The Substance Exposed Newborn Standards of Care

Sara Park MD
Chief Medical Officer
Comprehensive Medical and Dental Program
Department of Child Safety
CAP conference, July 2017
Disclosures

• I have no financial Disclosures
• An adaptation of Dr Stephen’s presentations
Objectives

• Prenatal Drug Use/Intrauterine Drug Exposure
• Arizona Data
• The Substance Exposed Newborn (SEN)
• Neonatal Abstinence Syndrome (NAS)
• Neonatal Opioid Withdrawal Syndrome (NOWS)
• Opioid Use disorder (OUD)
• Medication Assisted Treatment (MAT)
• Breast feeding concerns
• Care of the Substance Exposed Newborn
Prenatal Drug use - Intrauterine Drug exposure

• Impaired fetal growth
• Prematurity
• Neurobehavioral impairment
• Regulatory impairment
• Behavioral changes
• Developmental Delays
• Sudden Infant Death Syndrome (SIDS)
• Increased risk of Child abuse

Parental/Prenatal Drug use

Very often more than one drug is abused.

- The child’s medical /behavioral/cognitive issues are frequently the result of exposure to multiple drugs
  - Tobacco
  - Alcohol
  - Marijuana
  - Stimulants- Cocaine/Methamphetamines
  - Opioids/Heroin
Arizona Data: 2008 – 2014
Substance Exposed Infants

• In 2014, 1,671 children < 1 year of age were discharged from the hospital or emergency department with a billable diagnostic code indicating drug exposure.
Arizona Data: 2008 – 2014
Substance Exposed Infants

• From 2008-2014:
  • Newborns with narcotics in their system rose 235%
  • Babies born with fetal alcohol syndrome increased 50%
  • The number of infants hospitalized after birth due to maternal drug use in pregnancy increased 74.3 % between 2009 and 2015

ADHS- Arizona Hospital Discharge Data 2014
ADHS 2015 Population Health and Vital Statistics
Arizona Data: 2008 – 2014
Substance Exposed Infants

• Arizona’s rates of prenatal exposure have been historically under-reported
  • Lack of uniform medical coding
  • Lack of provider education, re: early identification of substance-exposed newborn (SEN)
  • * New mandatory reporting as a result of the governor’s declaration of a state of emergency will improve this issue.
Substance Exposed Infants

• Longer and much more costly hospital course
  • Costs continue on into infancy & childhood due to effects on
    • Growth
    • Behavior
    • Cognition/Executive functioning
    • Language
    • Achievement in school
Fetal Development Timeline

Critical Periods of Development
(RED denotes highly sensitive periods)

1. Period of dividing zygote, implantation & bilaminar embryo
   - C.N.S.
   - Heart
   - Eye
   - Arm
   - Leg
   - Usually not susceptible to teratogens

2. Embryonic period (in weeks)
   - Heart
   - Arms
   - Legs
   - Teeth
   - Palate
   - External genitalia
   - Ear

3. Prenatal death
4. Major morphological abnormalities
5. Minor morphological abnormalities
6. Physiological defects

7. Fetal period (in weeks)
8. Full term

- Indicates common site of action of teratogen
- Brain
- Skeletal system
- Organ systems
The Substance Exposed Newborn (SEN)

• SEN ≠ NAS
• Not all substance exposed Newborns will have Neonatal Abstinence syndrome
• SEN also includes infants who are exposed to medication that may have been prescribed- not just illicit use.
The Substance Exposed Newborn (SEN)

• Heroin and other opiates, including methadone, can cause significant withdrawal in the baby, with some symptoms lasting as long as four to six months.

• Prenatal use of amphetamines is associated with low birthweight and premature birth

• A mother's prenatal cocaine use is associated with poor fetal growth, developmental delay, learning disabilities, and lower IQ in her child
The Substance Exposed Newborn (SEN)

- Marijuana use is linked to babies with lower birthweights.
- Alcohol use in pregnancy also has significant effects on the fetus and the baby. Growth during pregnancy and after birth is slowed. Specific deformities of the head and face, heart defects, and intellectual disability are seen with FASDs.
- Cigarette smoking has long been known for its effects on the fetus. Generally, smokers have smaller babies than nonsmokers. Babies of smokers may also be at increased risk for premature birth and stillbirth.
Prenatal Drug exposure - Summary of Effects

<table>
<thead>
<tr>
<th>Short-term effects/birth outcome</th>
<th>Nicotine</th>
<th>Alcohol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fetal growth</td>
<td>Effect</td>
<td>Strong effect</td>
</tr>
<tr>
<td>Anomalies</td>
<td>No effect</td>
<td>Strong effect</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>No effect</td>
<td>No effect</td>
</tr>
<tr>
<td>Neurobehavior</td>
<td>Effect</td>
<td>Effect</td>
</tr>
<tr>
<td>Long-term effects</td>
<td>No consensus on effect</td>
<td>Strong effect</td>
</tr>
<tr>
<td>Growth</td>
<td>Effect</td>
<td>Effect</td>
</tr>
<tr>
<td>Behavior</td>
<td>Effect</td>
<td>Strong effect</td>
</tr>
<tr>
<td>Cognition</td>
<td>Effect</td>
<td>Effect</td>
</tr>
<tr>
<td>Language</td>
<td>Effect</td>
<td>Effect</td>
</tr>
<tr>
<td>Achievement</td>
<td>Effect</td>
<td>Strong effect</td>
</tr>
</tbody>
</table>

