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Practice Summary & Implementation Guidance

West Virginia Drug Free Moms and Babies

The West Virginia Drug Free Moms and Babies program is a statewide comprehensive and integrated model of care that supports healthy outcomes for mothers and babies by providing prevention, early intervention, treatment, and recovery services for pregnant and postpartum women with substance use disorder.

Cutting-Edge | Emerging | **Promising** | Best

Location	Topic Area	Setting
West Virginia	Mental Health & Substance Use, Primary & Preventative Care	Clinical

Population Focus	Date Added
Women & Maternal Health, Infant	May 2026

Contact Information
Amna Haque, WV Perinatal Partnership, 304-915-2441, ahaque@wvperinatal.org

Section 1: Practice Summary

PRACTICE DESCRIPTION

The Drug Free Moms and Babies (DFMB) program was created by the West Virginia Perinatal Partnership (the Partnership) in 2011 to address the growing concern of substance use in the pregnant and parenting population and its impact on the health of mothers and infants. West Virginia has been no stranger to the substance use epidemic, especially regarding opioids. This epidemic has had profound effects on a disproportionately affected population: mothers and babies. Substance use in pregnancy, including the use of tobacco, alcohol, prescription, and illicit drugs, has long been identified by West Virginia healthcare professionals as a major factor contributing to poor health outcomes for mothers and babies. To better understand the prevalence of substance use in pregnant patients, the Partnership in collaboration with other perinatal health professionals conducted a study at birthing hospitals across the state. Umbilical cord tissues were collected from every baby delivered in August 2009 in eight hospitals and were tested for substance metabolites and alcohol. Of the 759 samples collected, 19% of babies born were found to have intrauterine substance exposure with many of the infants experiencing polysubstance exposure—clearly indicating a need for identifying patients experiencing substance use and providing resources and a path towards treatment and recovery.

Although universal screening of pregnant women for substance use was recommended, prenatal care providers expressed reluctance to screen because they did not know what to do once it was identified. Similarly, most SUD treatment programs in the state did not admit pregnant women because they lacked the knowledge and expertise to care for the needs of this specific population. It was in this challenging environment, that the Partnership, in collaboration with state agencies, health care providers, and philanthropy created DFMB as a model to systematically integrate maternity and behavioral health care to provide prevention, early intervention, treatment, and recovery services for pregnant and postpartum women with SUD.

Pregnancy is a unique time in a woman's life, and for women with substance use disorders it is often the only time they have access to ongoing medical care. The increased motivation for improved health along with access to coverage that comes with pregnancy makes the prenatal and postpartum period ideal for addressing substance use. Research demonstrates that women who use substances, but who receive prenatal care have improved birth outcomes. Research also demonstrates that maternal, fetal, and child outcomes are improved when pregnant and parenting women receive care that addresses physical, mental and care coordination needs. That is why DFMB was structured using an integrated approach. DFMB promotes universal screening (i.e., first prenatal visit), utilizes the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model, incorporates a multi-disciplinary team that includes care coordinators and peer recovery support specialists, creates a referral network to link mothers experiencing substance use to treatment and other needed services, ensures program adherence through toxicology, and makes available continuing care and support through long-term follow-up.

Initially implemented as a pilot in four sites reflecting the state's diverse geography and delivery care settings, the DFMB program has now entered into its fifteenth year and is operating in 24 clinical sites. The initial four sites included a rural, small group physician practice, a federally qualified health center (FQHC), an urban delivery hospital equipped with comprehensive behavioral health services, and a university-affiliated OBGYN practice within a tertiary care hospital. After demonstrating that the program reached a medically disproportionately impacted population and decreased illicit substance use, the program expanded to additional hospitals, OBGYN clinics, FQHCs, and behavioral health centers across the state. Currently, at least one DFMB program is affiliated with every delivery hospital in West Virginia.

The goal of the DFMB program is to improve health outcomes of mothers and their infants by providing comprehensive, integrated care for pregnant and postpartum women struggling with substance use disorders. The program seeks to identify women with substance use as early in their pregnancy as possible, and connect them to the medical, behavioral, and social services needed to improve the health of the mother-baby dyad. The program is available to women for up to two years postpartum to help the mom maintain recovery, provide support, and ensure her baby's needs are met. Key to the program's success is a dedicated coordinator who provides individualized care by assessing patients' needs and helping patients access services and navigate complex systems. Peer recovery support specialists are incorporated into the program and play a critical role in engaging patients, establishing trust, and supporting the recovery of participants.

