MCH Innovations Database

EVIDENCE-INFORMED POLICY IMPLEMENTATION

Non-Punitive Approach to Substance Use in Pregnancy

Location	**Focus Area**	**Policy Type**
New Mexico	Mental Health/Substance Use, Access to Health Care, Health Equity, Prenatal Care, Service Coordination/Integration	Big P Policy

Target Population
Pregnant women who use substances and newborns with substance exposure

SECTION 1: POLICY DESCRIPTION

This policy was developed in New Mexico in response to the federal CARA amendment to the federal CAPTA law that stated all state child welfare agencies are required to ensure every baby born exposed to substances receives a Plan of Care and that the numbers of babies receiving Plans of Care are reported to the Federal Agency. Because women (especially women of color) were reporting that they were receiving discriminatory treatment with regard to drug screening and treatment of substance use in pregnancy, New Mexico decided to go beyond just reporting numbers of care plans but to try to put in place systemic changes and training of hospital staff to provide a less stigmatizing, more equitable response.

Led by the New Mexico Children, Youth and Families Department (CYFD) and the NM Department of Health (DOH), a task force consisting of healthcare providers, insurance care coordinators, state agency representatives, and other stakeholders has been working since September 2017 to articulate and implement New Mexico's response to CARA. The task force has been building partnerships with health insurance providers, medical organizations, hospitals, and reproductive justice organizations to facilitate access to support services for expectant mothers, newborns, and their families struggling with addiction. These partnerships were critical in the ultimate success of the legislation.

In January 2019, House Bill 230 was passed after much negotiation around language and many late nights testifying before legislative committees. This bill amended the Children's Code in New Mexico to require hospitals to create the Plans of Care and send them to CYFD and DOH and to require insurance companies to provide care coordinators for this population. The legislation also stated that substance use in pregnancy should not, by itself, be considered a reason for a mandatory child abuse report.

KEY ELEMENTS

NM changed the Children's Code statute to say that Plans of Care would be created for all newborns with substance exposure, that care coordination and other services would be offered as part of the plan, and clarify that substance use in pregnancy, by itself, is not considered a reason for mandatory referral to protective services.

The key elements of implementing this policy included ongoing partricipation of the task force composed of diverse partners, trainings provided in-person and by webinar to hospitals and providers, access to support services for families struggling with addiction, changing mindsets away from mandatory reporting, evaluation of the impact of the policy change, and QI efforts.

EVIDENCE TO SUPPORT POLICY APPROACH

New Mexico has one of the highest rates of any state when it comes to opioid and meth use, and over the past decade the state has seen skyrocketing rates of neonatal abstinence syndrome. According to a report released by the New Mexico Department of Health in November 2018, the rate of New Mexico newborns exposed to addictive substances in utero increased 324% between 2008 and 2017. This compares to an increase of 207% nationwide in the same timeframe. Infants born exposed to addictive substances may initially struggle to survive and then struggle with health, learning, and social challenges for the rest of their lives. Additionally, in NM 72% of births are paid for by Medicaid in contrast to 55% nationally. Supporting these children through infancy and into adulthood is costly to families and to society.

The benefits of screening for substance use in pregnancy and providing treatment are well documented, starting with the Kaiser studies from the 1990s. Punitive approaches to substance use in pregnancy have been shown to worsen outcomes, mostly because they deter women from seeking medical care for fear of having their children taken away, and they lead to higher rates of NAS.

HEALTH EQUITY

Provider discrimination has been reported on the New Mexico PRAMS survey of pregnant women who recently gave birth, and women may feel stigmatized if they are using substances during pregnancy. This policy addresses those concerns by requiring plans of care for ALL newborns born exposed to substances rather than automatically referring some families to CYFD and not referring others, as was being reported. It also mandates supports and services be offered to all families as well as care coordination services.

The work of the task force (two plus years prior to the legislation) included focus groups with women who had experienced substance use in pregnancy, as well as those who had been enrolled with CYFD. It also included organizations led by women of color (NM Birth Equity Collaborative, Bold Futures, TEWA Women United, etc). In developing webinar trainings on the policy, focus groups were utilized to get input from those most impacted.

Through the evaluation this policy, the team is surveying participants to get their perspectives on discrimination and stigma in regard to their pregnancy experience. Data is also being collected on who receives the Plans of Care to ensure that they are being done universally and not in a targeted way. DOH is also hiring an epidemiologist to do linkage of data sets to answer more questions about the long-term impact of the plans and what services work best for this population.