* Limited or no data available.
A.R.S. § 8-201.24(c) & (d)

Statute on Neglect as it pertains to a Substance Exposed Newborn

- A determination by a health professional that a newborn infant was exposed prenatally to a drug or substance that was not the result of a medical treatment
- Based on one or more of the following:
  - Clinical indicators in the prenatal period including maternal and newborn presentation
  - History of substance use or abuse
  - Medical history
  - Results of a toxicology or other laboratory test on the mother or the newborn infant
- Diagnosis by a health professional of an infant under one year of age with clinical findings consistent with fetal alcohol syndrome or fetal alcohol effects
The Substance Exposed Newborn (SEN)

• DCS can only become involved after the child is born.
The Substance Exposed Newborn (SEN)

• SEN ≠ NAS

• Not all substance exposed Newborns will have Neonatal Abstinence syndrome

• SEN also includes infants who are exposed to medication that may have been prescribed- not just illicit use.
Neonatal Abstinence Syndrome (NAS)  
Neonatal Opioid Withdrawal Syndrome (NOWS)

- NAS refers to the constellation of problems that occur when a newborn who was exposed to drugs while in utero
- Is when a newborn baby has signs of withdrawal
- Clinical signs would escalate over time as the drug is metabolized and eliminated from the body
Withdrawal Symptoms

- True Withdrawal- opiates, sedative hypnotics
- Withdrawal-like symptoms- antidepressants, antipsychotics and nicotine

- Onset of symptoms vary
  - Type and amount of drug
  - Time of Last Use
  - Meds used in Labor
  - Nutritional status of the mother
  - Any co-occurring conditions in the baby

- Onset of symptoms may present at birth to 72 hours of life
- Duration of symptoms 6 days to 3+ months
Neonatal Abstinence Syndrome (NAS)
Typically NAS occurs when the baby has been exposed in utero to certain drugs

Prescription Medications
- Oxycodone
- Codeine, Hydrocodone (Vicodin)
- Synthetic opioids (Dilaudid)
- Methadone
- Oxycodone (Oxycontin, Percocet)
- Methadone
- Buprenorphine
- Fentanyl
- Ativan
- Xanax
- Antidepressants
- Selective serotonin reuptake inhibitors (SSRIs) (Prozac, Paxil, Zoloft)
- Benzodiazepines
- Illicit Drugs (Heroin)
Neonatal Abstinence Syndrome (NAS)  
Neonatal Opioid Withdrawal Syndrome (NOWS)

- True NAS or non-specific neurobehavioral & regulatory impairment?
  - Seen to some extent with all substances of abuse
- Neurobehavioral and Regulatory Impairment
  - Tremors
  - Irritability
  - Difficulty being consoled
  - Hypertonicity
  - Increased startle response (Moro Reflex)
  - Respiratory, feeding and sleeping issues
Neonatal Abstinence Syndrome (NAS)
Neonatal Opioid Withdrawal Syndrome (NOWS)

- Neonatal abstinence syndrome includes a combination of physiologic and neurobehavioral signs
  - Nervous system problems
    - Hyper-irritability, tremors, twitches, increased reflexes, frantic suck
    - Persistent crying, difficulty being consoled, difficulty sleeping
    - Increased muscle tone, increased startle reflex, increased movement
  - Intestinal disturbances
    - Feeding problems, vomiting or diarrhea
  - Respiratory problems
    - Irregular breathing or apnea (breathing stops)
    - Autonomic dysfunction (unconscious body functions)
      - Yawning, sneezing, sweating, mottling, temperature variations, runny nose, watery eyes, fast heart rate
  - Infants with neonatal abstinence syndrome can require prolonged hospitalization and require treatment with medication
Neonatal Abstinence Syndrome (NAS)
Neonatal opioid Withdrawal Syndrome (NOWS)

• In 2014, 438 babies were born with NAS
• A 235% increase since 2008
Opioid Use Disorder (OUD)  
Substance Use Disorder (SUD)  

- Narcotics & pain killers  
  - Prescription medications  
    - hydrocodone/Vicodin, oxycodone/OxyContin, Percocet, morphine, codeine  
    - Heroin & Methadone  

- Chronic Brain Disease=Brain receptors altered  
  - Cycle of drug craving and drug withdrawal  

- Methadone/Buprenorphine Therapy  
  - Provides safer drug substitute  
  - Long half-life - eliminates craving and breaks cycle  
  - Goal is rehabilitation  

- Do not detox during pregnancy  
  - Preterm labor or pregnancy loss
Opioid Use Disorder (OUD)- prenatal exposure

• During pregnancy, chronic untreated heroin use is associated with an increased risk of
  • fetal growth restriction
  • abruptio placentae
  • fetal death
  • preterm labor and
  • intrauterine passage of meconium

• These effects may be related to the repeated exposure of the fetus to opioid withdrawal as well as the effects of withdrawal on placental function
Opioids Use Disorder (OUD)- prenatal exposure

- An association between first-trimester use of codeine and congenital heart defects has been found in three of four case–control studies.
- The observed birth defects remain rare with a minute increase in absolute risk.
- Although none of these studies investigated methadone or buprenorphine specifically, concern about a potential small increased risk of birth defects associated with opioid-assisted therapy during pregnancy must be weighed against the clear risks associated with the ongoing use of illicit opioids by a pregnant woman.
Opioids Use Disorder (OUD) - prenatal exposure

• The lifestyle issues associated with illicit drug use put the pregnant woman at risk of engaging in activities, such as
  • prostitution
  • theft and
  • violence
  to support herself or her addiction.