DFMB clinic sites are built upon the central hub of care coordination and provide required service components, yet they have the flexibility to provide services in a way that meets local needs and demands and are responsive to available resources. In creating the DFMB program, the Partnership was intentional in its efforts to develop a program that could be implemented statewide regardless of the makeup of the practice in which it is operational. The strong care coordination model incorporates wraparound recovery support and social services, and each site can shape how this care is delivered by utilizing the staff and resources available within their community. The Partnership continues to enhance the services available through the DFMB program by providing training and identifying resources. For example, the Partnership has conducted extensive training on recognizing substance use and mental health coercion through the Weave WV project which focuses on the intersection of intimate partner violence and substance use. Other enhancements include offering a tobacco and nicotine cessation program, providing training on perinatal mental health, and expanding opportunities to receive certifications intended to increase the capacity to effectively serve the perinatal population. These certification opportunities include training to become doulas, community health workers, and lactation consultants. The Partnership has also worked with state policy makers to establish a reimbursement mechanism for DFMB services under WV Medicaid with an eye toward sustainability.

All DFMB participants receive standard of care for treatment to address their substance use, including medication for opioid use disorder. Methadone and buprenorphine have proven to be successful and safe for pregnant women, as well as safe to use while breastfeeding, so DFMB encourages and tracks usage of these medications when appropriate. DFMB's framework aims to keep the mother-infant dyad together after birth because research has shown this is the best for promoting mother-infant bonding, as well as a primary motivator for the mother's continued recovery.

CORE COMPONENTS & PRACTICE ACTIVITES

The goal of the DFMB program is to provide pregnant and parenting women the medical, behavioral, and social services needed to improve the health of the mother and her baby. Our model incorporates strong care coordination and wraparound services, as shown in Appendix A. The core components of DFMB include screening to identify mothers at risk, integration of maternity and behavioral health services, collaboration with community partners, long-term follow-up with mothers, provider outreach and education, and evaluation of the program to determine effectiveness of the model.

Core Components & Practice Activities

Core Component	Activities	Operational Details
Screening	Implement Screening, Brief Intervention, Referral and Treatment (SBIRT)	Universal screening by prenatal care providers to identify substance use, to assess the severity and identify the appropriate level of treatment; providing a brief intervention to increase awareness and motivation toward behavioral change; referral to treatment as needed
Integration of maternity and behavioral healthcare services	Integrate behavioral healthcare into standard maternity care	DFMB care coordinator meets with identified patients and assesses medical, behavioral, and social needs. In collaboration with patient, a plan of care is developed. Care coordinator facilitates warm handoffs to behavioral health specialists on site when available, or through referral. Information shared with prenatal care providers, SUD treatment providers, peer recovery support specialists, and others on care team. All staff in the perinatal setting receive training on trauma-informed care and stigma.
Collaboration with community partners	Identify and connect with community resources who can provide treatment, resources, education, and support	Outreach to community resources, including SUD treatment, WIC, domestic violence, transportation, mental health, legal, housing, child welfare, home visitation, education/vocational, etc. Obtain information on eligibility and other requirements needed to access benefits. Obtain releases of information as needed.
Long-term follow-up	On-going communication with program participants to ensure needs are being addressed, help with navigating systems, and connecting them with resources	Participation in program extends throughout pregnancy and up to 2 years postpartum. During that time, care coordinators interact with participants as frequently as needed to ensure needs are addressed, and at a minimum once a month.
Provider outreach	Share new information, research, training opportunities, and educational resources with	Offering training, education, and resources to perinatal providers on substance use including screening, treatment, and stigma

	providers, not only those working directly in a DFMB program; outreach to perinatal providers to promote awareness of the program, services available, and referral pathways	reduction; providing education and resources on other related topics including intimate partner violence, tobacco and nicotine cessation, contraception shared decision-making, maternal mental health, and certification opportunities. Development of program materials to distribute, including contact information for individual clinical sites.
Program evaluation	Collect and analyze data to understand its reach and effectiveness	Collect data on participants, including demographics, urine drug screens, services, referrals, and birth outcomes; analyze data to determine program effectiveness, share results, and make improvements as needed.