POLICY IMPLEMENTATION CONTEXT

Led by the New Mexico Children, Youth and Families Department (CYFD) and the DOH, a task force consisting of healthcare providers, insurance care coordinators, state agency representatives, and other stakeholders worked from 2017 to 2019 to articulate and plan New Mexico's response to CARA. The group built partnerships with health insurance providers, medical organizations, hospitals, and reproductive justice organizations to facilitate access to support services for expectant mothers, newborns, and their families struggling with addiction.

The law went into effect in July 2019 and moved into the implementation phase. Over the next eight months (until COVID hit), staff from CYFD and DOH traveled the state, training hospitals and medical providers on the requirements of the law and its intended purpose. Evaluation of the project is ongoing and is an important part of the implementation process. As of early 2021, 1,120 Plans of Care have been submitted. What made this possible was that the New Mexico team had two years of groundwork already laid through the work of the task force. The task force gave stakeholders a voice in the process, so they were more willing to help with implementation later.

Enactment Plan

DOH and CYFD each assigned two staff to help implement the policy, providing in-person presentations and trainings around the state to promote understanding of the purpose of the law as well as ensuring hospitals, medical providers and insurers understood what was required from them. Additional staff time was allocated for the evaluation. The Department also contracted with UNM for TA to develop on-line webinar versions of the training so that staff would not have to continually retrain as new staff were hired in hospitals.

IMPLEMENTATION ASSETS & CHALLANGES

A huge implrementation asset was the two years of groundwork already laid by having the task force meeting since 2017. Additionally, there is strong political support, and the new Governor (since Jan. 2019) is supportive of interagency collaboration.

The New Mexico team has a new CARA Navigator who is following up on plans of care to obtain clarification where there is limited information, families have declined services (but agreed to a plan), are difficult to engage (per the MCO), or declined a Care Coordinator.

The CARA Navigator has had great success connecting with families and being able to make direct referrals to providers. The follow-up is very time-consuming however, and more navigator support would be helpful in reaching all families.

Quality Improvement

The initial challenge was training – New Mexico has 29 birthing hospitals that are scattered across a large, rural state. Staff spent six months traveling and then began developing webinar versions of the trainings. The second challenge has been changing the mindset away from mandatory reporting of any evidence of substance use to taking a more nuanced approach. No one is prohibited from making an abuse and neglect report, but it is stressed that it should not be a knee-jerk reaction.

A third challenge has been working with Medicaid and the three managed care organizations that cover most of the Medicaid lives in our state. Each MCO has slightly different ways of doing things, and even simple things like getting them to use the online portal we set up for sending the care plans has been challenging. All these things were approached as a team, utilizing our many partners from the task force as needed to work through the challenges.

There is a potential that the policy could backfire if families refuse the services (which are all voluntary) and are then lost to follow up. That is why offering services in a non-judgmental way is key so that there will be uptake and engagement.

SECTION 2: CONSIDERATIONS FOR FUTURE POLICY IMPLEMENTATION

LESSONS LEARNED

1. Take time to listen to a broad range of stakeholders and include them in the planning before proposing any legislative changes. This should include voices from the communities most impacted, as well as those who will be tasked with carrying out the policy.

2. Try to include dedicated funding in any legislation so it does not become an unfunded mandate.

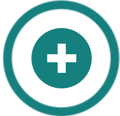
3. Any state-wide policy change requires extensive training to ensure proper procedures are followed and that those tasked with carrying out the policy understand the background and intent. This training needs to be accounted for in terms of staff time.

Overall, there has been a great response to the policy's implementation from state and community partners that are impressed by the effort to bring so many different partners together to collaborate on this. Hospitals haved asked the trainers to come back and discuss how to have a conversation with a pregnant person who is struggling with substance misues and how to approach with the Plan of Care.

FUTURE CHANGES

General

Training for providers and hospitals to implement the policy is a critical piece of this policy. Pivoting to offer the trainings online, versus travleling to all the hospitals, has been helpful in reducing staff burden and addressing training for new staff when there is turnover.



Health Equity

As the policy's roll out and implementation continues to improve, feedback from people with lived experience will be included as much as possible to guide these efforts.

Stakeholder/Advocacy Efforts

The New Mexico team continues to work with hospitals to help them implement and comply with this policy change. Additional partnership opportunities are being explored with the Indian Health Service System and Navajo Nations' Social Service Department.

NECESSARY RESOURCES

While this policy was implemented with no additional funds, four staff members were allocated to work on this, and other work was swapped out. Recently a small amount of private foundation funding was obtained to help increase staffing. The team is currently looking for funding opportunities to help with this effort.

ADDITIONAL RESOURCES

These resources were helpful in supporting the need for this policy in New Mexico:

- Policies That Punish Pregnant Women for Substance Use Are Linked to Higher Rates of Newborns Experiencing Opioid Withdrawal (RAND)
- A Public Health Response to Opioid Use in Pregnancy (American Academy of Pediatrics)

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