• Such activities expose women
  • to sexually transmitted infections
  • becoming victims of violence and
  • legal consequences
    • including loss of child custody
    • criminal proceedings or
    • incarceration
Opioid Use Disorder (OUD) – Treatment

- Any treatment modality has to address both the physiologic as well as the psychologic aspects of addiction.
- These programs should include:
  - Counseling
  - Cognitive and behavioral therapy
  - Pharmacologic therapy if indicated - Medication Assisted Treatment (MAT)
Opioid Use Disorder (OUD) Treatment - Medication Assisted Treatment (MAT) in Pregnancy

- American College of Obstetrics and Gynecology issued a practice advisory in March 2016 Regarding Opioid Mediation and all prescription opioids
- It addressed the committee opinion of 2012 that was reaffirmed in 2016
  - Opioid Abuse, Dependence and Addiction in Pregnancy: A Joint Opinion of the American College of Obstetricians and Gynecologists' Committee on Health Care for Underserved Women and the American Society of Addiction Medicine Adoption Date: May 2012
Opioid Use Disorder (OUD) Treatment - Medication Assisted Treatment (MAT) in Pregnancy

American College of Obstetrics and Gynecology

• During the intrapartum and postpartum period, special considerations are needed for women who are opioid dependent to
  • ensure appropriate pain management
  • to prevent postpartum relapse and a risk of overdose
  • to ensure adequate contraception to prevent unintended pregnancies.
Opioid Use Disorder (OUD) Treatment - Medication Assisted Treatment (MAT) in Pregnancy

American College of Obstetrics and Gynecology

• To assure optimal health outcomes for both a woman and her baby, it is recommended that patients and providers continue opioid agonist treatment in pregnancy.
Opioid Use Disorder (OUD) Treatment - Medication Assisted Treatment (MAT) in Pregnancy

American College of Obstetrics and Gynecology

• The rationale for opioid-assisted therapy during pregnancy
  • prevent complications of illicit opioid use and narcotic withdrawal
  • encourage prenatal care and drug treatment
  • reduce criminal activity and
  • avoid risks to the patient of associating with a drug culture

• Comprehensive opioid-assisted therapy that includes prenatal care reduces the risk of obstetric complications

Opioid Abuse, Dependence and Addiction in Pregnancy: A Joint Opinion of the American College of Obstetricians and Gynecologists' Committee on Health Care for Underserved Women and the American Society of Addiction Medicine Adoption Date: May 2012
Opioid Use Disorder (OUD) Treatment - Medication Assisted Treatment (MAT) in Pregnancy

American College of Obstetrics and Gynecology

• While some studies have suggested an association between birth defects and other adverse outcomes with opioid use in pregnancy, the absolute risk of these problems is low and data demonstrating a causal connection are lacking.

• As a result, there are circumstances in which the balance of risk and benefits argues for judicious use of these medications in pregnancy, either for pain management or opioid agonist treatment.
Opioid Use Disorder (OUD) Treatment - Medication Assisted Treatment (MAT) in Pregnancy

American College of Obstetrics and Gynecology

- Neonatal abstinence syndrome is the most established risk to newborns from use of opioids in pregnancy, but it is expected and treatable, and does not appear to pose permanent risks to the neonate.
Opioid Use Disorder (OUD) Treatment - Medication Assisted Treatment (MAT) in Pregnancy

American College of Obstetrics and Gynecology

• Evidence shows that withdrawal from opioid use during pregnancy may be associated with complications including fetal demise.
Opioid Use Disorder (OUD) Treatment - Medication Assisted Treatment (MAT)

American College of Obstetrics and Gynecology

- Methadone maintenance, as prescribed and dispensed on a daily basis by a registered substance abuse treatment program is part of a comprehensive package of:
  - prenatal care
  - chemical dependency counseling
  - family therapy
  - nutritional education and
  - other medical and psychosocial services as indicated for pregnant women with opioid dependence
Opioid Use Disorder (OUD) Treatment - Medication Assisted Treatment (MAT)

American College of Obstetrics and Gynecology

• Medically supervised withdrawal from opioids in opioid-dependent women is not recommended during pregnancy because the withdrawal is associated with high relapse rates
Opioid Use Disorder (OUD) Treatment - Medication Assisted Treatment (MAT)

American College of Obstetrics and Gynecology

• If the pregnant woman is receiving methadone therapy, she should not consider transitioning to buprenorphine because of the significant risk of precipitated withdrawal.

• The potential risk of unrecognized adverse long-term outcomes, which is inherent with widespread use of relatively new medications during pregnancy, should always be taken into consideration.
Opioid Use Disorder Treatment & Neonatal Abstinence Syndrome (NAS) Neonatal Opioid Withdrawal Syndrome (NOWS)

• Methadone exposure has been associated with more severe withdrawal than has exposure to heroin.

• Early reports regarding buprenorphine, a more recent alternative to methadone, suggest minimal to mild withdrawal in exposed infants.

