Care must include specific follow up plans that support the family and focus on the longer-term well-being of the infant, mother and family.
We should be the first to try something new...

Quick! Form a committee!!
The New Hampshire Team

- In full partnership with our child protection agency (DCYF), we worked with stakeholders across the state to develop a draft plan. Stakeholders included:
  - Northern New England Perinatal Quality Improvement Network
  - Birth Attendants
  - Hospital Social Workers
  - Prenatal Providers
  - Hospital Risk Management
  - Medication Assisted Treatment Providers
  - Advocacy Organizations
  - Representation from the NH Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment, and Recovery
The Role of Plans of Safe Care in Ensuring the Safety and Well-Being of Infants with Prenatal Exposure, Their Mothers and Families

A Discussion draft in Development of A Technical Assistance White Paper

March 26, 2016
Updated October 4, 2016
Plans of Safe Care

Requirements

• The Plan of Safe Care for each family must involve an assessment of the strengths of and challenges for the mother, her infant and her family. Including:
  – Safety
  – Risk
  – Strengths
  – Protective Capacities/Support System

• Optimally, the plan is developed with a pregnant woman and her prenatal and treatment team over the course of her pregnancy

• The plans should be based on a preference that infants, mothers, and families can remain together.
Infant Safe Plan of Care

NAME OF PARENT(0):
Mother’s Full Name ___________________________ DOB ______________ Contact Number: ______________
Street Address ______________________________ City/Town ______________ State __________ Zip __________

Father’s Full Name ___________________________ DOB ______________ Contact Number: ______________
Street Address ______________________________ City/Town: ______________ State: ______________ Zip: __________

1. HOUSEHOLD MEMBERS (Those who live in the home where the infant will reside):

<table>
<thead>
<tr>
<th>NAME</th>
<th>DATE OF BIRTH</th>
<th>RELATIONSHIP (e.g. maternal/parental, grandparent, sibling, aunt, uncle, etc.)</th>
<th>PRIOR DCYF INVOLVEMENT, if known</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

siblings not in the household? □ Yes □ No □ Unknown

Parent has supportive relationships with one or more persons willing to participate in safe care planning:

If yes, identify name and relationship to parent

<table>
<thead>
<tr>
<th>(Name)</th>
<th>(Relationship)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

□ Yes □ No □ Unknown

Page 1 of 8
Current Plan

- Five Hospital Systems are Beta Testing
  - Twice Monthly Group Calls To Provide Feedback, Support and Problem Solving

- Anticipated July 2017 Statewide Rollout
  - Training needs are undetermined at this time
Challenges and Lessons Learned

• Balancing the need for broad stakeholder input, consensus building and form development
  
  • Beta Testing is key

• Implementation based on less than optimal or imprecise Federal language
  
  • “born and identified as affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure”

• Confidentiality of Drug and Alcohol Treatment/42 CFR part 2 Considerations

• NAS as a result of Medication Assisted Treatment
Value of Public Health/MCH Leadership

- Substance misuse and child maltreatment are multifaceted problems that require a multidisciplinary solution

- Public Health/MCH Leadership was a logical convener of the medical community

- Increased coordination with other Neonatal Abstinence Syndrome efforts, as well as:
  - Data Collection and Dissemination
  - Guidelines/Protocols
  - Fatality Reviews
  - MCH Services- Home Visiting, Prenatal Care, etc.
Opiate Abuse and the Growing Impact on Maternal and Child Health in West Virginia

Christina Mullins, Director
Office of Maternal, Child and Family Health
Bureau for Public Health
May 9, 2017
Overview

• Describe epidemic in West Virginia.
• Discuss the collaborative relationships used to develop and implement recommendations and strategies.
• Provide an overview of key strategies.
Drug Overdose Rates by State

US Resident Overdose Deaths by State, 2015

West Virginia #1
41.5 deaths per 100,000

Data Source: CDC Wonder

Age-Adjusted Rate
Per 100,000 Population

- 6.9 – 12.7
- 12.8 – 16.3
- 16.4 – 21.2
- 21.3 – 41.5

NC – 34.3
VT – 16.7
MA – 25.7
RI – 28.2
CT – 22.1
NJ – 16.3
DE – 22.0
MD – 20.9
DC – 18.6

US Rate – 16.3
2001-2015 Resident Drug Overdose Mortality Rate
West Virginia and United States