COMMUNITY WELLNESS

The presence of DFMB programs across the state has allowed for more collaboration and education with community partners. A key part of this community education is aimed at reducing the stigma of substance use, MOUD/MAT, and recovery services, especially for the pregnant and parenting population. In 2025, we conducted a series of thirteen regional trainings, in partnership with local delivery hospitals, across the state titled “It Takes a Community: Improving Care for the Mother-Baby Dyad and Their Families Affected by Substance Exposure.” This series brought together OB-GYNS, pediatricians, family practice, advanced practice nurses, nurses, social workers, hospital care managers, behavioral health care and SUD treatment providers, early childhood programs, child protective services, home visitors, peer recovery support specialists, courts, domestic violence assistance groups, and others caring for mothers and infants affected by SUD to discuss how the community can better meet the needs of this population.

Across the thirteen trainings, 408 participants with varying levels of SUD knowledge, experience, and backgrounds attended. At the start of each training, participants were encouraged to share a top strength they see in their work with families affected by substance exposure. The training included evidence-based practice and research followed by an application-based exercise, allowing for reflection and connection between attendees. A post-training evaluation indicated that 82% of attendees reported an increase in their ability to identify common strengths and challenges faced in treatment and support for their perinatal SUD population; 85% of attendees reported an increased ability to articulate and apply best practices to improve outcomes for these families. By opening the training to a wide variety of professionals, attendees were able to make connections with groups they were unfamiliar with, learn more about SUD and resources, and start conversations and collaboration across disciplines.

Attendees of the training also heard from someone with personal experience who recounted her delivery experience and shared the stigma and shame she faced years ago. Now in recovery, she works as a peer recovery support specialist in one of the DFMB programs. Her personal experience as well as the experiences of other peer recovery support specialists working across DFMB programs have shaped the way we educate providers and communities through trainings. We utilize their expertise when developing materials, such as pamphlets and brochures for providers to use with patients. DFMB sites rely on the specialized skillset of peer recovery support specialists to engage with patients and understand their needs. The inclusion of these voices,

experiences, and knowledge into the DFMB program has shaped the way the DFMB clinical staff, as well as the health systems they represent, interact with their patients. As program implementers, we continuously work with DFMB clinical sites to hear the needs of the population served through the program. Through monthly meetings and data collection, we are able to understand what services are utilized, what mothers in the program are experiencing regarding their medical care, access to services, and resource needs, and how we can best modify the program to improve care.

EVIDENCE OF EFFECTIVENESS

The evaluation was designed to assess program effectiveness. De-identified data on DFMB program participants is collected from each of our clinical sites. Data is entered into the REDCap system by each clinical site on an on-going basis while the participant is active in the program. Data is collected through various forms, including interviews with patients and review of medical records. Information collected includes demographics (i.e., age, education, income, insurance status, race and ethnicity, gestational age at program entry, etc.), medical history, substance use history, services received (i.e., prenatal care and substance use treatment, including medication assisted treatment and counseling), referrals to services to address health-related social needs (i.e., housing, utilities, food/nutrition, transportation, intimate partner violence, recovery support, etc.), and outcomes. Outcome data includes information related to pregnancy and birth (i.e., gestation at time of delivery, method of delivery, infant weight, infant's APGAR score, etc.) and information related to substance use (mother's urine drug screen results throughout pregnancy and at delivery, infant cord tissue results, neonatal abstinence syndrome diagnosis, NICU admissions, etc.).

Data is also collected on other important perinatal indicators such as breastfeeding, Child Protective Services involvement, and if the baby was discharged to mother's care. The data is primarily used to demonstrate program effectiveness and shared regularly with hospitals, state policymakers, community-based organizations, and other interested parties.