• Currently there is limited data on the use of buprenorphine in pregnancy and the effects on the fetus, but this body of information is growing.
Opioid Use Disorder Treatment & Neonatal Abstinence Syndrome (NAS) Neonatal Opioid Withdrawal Syndrome (NOWS)

• Prevention
  • Prevent women of child bearing age from using opioids- alternative medications for pain
  • Prevent women on opioids becoming pregnant- reproductive health counseling and resources
  • Prevent pregnant women who are already on opioids from having infants with NAS/NOWS (no research/information on this as of yet)
Opioid Use Disorder Treatment & Neonatal Abstinence Syndrome (NAS) Neonatal Opioid Withdrawal Syndrome (NOWS)

• Treatment of the Mother
  • MAT

• Treatment of the Neonate with NAS/NOWS
  • The primary goal is to promote normal growth and development and to avert or minimize negative outcomes including discomfort and seizures in the infant and impaired maternal bonding.

Opioid Use Disorder Treatment & Neonatal Abstinence Syndrome (NAS)
Neonatal Opioid Withdrawal Syndrome (NOWS)

• Treatment of the Neonate with NAS/NOWS
  • Supportive Care- creating a gentle soothing environment with minimal stimulation in an effort to calm and soothe the baby
  • Current standard of care involves
    • Limiting exposure to lights and noise
    • Clustering care to minimize handling and promote rest
    • Swaddling and holding the infant
    • Providing opportunities for non nutritive sucking

Opioid Use Disorder Treatment & Neonatal Abstinence Syndrome (NAS)
Neonatal Opioid Withdrawal Syndrome (NOWS)

• Treatment of the Neonate with NAS/NOWS
  • Additional supportive interventions – music therapy, massage, recruitment of volunteers to cuddle the infant when mom is not available
  • Breast feeding (unless there are contraindications)
  • Rooming in (if possible)

Opioid Use Disorder Treatment & Neonatal Abstinence Syndrome (NAS)
Neonatal Opioid Withdrawal Syndrome (NOWS)

- Treatment of the Neonate with NAS/NOWS
  - Treatment of any other medical issues the baby has, e.g.
    - Low birth weight – follow feeding and weight gain
    - Seizures- occur in less than 1-3% of heroin exposed babies
    - Making sure there are no other medical conditions that are mimicking NAS

Opioid Use Disorder Treatment & Neonatal Abstinence Syndrome (NAS) Neonatal Opioid Withdrawal Syndrome (NOWS)

• Treatment of the Neonate with NAS/NOWS
  • Pharmacologic treatment
    • The main objective of pharmacologic treatment is to relieve moderate-to-severe signs such as seizures, fever, and weight loss or dehydration
    • Despite the importance of pharmacologic treatment, there is no universally accepted standard of care, and variations exist in the use of doses based on weight or symptoms, as well as the threshold for initiating treatment, starting doses, weaning protocols, and adjunctive medications
    • There is current consensus in practice that first-line pharmacotherapy consists of opioid replacement with either oral morphine solution or methadone. Oral morphine is the most common treatment in the United States
  • Most NAS will be treated with comfort measures and not medications

Opioid Use Disorder (OUD)- Challenges

• Research on both NAS and NOWS is confounded by polysubstance exposure and maternal comorbidity.
• MAT capacity is inadequate
• Pregnant women are identified as a priority population
  • If programs are unavailable- this designation does not help
Opioid Use Disorder (OUD)- Challenges

• Perception that regulation of MAT is burdensome

• Persistent lack of acceptance of Substance Use Disorder (SUD) as a **chronic brain disease** despite abundant supporting research and extensive public education

• Rejection of the evidence for MAT by abstinence-based programs results in the exclusion of persons receiving MAT from social and behavioral services available to others through these programs
Opioid Use Disorder (OUD) - Challenges

• Prejudice remains perhaps the greatest barrier to the adoption and dissemination of effective, evidence-based interventions,
• Compartamentalization of data, knowledge, and skills across levels of government, service providers, and professional disciplines follows as the next greatest barrier.
Breast Feeding- Opiates

• For women in well-supervised methadone-maintenance programs for treatment of opioid dependence
  • breastfeeding is encouraged and may be important to avoid neonatal abstinence syndrome
Methadone & Breast Feeding

• Concentrations of methadone in breast milk were low
• Concentrations of methadone in infant plasma were low
• No significant effects on neurobehavioral outcomes
Methadone & Breast Feeding

• Lower incidence of NAS
• Fewer infants required medications for NAS
• Require shorter pharmacotherapy for NAS
• Increased maternal confidence
• Enhanced mother-infant bonding
• Improvement of familial social functioning through stress reduction
Factors to consider

- Drugs used
- Medical Complications
- Postnatal Caregiving Environment
- Parental Resilience
- Social Connections
- Concrete Support
Factors to consider

• Currently the standard of care for medication assisted treatment for opioid addiction in pregnancy is Methadone
• Buprenorphine (Subutex) (not studied in pregnancy)
• Buprenorphine/Naloxone (Suboxone). Naloxone (not studied in pregnancy)
  • Can precipitate withdrawal in the fetus
• Reduce problem addiction behavior
• Can take MAT as long as needed
  • Not uncommon for this to be lifelong treatment
  • Dose is not relevant
  • Taper will likely lead to relapse
  • Can safely parent & drive while on MAT
    • Assuming compliance with program requirements
    • Check with Addiction Specialist managing the parent
Care of the SEN baby- in the hospital

- Babies may go home if the intrauterine exposure was not known
- They may return to the hospital with concerns of being fussy, inconsolable or having poor feeding
- Substance exposure may not be identified and the child may be treated for a presumed infection
Care of the SEN baby - in the hospital

