Commonwealth of Massachusetts

Interagency Task Force on Newborns with Neonatal Abstinence Syndrome

State plan for the coordination of care and services for newborns with neonatal abstinence syndrome and substance-exposed newborns

March 17, 2017
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Overview
Purpose

There shall be an interagency task force on newborns with neonatal abstinence syndrome and substance-exposed newborns to develop a unified statewide plan to collect data, develop outcome goals, and ensure quality service is delivered to those newborns.

The statewide plan shall ensure that, to the extent possible, all executive agencies work in coordination to address the needs of newborns, infants, and young children impacted by exposure to substances.

Final Report

The task force shall file a report of its findings and the recommended statewide plan, along with any proposed legislation or regulatory amendments necessary to implement the statewide plan not later than March 2017.
Develop a State Plan for the *coordination of care and services* for newborns with neonatal abstinence syndrome and substance-exposed newborns including, but not limited to, those related to early intervention, substance use disorders and healthcare access issues.

The State Plan shall include:

1. An **inventory of the services and programs available** in the Commonwealth to serve newborns with neonatal abstinence syndrome and substance-exposed newborns;

2. Identification of **gaps in available services and programs**;

3. A plan to **address identified gaps**; and

4. An interagency plan for **collecting data**, developing **outcome goals** and ensuring **quality service** is delivered.
Substance Abuse and Mental Health Services Administration’s (SAMHSA) definitions for NAS/SEN are the following:

- **Substance-Exposed Newborns (SEN)** are infants exposed to alcohol or other drugs ingested by the mother in utero, whether or not this exposure is detected.¹

- More specifically within SEN, **Neonatal Abstinence Syndrome (NAS)** is the term used to represent the pattern of effects that are associated with opioid withdrawal in newborns.² NAS can also be caused by exposure to other drugs (e.g. barbiturates, benzos, SSRIs).²

- NAS symptoms are affected by a variety of factors, including the type of opioid the infant was exposed to, the point in gestation when the mother used the opioid, genetic factors, and exposure to multiple substances.³

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A Five-Point Framework (Framework) is the organizing foundation for a highly acclaimed SAMHSA report Substance-Exposed Infants: State Responses to the Problem. This publication serves as a comprehensive and widely-accepted model to establish the five major time frames when intervention can help reduce the potential harm of prenatal substance exposure.

The Framework emerged from a multi-year review and analysis of existing polices and practices across 10 states regarding prenatal exposure to alcohol and other drugs.

One benefit of the Framework is that it identifies the birth event as only one of several opportunities to affect outcomes.

The Framework also makes it apparent that cross-system linkages are necessary to ensure services are coordinated across the spectrum of prevention, intervention, and treatment.

The Task Force adopted this Framework in its deliberations and development of the State Plan.
Five-Point Intervention Framework

1. **Pre-pregnancy:** During this time, interventions can include promoting awareness among women of child-bearing age and their family members of the effects that prenatal substance use can have on infants.

2. **Prenatal:** During this time, health care providers have the opportunity to screen pregnant women for substance use as part of routine prenatal care and to make referrals that facilitate access to treatment and related services for the women who need these services.

3. **Birth:** Interventions during this time include health care providers testing newborns for prenatal substance exposure at the time of delivery.

4. **Neonatal:** During this time, health care providers can conduct a developmental assessment of the newborn and ensure access to services for the newborn as well as the family.

5. **Postnatal** (Throughout childhood and adolescence): During this time, interventions include the ongoing provision of coordinated services for both child and family.

*A Collaborative Approach to the Treatment of Pregnant Women With Opioid Use Disorders: Practice and Policy Considerations for Child Welfare, Collaborating Medical, and Service Providers published by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration*
Five-Point Intervention Framework

Source: 2017 Policy Academy “Improving Outcomes for Pregnant and Postpartum Women with Opioid Use Disorders and Their Infants, Families, and Caregivers”
Inventory of Services and Programs Available in the Commonwealth

*Component #1 of State Plan:* Include an inventory of the services and programs available in the Commonwealth to serve newborns with neonatal abstinence syndrome and substance-exposed newborns
Process for Developing the Inventory Survey

1. The Task Force sought to create an accessible mechanism that could:
   
   1. Be widely distributed across the entire care system
   2. Fully capture the existing inventory of services and programs in the Commonwealth
   3. Gather information regarding existing gaps in services and programs, including gaps that
      are more systemic in nature

2. Survey

   1. The Task Force decided to develop an online survey mechanism using Survey Monkey in
      order to solicit responses.
   2. An example survey response was also created to demonstrate the level of detail sought
      from those who completed the survey.