The data collected consistently shows that DFMB reaches a disproportionately affected population and that the program is effective in decreasing substance use throughout pregnancy. In 2024, illicit substance use decreased from 77% in the first trimester to 29% at delivery for program participants. Only 12% of the babies born to DFMB participants were preterm, lower than the statewide average. The latest report card from the March of Dimes indicates WV's preterm birth rate is 13.4%. Over 80% of the babies born to DFMB participants are discharged to their mother's care. Qualitative information demonstrates the positive impact the program has had on both healthcare providers, as well as program participants. Here is one success story that was shared by a DFMB are coordinator:

> *We had a patient who came to our clinic at 32 weeks pregnant after being in jail for substance use. She was prescribed buprenorphine in jail but had no way to access it once she was released. We were able to refer her to an MAT program and provide her with resources, such as SNAP and transportation for prenatal appointments. Because of this, she was able to take her baby home with a 90-day safety plan, despite originally considering adoption. She has since had another child who did not require a safety plan after birth, and she is in a stable relationship.*

Section 2: Implementation Guidance

COLLABORATORS AND PARTNERS

The DFMB program relies on the collaborative efforts of the clinical sites, perinatal providers, mothers with a history of SUD, professionals who are working in the field of substance exposure, and state agencies who help with dissemination of information and engaging key stakeholders. These partners have been involved since DFMB's inception, and their networks and knowledge have grown through years of implementation, allowing us to continue the program and expand to other needs.

Practice Collaborators and Partners			
Partner/ Collaborator	**How are they involved in decision-making throughout practice processes?**	**How are you partnering with this group?**	**Does this collaborator have lived experience/come from a community impacted by the practice?**
DFMB program sites (including health care providers, SUD treatment providers, care coordinators, Peer Recovery Support Specialists)	Program sites implement the project daily in their respective locations and provide feedback on their experiences	Project sites meet with one another and Partnership staff monthly to share updates	Yes, programs include peer recovery support specialists who have direct experience with substance use
Mothers with history of SUD	Mothers are the primary participants of the program and share their feedback and experiences with their sites which is used to inform program design	We occasionally request, but also receive input including quotes and stories, from our sites when mothers have volunteered to share their experiences	Yes, mothers are the primary target population of the program
Governor's Council on Substance Abuse and Prevention	The Pregnant and Parenting Women (PPW) Subcommittee of the Governor's Council identifies needs for the	A few members from the Partnership and DFMB sites sit on the Subcommittee and offer updates on project	Yes, the PPW Subcommittee includes health care providers, treatment program staff, and state health office staff that all

	state which informs program design	needs during monthly meetings	have projects or care affected by the program
Substance Use During Pregnancy Advisory Council	The Advisory Council, made up of health care providers, social service providers, and others working in SUD education, treatment, and care, informs program design	The Advisory Council meets quarterly	Yes, members of this Advisory Council include individuals who work daily with substance use impacted mothers and infants and in areas where there are program sites
State agencies, including Title V (WV Office of Maternal, Child and Family Health) and Bureau for Behavioral Health	Representatives from state agencies provide funding, participate in Advisory Councils, and share training opportunities	Funding partners who support our work	As the state agencies responsible for implementing these programs, they have a wide range of experience and expertise

REPLICATION

The DFMB program began as a pilot in four clinical locations starting in 2011. As of 2026, we have replicated the program numerous times, and DFMB is currently located in 24 clinical sites. Each program follows the same framework, but since clinical sites may be in a different health setting and region of the state with access to varying resources, flexibility in the way each program operates is built into the model. Differences are seen in the credentials and background of care coordinators (i.e., nurses, social workers, etc.). Other differences are seen in which services are offered on-site and which are referred to community partners (e.g., substance use treatment, including MAT and peer recovery support). Importantly, we encourage programs to "brand" their DFMB program by calling it something different if they want. This has yielded some very powerful, hopeful, and creative names that are recognized in the communities in which they are located.

As a new site is established, we meet with them to discuss our framework and program components and explore the best way for the model to be incorporated into their practice, taking into account the services that are available on site and what resources exist in that community. Changes made to the overall DFMB program are applied to each clinical site, not just to the new sites. Examples of changes include scope of trainings and expansion of data elements collected for analysis. Core components have been maintained. Rather, we have found ways to strengthen the model to ensure its success and effectiveness in serving West Virginia families.