• If Known – the infant will be monitored for signs of withdrawal for about 72 hours
• The nurses will use abstinence scoring to numerically follow the signs of withdrawal. This scoring is also used to attempt to wean the child off of medication if they do need it
• If comfort measures are not adequate to treat the baby – then oral morphine may be used to treat their symptoms followed by a taper
Care of the SEN baby- in the hospital

• Any other medical issues will also be treated in the hospital
• Poor feeding
• Seizures
Care of the SEN baby- in the hospital

• The baby should be screened in the nursery
  • Hearing Screening
  • Congenital heart disease
  • Newborn screening for inborn errors of metabolism
Care of the SEN baby- who has left the hospital

- Establish Primary Care Pediatrician (PCP) & Medical Home
  - 10 EPSDTs (well child visits) in 1st 2 years of life
    - Developmental & Behavioral Health Screening
  - At least annual EPSDT after age 2
  - Use of developmental screening tool

- Establish a Dental Home
  - No referrals needed for dental care
  - Dental care begins at age one (1)!!
  - Routine preventative visits twice/year

- Ensure RBHA (behavioral health) services ASAP
  - Rapid Response within 72 hours of placement- which include the use of a developmental screening tool
  - Assessment starts 7 days after the rapid response and involves the Birth to Five assessment
  - Do NOT take “wait and see” attitude
  - RBHAs must keep children in out of home care open for services for a minimum of 6 months
Care of the SEN baby- who has left the hospital

• Early frequent visits with the pediatrician to follow up on signs of withdrawal, development, feeding, infant bonding etc..
• The schedule is actually similar to that of any newborn, but with attention to symptoms the infant presented with and close follow up of development.
• All infants should be referred to AZEIP- the early intervention program for developmental issues.
• AZEIP does not take the place of the RBHA services that have specialized services and assessments of the Birth to five population.
• The RBHA is charged with doing birth to five assessments that include both behavior as well as development.
Birth – Five Assessments
Developmental & Behavioral Screening

Primary Care Provider (PCP)
--EPSDTs (Dev & BH Screens)
  • 10 in 1st 2 Years
  • Annual thereafter
--PEDS Tool
--ASQ
--mCHAT–R/F - autism

RBHA
--Dev Check
--ASQ
--Behavioral Assess

AZEIP-dev assess
CMDP encourages enhanced visits with the PCP for children in Foster Care

- The American Academy of Pediatrics (AAP) issued a policy statement addressing Health Care Issues for Children and Adolescents in Foster Care and Kinship Care

  Health Care Issues for Children and Adolescents in Foster Care and Kinship Care
  COMMITTEE ON ADOLESCENCE, and COUNCIL ON EARLY CHILDHOOD
  COUNCIL ON FOSTER CARE, ADOPTION, AND KINSHIP CARE and COMMITTEE ON ADOLESCENCE, and COUNCIL ON EARLY CHILDHOOD
  Pediatrics 2015;136:e1131; originally published online September 28, 2015; DOI: 10.1542/peds.2015-2655

- [http://pediatrics.aappublications.org/content/pediatrics/136/4/e1131.full.pdf](http://pediatrics.aappublications.org/content/pediatrics/136/4/e1131.full.pdf)

- These are recommendation and are not currently mandated by statute
CMDP encourages enhanced visits with the PCP for children in Foster Care

- In addition to the routine EPSDT (well check) schedule that is expected for all children in AHCCCS, it is **recommended** that children in foster care are provided with the **Recommended Screening, Assessment and Enhanced Visitation schedules for children in Foster Care** which include:
  - An **initial health screening** within 72 hours of placement
  - Followed by a **comprehensive evaluation by the pediatrician and the dentist** in the first 30 days of being in DCS custody - the EPSDT (Well Child Visit) and the preventative Dental visit.
  - All Children should be seen monthly in the first 3 months of foster care
    - Allowing the pediatrician to monitor the child’s adjustment to the placement and assist the caregiver in helping the child.

**Health Care Issues for Children and Adolescents in Foster Care and Kinship Care** *Pediatrics* 2015;136;e1131; originally published online September 28, 2015; DOI: 10.1542/peds.2015-2655
CMDP encourages enhanced visits with the PCP for children in Foster Care

For children in foster care the recommendation is that children are seen by the PCP at the following intervals

• Monthly in the first 6 months of life
• Every 3 months from 6-24 months of age
• And then at a minimum every 3-6 months
• CMDP recommends that children older than 2 years be seen 4 times a year (including the yearly EPSDT visit)

Health Care Issues for Children and Adolescents in Foster Care and Kinship Care Pediatrics 2015;136;e1131; originally published online September 28, 2015; DOI: 10.1542/peds.2015-2655
CMDP encourages enhanced visits with the PCP for children in Foster Care

The Goal is for the physician to monitor the child’s

- Health
- Emotional wellbeing
- Development
- Psychosocial stressors
- Continued adjustment to their foster family and
- Visitation with birth parents or other relatives

- The default should be close monitoring as transitions in placement, changes in visitation and separation of siblings are all events that indicate the need for closer supervision

Health Care Issues for Children and Adolescents in Foster Care and Kinship Care *Pediatrics* 2015;136;e1131; originally published online September 28, 2015; DOI: 10.1542/peds.2015-2655
CMDP encourages enhanced visits with the PCP for children in Foster Care