Data Source: WV Health Statistics Center, Vital Surveillance System and CDC Wonder
Rates are adjusted by age to the 2000 US Standard Million
Maternal and Child Health Impact

• Neonatal intensive care units at capacity.
• The number of children in foster care rapidly increasing.
• Enrollment in Birth to Three/Early Intervention Services steadily increasing.
• Increasing substance use identified as present in infant death reviews.
• Data desperately needed for program planning.
• Lack of infrastructure.
• Lack of expertise.
• Lack of treatment options.
Critical Partnerships

Relationships

- Vital Registration
- Office of Chief Medical Examiner
- Office of Emergency Medical Services
- Bureau for Children and Families
- Medicaid
- Bureau for Behavioral Health and Health Facilities
- WVU Injury Control and Research Center
- Perinatal Partnership
Perinatal Partnership

• Founded in 2006 to bring together individuals and organizations involved in all aspects of perinatal care.
• The Partnership formed the Substance Use in Pregnancy Committee to:
  o Make policy recommendations;
  o Identify best practices; and
  o Develop a collaborative and coordinated approach to best meet the needs of this high risk population.
• In conjunction with Bureau for Behavioral Health and Health Facilities, funded the Perinatal Partnership for Drug Free Moms and Babies Project.

• Worked with Perinatal Partnership to support:
  ○ Physician agreement on definition for Neonatal Abstinence Syndrome (NAS);
  ○ Physician training; and
  ○ Design of a data collection tool.

• Implementation of data collection tool through West Virginia’s Birth Score instrument.
Drug Free Moms and Babies

• To address the need for integrated and comprehensive care models for pregnant women with substance use disorders, the Partnership developed the Drug Free Moms and Babies project in 2011. The goal of the project is to support healthy pregnancy outcomes by providing prevention, early intervention, addiction treatment, and recovery support services for pregnant and postpartum women.
Overview of Initial Sites

• **Greenbrier Physicians Clinic, Inc.** is a private group practice that provides multiple medical specialty services including obstetrical and gynecological care. The physician group practice serves a small, rural hospital. The patient population comes from six southeastern West Virginia counties and one county in Virginia.

• **Shenandoah Community Health** is a federally qualified community health center in the Eastern Panhandle of the state. Its rural patient population comes from surrounding counties in West Virginia, Maryland, and Virginia.

• **Thomas Memorial Hospital** is a private, nonprofit community hospital located in South Charleston that serves a twelve-county area in the southwestern part of the state.

• **West Virginia University Ob-Gyn Department** is located within a large level III tertiary care center in Morgantown. It serves women from all over the state, as well as women from southwestern Pennsylvania, western Maryland, and eastern Ohio.
Key Aspects

- Integrated and comprehensive care.
- Long term follow-up (two years post-partum): may include, but is not limited to, referrals for ongoing health care, family planning, counseling, social services, home visiting, recovery support, vocational, and housing services.
- Program evaluation.
- Provider outreach.
Results

• Effective screening of patients has resulted in improved identification of substance use in pregnancy.

• More collaboration and enhanced communication between obstetric and behavioral health care providers has occurred.

• Availability of case management has been instrumental in assuring women are able to access the wide range of services needed to meet their complex needs.

• Programs experienced increasing numbers of self-referrals as more women learned about the program through word of mouth.

• Preliminary evaluation results indicate that approximately 429 women participated in the project. In addition, 72 - 95 percent of participants tested negative for illicit substances at delivery.
Lessons Learned

• Requires investments in time, flexibility, and patience.
• Establishing trust takes time and affects early enrollment.
• Transportation and childcare are significant barriers.
• Co-morbidities are common and complicate treatment; the programs found that most women who are using in pregnancy also have other mental health problems.
• Coordinating care with physicians in private practice is difficult and fragmentation of care exists without such coordination.
• Following women past the postpartum period is challenging, as many women do not maintain regular contact with the health care system after pregnancy.
• Recovery coaching services are often hard to locate and may be difficult to manage.
Standardized Definition

• In September 2014, West Virginia neonatologists and pediatricians met with coders and members of Perinatal Partnership to develop a standardized definition for neonatal withdrawal and guidance on documenting exposure and withdrawal in newborns.
  - NAS includes neonatal withdrawal from many substances, not just opiates;
  - It is exposure with clinical symptoms; and
  - It is not limited to those cases that require pharmacological treatment.
Birth Score started collecting Intrauterine Substance Exposure and NAS data October 1, 2016.