When a new DFMB clinical site joins the program, delays in implementation are unavoidable. Hiring new staff, integrating team members, changing clinic workflow and processes, providing education, building relationships with new and different providers, and collecting data is typically more challenging than expected. The Partnership offers technical assistance and mentoring opportunities with more experienced DFMB clinical staff to new clinical staff. These methods have helped NAS birth rates consistently decrease across sites (37% in 2018

to 18% in 2025) and have also helped keep mothers and infants together at discharge, with over 80% of infants being discharged into mother's care each year. Program completion of participants has also been consistent across sites since 2018. DFMB data consistently shows decreases in illicit substance use and improved birth outcomes for the over 5,000 women served in the program through 2025.

INTERNAL CAPACITY

Each clinical site requires a dedicated care coordinator that oversees the program at their location. This person is primarily responsible for meeting with participants throughout their time in the program, connecting them with resources, and ensuring access to needed services. Oftentimes, the coordinator's initial meeting with the patient occurs prior to them becoming a participant; when a referral is made, they meet with the prospective participant and provide the initial support, education, and resources the program emphasizes. Establishing rapport and trust with the patient is crucial to the program's success. Peer recovery support specialists (PRSSs) are important members of the team. The firsthand experience they offer is unmatched and provides a level of trust and understanding that is not seen with other healthcare staff. Other members of the program team include OB/GYN providers, nurses, and counselors that work within that facility. The patient volume of specific facilities determines the number of individuals serving in these roles. Regardless of the number, DFMB staff members practice destigmatized care and focus on ensuring collaboration with those within their systems as well as external resources to help support the program participants.

To help oversee all the participating clinical sites, the Partnership has a team of dedicated staff that provide technical assistance to sites, ensure that education and resources are provided to DFMB clinical staff, and help manage and ensure the database is utilized. The team enlists the expertise of a biostatistician who analyzes the data, provides reports and updates to the DFMB clinical sites and other key stakeholders. The Partnership's close and collaborative relationship with state agencies, hospital systems, and individual providers has assisted in the continuation and expansion of DFMB to additional clinical sites.

PRACTICE TIMELINE

A DFMB program gets established at a new clinical location when an area is recognized as having a need for SUD treatment and resources for the pregnant and parenting population. This need can be recognized by the Partnership through state health data, by hospitals or providers being interested in becoming a DFMB site based on what they are seeing in their practice and hearing about the success of the program in other areas. Partnership DFMB staff meet with the site to provide information on the DFMB model and brainstorm effective ways of implementation for that specific clinical site. A benefit of having a wide variety of sites established is that there is typically a site already in place that mirrors the setup of the proposed site; this helps streamline the program's setup. Additionally, a number of the clinical sites now have years of experience, and staff from these sites are able to provide assistance and support to the newer sites. Having monthly all-site meetings, 1-2 in-person meetings throughout the year, and site visits as needed, the DFMB clinical staff are able to learn from one another and from the Partnership team on ways to sustain and improve the care they provide.

For more information on this practice's timeline and specific practice activities, please contact Amna Haque at ahaque@wvperinatal.org.

Phase: Planning/Pre-Implementation		
Activity Description	**Time Needed**	**Responsible Party**
Assess prevalence of substance use within the perinatal population and method for screening and identification.	3-6 months	Partnership staff in collaboration with provider champion at clinical site.
Hire dedicated care coordinator to develop processes	4-5 months	Maternity clinical staff
Identify SUD treatment options and community resources and establish referral pathways.	4-5 months	Maternity clinical staff, including care coordinator
Conduct training on needs of pregnant and postpartum patients with SUD with clinical staff	3-6 months	West Virginia Perinatal Partnership in collaboration with maternity care staff
Onboarding of new DFMB team members (care coordinator and PRSS)	4-5 months	West Virginia Perinatal Partnership
Outreach to medical staff, treatment programs, community-based resources, etc. To promote the program	3-6 months	Dedicated care coordinator and other members of the local DFMB team

Phase: Implementation		
Activity Description	**Time Needed**	**Responsible Party**