<table>
<thead>
<tr>
<th>NB infant – 6 months</th>
<th>6 months to 2 years</th>
<th>2 years and older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly for the first 6 months of life</td>
<td>Monthly for the first 3 months after removal</td>
<td>Monthly for the first 3 months after removal</td>
</tr>
<tr>
<td>Every 3 months from 6-24 months of age</td>
<td>Then every 3 months until 24 months</td>
<td></td>
</tr>
<tr>
<td>Then every 3-6 months. <em>(CMDP recommends 4 times a year = every 3 months)</em></td>
<td>Then every 3-6 months. <em>(CMDP recommends 4 times a year = every 3 months)</em></td>
<td>Then every 3-6 months. <em>(CMDP recommends 4 times a year = every 3 months)</em></td>
</tr>
</tbody>
</table>

Health Care Issues for Children and Adolescents in Foster Care and Kinship Care
*Pediatrics* 2015;136;e1131; originally published online September 28, 2015; DOI: 10.1542/peds.2015-2655
Summary

• Substance abuse is a large reason for the entry of children into DCS care
• We are in the middle of an opiate epidemic
• MAT – needs to be evaluated carefully and in the context of the family and the MAT program.
• DO NO HARM
Summary

• Our responsibility
  • Ensure the child has the Medical, Dental and Behavioral health Services to optimize their health

• Parental Responsibility
  • Accept services
  • Accept responsibility
  • Apply for services to be able to continue maintaining good health after our involvement
    • – AHCCCS Universal Application
      • Cash benefits, Food stamps, Medical & BH healthcare
Specialized Care and Services

• Division for Developmental Disabilities (DDD)
• DDD/ALTCS (Az Long Term Care Services)
• AZ Early Intervention Program (AzEIP)
• Behavioral Health (RBHAs)
• Children’s Rehabilitative Services (CRS)
Light at End of the Tunnel?


4. SB 1032 - AHCCCS; contractors; prescription monitoring. AHCCCS contractors shall intervene when a member has 10 or more prescriptions for a controlled substance within a 3 month period http://www.azleg.gov/legtext/52leg/1r/bills/sb1032s.htm

Helpful References

• Special Care for the Substance-Exposed Newborn - brochure for caregivers [https://dcs.az.gov/sites/default/files/CSO-1072A.pdf](https://dcs.az.gov/sites/default/files/CSO-1072A.pdf)

• Mothertobaby.org
Contact information

- **CMDP**
  - 1.602.351.2245 or 1.800.201.1795
  - Member services [CMDPMemberServices@azdcs.gov](mailto:CMDPMemberServices@azdcs.gov)
  - Medical Services [CMDPNurse@azdcs.gov](mailto:CMDPNurse@azdcs.gov)
  - Behavioral Health Services- Contact the RBHA, if need additional assistance contact the CMDP BH unit at [DCSBHunit@azdcs.gov](mailto:DCSBHunit@azdcs.gov)
# Behavioral Health Services for Children in Foster Care

Arizona Health Care Cost Containment System (AHCCCS) is committed to ensuring the availability of timely, quality health care for foster children, including behavioral health services through our three contracted regional behavioral health authorities (RBHAs) and the Children’s Rehabilitative Services (CRS) program. If you experience any difficulty accessing needed behavioral health services or have any concerns regarding the quality of those services, we encourage you to contact the RBHA or CRS in your area using the contact information below.

### Step 1: Call Your Designated DCS Contact at the RBHA or CRS.

<table>
<thead>
<tr>
<th>Mercy Maricopa Integrated Care (MMIC)</th>
<th>Compasite Integrated Care (CIC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maricopa County</td>
<td>Cochise, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz &amp; Yuma Counties</td>
</tr>
<tr>
<td>(and part of Pinal County based on Zip Code)</td>
<td><a href="mailto:DCS@compasitecare.com">DCS@compasitecare.com</a></td>
</tr>
<tr>
<td><a href="mailto:DCS@maricopa.org">DCS@maricopa.org</a></td>
<td>Jennifer Kent, Mwand</td>
</tr>
<tr>
<td>Randy Grover, LGW</td>
<td>DCS License</td>
</tr>
<tr>
<td>Child Welfare Manager</td>
<td>(530) 839-3657</td>
</tr>
<tr>
<td>(602) 453-8095</td>
<td>RBHA Customer Service</td>
</tr>
<tr>
<td>RBHA Member Services</td>
<td>(866) 495-6718</td>
</tr>
<tr>
<td>1 (800) 564-5465</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Choice Integrated Care (HCIC)</th>
<th>CRS operated by UnitedHealthcare Community Plan (UHCP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apache, Cochise, Gila, Mohave, Navajo &amp; Yavapai Counties</td>
<td>Statewide for children with qualifying CRS medical conditions</td>
</tr>
<tr>
<td><a href="mailto:DCS@ashealtheare.com">DCS@ashealtheare.com</a></td>
<td><a href="mailto:Manta.urban@uhc.com">Manta.urban@uhc.com</a></td>
</tr>
<tr>
<td>Scott Brown</td>
<td>Manta Urban, UHCP License to DCS</td>
</tr>
<tr>
<td>Director of Children's Services</td>
<td>(602) 214-1194</td>
</tr>
<tr>
<td>(530) 214-1194</td>
<td>CRS Member Services</td>
</tr>
<tr>
<td>RBHA Member Services</td>
<td>1 (800) 640-2123</td>
</tr>
<tr>
<td>1 (800) 640-2123</td>
<td></td>
</tr>
</tbody>
</table>

### Step 2: Call AHCCCS Customer Service. If you are unable to satisfactorily resolve your concern through the RBHA or CRS, please contact the AHCCCS customer service line for support at 602-365-6555 or 1-800-887-5808. By calling Customer Service, you help AHCCCS not only address individual concerns but also identify potential system barriers to accessing quality behavioral health services. Anyone can call Customer Service at any time whenever you are experiencing difficulty accessing needed services. Thank you for your support and commitment to improve the lives of DCS involved children and their families!