What exactly is collected?

- **Intrauterine Substance Exposure**
  - Includes any medication prescribed and not prescribed by a physician that has a psychoactive affect

- **How Intrauterine Substance Exposure is documented**
  - Self-reported, documented in prenatal record, positive maternal drug test, unknown, other

- **Infant has clinical signs consistent with NAS diagnosis**
Cumulative percent (n) of infants born at West Virginia birthing facilities who received a Birth Score with Intrauterine Substance Exposure from October 2016 through February 2017.

<table>
<thead>
<tr>
<th>Cumulative Intrauterine Substance Exposure</th>
<th>From October 2016 to February 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumulative Intrauterine Substance Exposure</td>
<td>14.2% (1,171)</td>
</tr>
</tbody>
</table>

Monthly percent (n) of infants born at West Virginia birthing facilities with Intrauterine Substance Exposure from October 2016 through February 2017.

<table>
<thead>
<tr>
<th>Monthly Intrauterine Substance Exposure</th>
<th>October</th>
<th>November</th>
<th>December</th>
<th>January</th>
<th>February</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>12.3% (208)</td>
<td>15.2% (240)</td>
<td>15.2% (252)</td>
<td>14.7% (223)</td>
<td>15.4% (252)</td>
</tr>
</tbody>
</table>
Cumulative percent (n) of infants born at West Virginia birthing facilities who received a Birth Score with symptoms consistent with NAS from October 2016 through February 2017.

<table>
<thead>
<tr>
<th>Cumulative NAS</th>
<th>Cumulative NAS From October 2016 to February 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>(462)</td>
<td>5.7%</td>
</tr>
</tbody>
</table>

Monthly percent (n) of infants born at West Virginia birthing facilities who received a Birth Score with symptoms consistent with NAS from October 2016 through February 2017.

<table>
<thead>
<tr>
<th>Monthly NAS</th>
<th>October</th>
<th>November</th>
<th>December</th>
<th>January</th>
<th>February</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5.37%</td>
<td>5.77%</td>
<td>6.58%</td>
<td>5.5%</td>
<td>5.4%</td>
</tr>
<tr>
<td></td>
<td>(91)</td>
<td>(91)</td>
<td>(109)</td>
<td>(84)</td>
<td>(87)</td>
</tr>
</tbody>
</table>
Other MCH Efforts

• Naloxone distribution program for emergency responders.
• Developing heat maps and data dashboards.
• Co-presentations with sister agencies to law enforcement to share work and build partnerships.
• Promoting family planning services to harm reduction clinics.
• Co-location of Board of Pharmacy staff within the Office to maximize ability to use the Prescription Drug Monitoring Program.
Contact Information

Christina Mullins, Director
West Virginia Department of Health and Human Resources
Bureau for Public Health
Office of Maternal, Child and Family Health
350 Capitol Street, Room 427
Charleston, WV 25301
Email: Christina.R.Mullins@wv.gov
Phone: 304-356-4392
Resources

- AMCHP 2017 Annual Conference Workshop Session
- *Soon to be release AMCHP Issue Brief on The Opioid Epidemic*
- Partner resources
- ASTHO Resources
Save the Date

2017 President’s Challenge | Expert Series

Exploring the Science and Practice of Prevention: Insights for State and Territorial Public Health Leaders

June 1, 2-3 p.m. EDT
Aug. 17, 2-3 p.m. EDT

Visit www.astho.org/addictions or contact pr@astho.org for more information.
Thank you!

AMCHP & ASTHO are here to help!

Atyya Chaudhry, AMCHP
achaudhry@amchp.org

Ellen Pliska, ASTHO
epliska@astho.org