Establish clinical workflows to screen, identify and refer patient to care coordinator	6 months	Maternity clinical staff
Conduct comprehensive needs assessment and develop individualized care plan, make warm hand-offs to needed services	On-going	Dedicated care coordinator
Follow up, including obtaining informed consents to share information between service providers, including SUD treatment, medical care, and others	On going throughout pregnancy, labor and delivery and postpartum periods	Dedicated care coordinator and PRSS
Outreach to promote the program	On-going	Dedicated care coordinator, PRSS, and other members of the local DFMB team
Data entry on program participants	On-going	Dedicated care coordinator

Phase: Sustainability		
Activity Description	**Time Needed**	**Responsible Party**
Education and training on emerging issues	On-going	West Virginia Perinatal Partnership, DFMB team members
Statewide meetings	Monthly	West Virginia Perinatal Partnership, DFMB team members
Seeking grant funding	Annually	West Virginia Perinatal Partnership
Maximizing reimbursement	12 months	Maternity clinical staff

PRACTICE COST

For more information on this practice's budget, please contact Amna Haque at ahaque@wvperinatal.org.

Budget			
Activity/Item	**Brief Description**	**Quantity**	**Total**
Care Coordinator	Oversee program and meet with participants	1 at .5 to 1 FTE	Depends on size of program/hours needed and experience of candidate
Peer Recovery Support Specialist	Meet with participants and help support them through the program and recovery	1 at .5 to 1 FTE	Depends on size of program/hours needed and experience of candidate
Provider Training	Training opportunities including attending conferences and training/certification courses/exams	Typical schedule includes about 3-5 opportunities each year	Depends on number of trainings, location, and duration of each. Typically about $1,000 to $2,000 is set aside for each program to support this
Supplies	Office supplies, meeting materials, medical supplies to support program	Depends on program size and what is provided by program's health care system	Depends on items/quantity needed
Participant Support Costs	Items to support participants' participation including incentives or mother/baby resources	Depends on program participant needs and what is available through the community	Depends on size of program and what is received from external resources
		Total Amount:	**$Varies**

LESSONS LEARNED

A key element to the DFMB program's success is the utilization of peer recovery support specialists (PRSS). Clinical sites have found higher rates of program engagement when the PRSS are added. Having someone with personal experience as part of the team is invaluable; they are able to offer a level of support and build trust with program participants that others struggle to obtain.

Some sites also integrate community health workers into their program. Community health workers provide essential support to program participants and their families. They are able to promote health education and program adherence through their outreach efforts, which oftentimes includes connections to other community supports and resources. In many instances, the PRSS is dually trained as a community health worker.

One challenge experienced during the implementation of DFMB has been addressing the stigma around SUD. This stigma is especially pervasive when mothers are the patient, and it exists throughout society, including clinical settings. The latter was especially important to address when getting each DFMB site established. When a new program site joins the DFMB model, it is important for the clinical site and the Partnership to initiate communication between the program and the providers in that area. This ensures that patients are being properly screened and referred, so that they are able to get the care they deserve instead of falling through the cracks. Addressing stigma can also help in reducing the likelihood of the patient avoiding medical care, which often happens. This leads to worse health outcomes for the mother and her baby. In addition to letting providers know that there is are services available for their perinatal patients experiencing SUD, education to all providers and staff about the appropriate, destigmatizing language that should be used is provided. Throughout implementation using a non-judgmental approach to caring for these patients is emphasized. To aid in these endeavors, the Partnership has created an anti-stigma resource toolkit.

Even after a program is established in a clinical site, setting up effective referral pathways can be challenging. Additionally, patients may be reluctant to accept the services. This can be a combination of providers not making referrals, personal bias and stigma against screening/caring for this population, or lack of a defined process for that health system (i.e., not an option or not clearly labeled in the electronic medical record). The Partnership staff offers technical assistance through education, sharing resources, and strategizing with clinical staff on how to overcome these barriers. Examples include education and training on the use of screening tools, establishing protocols, and a well-defined set of processes for connecting patients with the DFMB care coordinator.

Even after a referral is made, a patient may be reluctant to enroll in the program. In those instances, care coordinators provide resources. To capture this outreach and education, fields were added to the DFMB database to capture the number of contacts made by coordinators and/or PRSSs, including the resources, education, and referrals provided to eligible participants.