Foster Families have a voice. DO NOT WAIT. Call your designated DCS contact.

April 1, 2018
AHCCCS is committed to ensuring the availability of timely quality health care for children in out of home placement and adopted children. AHCCCS has behavioral health appointment standards in place to ensure access to services are delivered in a timely fashion. Below are the standards related to behavioral health services. If you experience any difficulty accessing needed behavioral health services or have any concerns regarding the quality of those services, we encourage you to contact the assigned health plan and AHCCCS customer service.

**BEHAVIORAL HEALTH APPOINTMENT STANDARDS**

<table>
<thead>
<tr>
<th>Duration</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>72 Hours</td>
<td>Rapid Response (2 hours for an urgent need)</td>
</tr>
<tr>
<td>7 Days</td>
<td>Initial Assessment (24 hours for an urgent need)</td>
</tr>
<tr>
<td>21 Days</td>
<td>Behavioral Health Service Appointment</td>
</tr>
</tbody>
</table>

An initial in-home assessment for children entering into the Department of Child Safety (DCS) custody, which may be requested by DCS or a caregiver. Clinicians will assess immediate needs and track any crises or trauma-related issues. Includes behavioral health assessment, screening for developmental delays, support to child/family placement and connection to ongoing services.

If recommended services are not initiated within 21 calendar days, the caregiver must notify both the health plan’s Children’s Liaison and AHCCCS Customer Service using the contact information listed below. After notification, any AHCCCS registered provider may be seen for the recommended services (even when outside of the health plan’s network). A complete list of AHCCCS registered providers can be found at [https://www.ahcccs.gov/Member/ProgramAndServices/ProviderInformation](https://www.ahcccs.gov/Member/ProgramAndServices/ProviderInformation).

Additional resources are available online at [https://www.azahcccs.gov/Members/MemberResources/Foster/](https://www.azahcccs.gov/Members/MemberResources/Foster/)

**HEALTH PLAN CONTACT INFORMATION**

- **Mercy Maricopa Integrated Care**
  - Maricopa County and Pinal zip codes 85220, 85110, 85143, 85264, 85041, 85249
  - Children’s Liaisons: 480-751-6411
  - Member Services: 1-800-594-6485
  - DCS@mercycareaz.org

- **Community Integrated Care**
  - Cochise, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz and Yuma
  - Children’s Liaisons: 520-635-4132
  - Member Services: 1-844-385-3144
  - DCS@cithelp.com

- **Health Choice Integrated Care**
  - Apache, Cochise, Gila, Maricopa, Navajo & Yaqui
  - Children’s Liaison: 928-244-2373
  - Member Services: 1-800-640-2123
  - DCS@healthchoice.com

- **UnitedHealthcare Community Plan (CRS)**
  - Arizona CRS medical conditions
  - Children’s Liaison: 602-285-1923
  - Member Services: 1-800-345-4068
  - CRS_AZ@ahcccs.az.gov

AHCCCS Customer Service: 602-394-4558 or 1-800-867-6800 or DCS@azahcccs.gov
Crisis Services for Children in Foster, Kinship & Adoptive Care

IF YOUR CHILD IS FACING A CRISIS, DON’T WAIT.
CALL THE BEHAVIORAL HEALTH CRISIS LINE

| Maricopa county and Pinal zip codes 85210, 85140, 85143, 85228, 85240, 85243 | 1-800-631-1314 |
| Cochise, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz and Yuma counties | 1-866-493-6739 |
| Apache, Coconino, Gila, Mohave, Navajo and Yavapai counties | 1-877-756-4660 |

A crisis is any situation in which a person’s behaviors put them at risk of hurting themselves or others and/or when they are not able to resolve the situation with the skills and resources available.

For behavioral health emergencies, contact your provider (if you have one) or the 24-Hour Behavioral Health Crisis Line. The Crisis Line is available at no cost, 24 hours a day, 7 days a week.

The Crisis Line can connect you to in-home supports within 2 hours in most areas of Arizona.

Crisis Line Services include: dispatch of a mobile team, providing stabilization services over the phone, initiating rapid response assessments for DOS-involved children, as well as warm transfers to representatives of the behavioral health plans.

If the crisis mobile team does not respond within two hours, call the crisis line and your behavioral health plan.

IF A SITUATION IS LIFE THREATENING, ALWAYS CALL 911.

BEHAVIORAL HEALTH PLANS

| Mercy Maricopa Integrated Care | CareCenters Integrated Care |
| Children’s Liaison: 480-751-5471 | Children’s Liaison: 520-839-4432 |
| Member Services: 1-800-564-5465 | Member Services: 1-844-305-3144 |
| DCG@maricopainfo.org | DCG@carecenters.net |

Health Choice Integrated Care

| Children’s Liaison: 480-496-2123 | UnitedHealthcare Community Plan (CSP) |
| Member Services: 1-800-440-4150 | Children’s Liaison: 520-555-1952 |
| CG@healthchoice.com | Member Services: 1-888-364-4150 |

PHYSICAL HEALTH PLAN

| Comprehensive Medical Dental Program | Arizona Health Care cost Containment System (AHCCCS) |
| Member Services: 602-351-2245 or 1-800-201-1795 | Member Services: 928-364-4558 or 1-888-867-5808 |
| CMDD/MemberServices@azdhs.gov | DCG@azahcccs.gov |

AHCCCS Customer Service: 928-364-4558 or 1-800-867-5808 or DCG@azahcccs.gov

Revised 4/18/2017
The Opioid Epidemic and Arizona’s Response

Opioid Report
June 15 - July 20, 2017

Opioid Overdoses & Deaths

1,102 possible opioid overdoses reported

Real Time Opioid Data

For the first time, statewide opioid data is available in real time. Check out the details of the five categories of data we are now collecting.

146 suspect opioid deaths
1102 suspect opioid overdoses
67 neonatal abstinence syndrome
844 naloxone doses dispensed
820 naloxone doses administered

Arizona Department of Health Services - Opioid Epidemic as of 7/27/2017 5 am
State of Emergency Due to Opioid Overdose Epidemic effective June 5, 2017.

- Declaration of Emergency and Notification of Enhanced Surveillance Advisory - Opioid Overdose Epidemic
- Authorize the Director of the Arizona Department of Health Services to coordinate all matters pertaining to the public health emergency response of the State in accordance with A.R.S. § 36-787(A)(2)
  - Enhanced Surveillance
  - Emergency rule making (pertaining to opioid prescribing and treatment)
  - Develop Guidelines to educate health care providers on responsible prescribing
  - Develop and provide training to local law enforcement for carrying, and administering Naloxone for overdose
  - Provide a report on findings and recommendations that require legislative action by Sept 5 2017
State of Emergency Due to Opioid Overdose Epidemic effective June 5 2017

• The collection of information allows there to be tangible and measurable baselines that allows for the evaluation of intervention strategies.
The National Opioid Influx

- A 4 fold increase in the quantity of Rx Opioids sold in the U.S.
- The U.S. makes up 4.6% of the world’s population, but consumes 80% of its Rx opioids
- 91 opioid deaths every day!
Nearly 2 million Americans abused or were dependent on prescription opioids in 2014.
Emerging Heroin Trends

Prescription opioid misuse is a major risk factor for heroin use

3 out of 4 people who used heroin in the past year misused opioids first

7 out of 10 people who used heroin in the past year also misused opioids in the past year

Availability of Rx Opioids in Arizona

- ~575 million Class II-IV pills are dispensed each year in Arizona
- Opioids account for 60%
- Access & probability
Volume: Access Ratio

• Enough Rx opioids were dispensed last year to medicate every Arizona adult around the clock for more than 2 weeks.
Number of Drug Overdose Deaths Involving Opioids, Arizona 2006-2015 (ADHS)
Neonatal Abstinence and Newborn Drug Exposure Rates per 1,000 Births

AHCCCS represented 51% of Arizona hospital births between 2008 and 2014, but was the payer for 79% of the NAS cases.
Addressing the Problem

• Promoting responsible Prescribing and Dispensing
• Reducing Harm – Prevention of Overdose deaths
• Enhance access to Integrated Medically Assisted Treatment
• Prevention- Education
Governor’s Initiatives/Legislation

• Substance Abuse Task Force appointed February 2016

• Legislation requiring the review of the Controlled Substance Prescription Monitoring Program Database (PMP) by Medical Practitioners prior to the prescribing of controlled substances in an effort to deter Doctor shopping, and promote appropriate prescribing. (SB 1283, May 12, 2016);

• Legislation that allowed pharmacists to dispense Naloxone to prevent deaths from opioid overdose (HB 2355, May 12, 2016);

• Partnership with Walgreens to promote Safe disposal of Medications-opiates and other leftover prescription drugs (September 3, 2016);
Governor’s Initiatives/Legislation

• An Executive Order limiting the first fill of opioid to 7 days where the state is the payer. (October 24, 2016)

• Governor issuance of a letter to the American Medical Board and Arizona Board of Osteopathic Examiners requiring all physicians in Arizona to complete Continuing education in drug addiction

• An Executive Order making treatment for addiction more accessible for inmates by giving them the opportunity to enter a pilot program for addiction. (January 9, 2017); and

• The investment in Substance Abuse Programs in Arizona High Schools. (January 9, 2017)
Governor’s Initiatives/Legislation-Implementation

• AHCCCS has implemented and directed limitations to opioid prescription fills for all Medicaid health plans, and CMDP has implemented these limitations.

• CMDP requires prior authorization of all long acting opioids and has fill limits on short acting opioids.

• CMDP also monitors opioid utilization in attempt to identify children who may be at risk for developing opioid use disorder and refer them to appropriate services.

• CMDP, with other community stakeholders, collaborate with the Arizona Department of Health Services via participation in the Arizona Prescription Drug Misuse and Abuse Initiative Health Care Advisory Team. The goal is to address the opioid epidemic and discuss possible approaches at a statewide level.

• CMDP also participates in Arizona’s Statewide Taskforce on Preventing Prenatal Exposure to Alcohol and other Drugs. This taskforce is working to create SEN Guidelines and Insurance Plans Best Practice Guidelines. This initiative also has a resource page that details the effects of prenatal exposure to multiple substances and resources available for parents and health care providers.