Since its inception, DFMB funding amounts and sources have changed. Since its launch in 2011, the DFMB model has relied on grants from the WV Department of Health, Department of Human Services, and private foundations to grow and expand. In 2020, West Virginia was selected to participate in the Center for Medicare and Medicaid Services Innovation Center's Maternal Opioid Misuse (MOM) model. Through this initiative, a state plan amendment adding DFMB services as a Medicaid benefit for pregnant and postpartum women with SUD was adopted. By becoming a Medicaid-billable service, the program is transitioning from temporary, grant-based funding to a more stable reimbursement stream to sustain services withing clinical settings.

NEXT STEPS

When the DFMB program was first created, one of the top goals was to have a program affiliated with each delivery hospital in the state. This goal was achieved in 2023. However, given the rurality of West Virginia, there are areas where the nearest DFMB program may be over an hour drive away. Lack of transportation and road conditions, especially in poor weather, exacerbate these distances. We hope to expand into these areas in the state and create more DFMB programs, as well as other prenatal care services for WV families.

We are expanding the capacity of our DFMB programs to better address perinatal mental health. Education on perinatal mental health conditions, training on screening and identification, and opportunities to become certified in perinatal mental health have been made widely available to DFMB clinical staff. Since perinatal patients with SUD often also experience mental health problems, these efforts are seen as critical to better meeting the needs of the population. In addition, as many as 1 in 5 pregnant women experience a perinatal mental health condition, so having more clinical staff able to screen and identify these conditions is crucial to improving our system of care. Future plans include transitioning away from a model solely for the SUD population to one that addresses all behavioral health conditions.

An expansion of the DFMB model into pediatric settings is being piloted. This new endeavor seeks to increase collaboration between maternity care and pediatric providers, especially for those caring for families affected by substance exposure. By replicating the DFMB model and utilizing the services of a dedicated care coordinator, we hope to continue services for both mother and baby in the pediatric clinic. In addition to piloting the program in two pediatric clinics, existing DFMB clinical sites have been surveyed to better understand their current collaborative efforts with pediatric providers.

The Partnership is planning a strategic evolution of the DFMB model to further reduce stigma, improve engagement, and align more closely with federal and state policy related to Plans of Safe Care (POSC). Under federal and state requirements, all infants affected by prenatal substance exposure must have a Plan of Safe Care, which may be implemented either as part of a child welfare case plan or as a standalone plan when no maltreatment is identified. However, POSC are often perceived as a child welfare-driven process initiated at delivery and associated with surveillance or potential family separation. In contrast, federal guidance positions POSC as a preventive, family-centered approach to care coordination that addresses the needs of both the infant and caregiver.

Building on this framework, DFMB is exploring a rebranding and programmatic shift that integrates POSC into the model. This approach would move the development of care plans earlier in pregnancy, rather than at delivery, and position them as a standard, supportive component of care for individuals with substance use and related risk factors.

This evolution would include efforts to:

- Normalize care coordination by embedding POSC-aligned planning into standard perinatal care workflows
- Expand eligibility to include individuals with a broader range of substance use and social risk factors
- Promote consistent screening and enrollment practices across sites to reduce variability and potential bias
- Strengthen collaboration between healthcare providers, behavioral health services, and child protective services
- Reframe engagement in services as supportive and preventive, rather than punitive

By aligning DFMB more explicitly with POSC, we aim to ensure that more families receive coordinated, comprehensive support and improve outcomes for mothers and infants. This approach has the potential to position DFMB as a leading model for upstream implementation of POSC principles within healthcare settings.

RESOURCES PROVIDED

- WV Perinatal Partnership Drug Free Moms and Babies Program Website
- 2009 Cord Tissue Study – Prevalence of Drug Use in Pregnant West Virginia Patients
- Drug Free Moms and Babies Pilot Program Report
- SBIRT For Us—What It Is, How and Why to Use
- Care & Service Coordination for Women Identified with Substance Use Disorder (SUD) in Pregnancy
- Preparing Your Patients with Substance Use Disorder for Labor and Delivery
- Planning for Discharge: Special Considerations for the Mother-Infant Dyad

APPENDIX

Appendix A: Drug Free Moms and Babies Care Coordination Model