3. Distribution

   1. All materials were distributed to the Task Force, Advisory Council, and other stakeholders.
   2. It was requested that, in addition to completing the survey on behalf of their organization,
      they would disseminate the materials to their networks.
Components of Inventory Survey*

1. Contact Information

2. Organization; Name of Service/Program/Initiative

3. Organization/Program Description as It Relates to NAS/SEN

4. Geographic Region(s) Served
   - Northeastern (Essex and Middlesex); Boston area (Norfolk and Suffolk);
     Southeastern (Bristol and Plymouth); Cape and Islands (Barnstable, Dukes, and Nantucket);
     Central (Worcester); Pioneer Valley (Franklin, Hampshire, and Hampden);
     Western (Berkshire)

5. Intervention Stage
   - Pre-pregnancy; Prenatal; Birth; Neonatal; Postnatal (Throughout Childhood and Adolescence)

* Full Inventory Survey can be found in the Appendix
Components of Inventory Survey*

6. Type of Intervention
   - Prevention/Education/Outreach; Screening/Testing/Assessment; Treatment; Social Services; Training; Data Collection; Quality Improvement

7. Target population
   - Women of childbearing age; pregnant women (with SUD/OUD); mothers; at-risk parents; other caretakers; newborns/infants; older children; providers

8. Capacity

9. Funding Source and Duration
   - State appropriation; grant (federal or state); private; payer reimbursement

10. Gaps in Services and Programs

* Full Inventory Survey can be found in the Appendix
| 1.       | Adcare                      | 26. | Fallon Health Plan       |
| 2.       | Anna Jacques Hospital       | 27. | Falmouth Hospital         |
| 4.       | BAMSII Early Intervention   | 29. | Gandara Center            |
| 5.       | Baystate Children’s Hospital| 30. | Granada House             |
| 6.       | Bay State Community Services| 31. | Habit OPCO (Fitchburg and Boston) |
| 7.       | Berkshire Medical Center    | 32. | Harvard Pilgrim Health Plan |
| 8.       | Beth Israel Deaconess Medical Center/ Children’s OT | 33. | Health Care Resources Centers (FKA CSAC) |
| 9.       | Beverly Hospital            | 34. | High Point OTP, Brockton  |
| 10.      | Boston Children’s Hospital  | 35. | Holyoke Medical Center    |
| 11.      | Boston Medical Center       | 36. | Institute for Health and Recovery |
| 12.      | Boston Medical Center HealthNet Plan | 37. | Latinas Y Ninos for Families |
| 13.      | Cape Cod Children’s Place   | 38. | Lawrence General Hospital |
| 14.      | Cape Cod Hospital           | 39. | Learn to Cope Inc.        |
| 15.      | Catholic Charities          | 40. | LHBS Gloucester Opioid Treatment Center |
| 16.      | CeltiCare Health            | 41. | Lowell General Hospital   |
| 17.      | CleanSlate                  | 42. | March of Dimes Foundation |
| 18.      | Community Catalyst          | 43. | Massachusetts General Hospital |
| 19.      | Community Health Link (Orchard Street, Worcester Community Housing, North Village Community Housing, and Faith House) | 44. | Massachusetts Law Reform Institute |
| 20.      | Criterion Child Enrichment  | 45. | Massachusetts Organization for Addiction Recovery |
| 21.      | DPH Essential School Health Services | 46. | May Center for Early Intervention |
| 22.      | Early Intervention Partnerships Program | 47. | Melrose-Wakefield Hospital |
| 23.      | EMPOWER Program             | 48. | Minutemen Health Plan     |
| 24.      | Emerson House               | 49. | Morton Hospital           |
| 25.      | Enable Early Intervention   | 50. | Neighborhood Health Plan  |
|          |                             | 51. | Neonatal Quality Improvement |
|          |                             | 52. | Collaborative of Massachusetts |
|          |                             | 53. | Newday                    |
|          |                             | 54. | Optum                     |
|          |                             | 55. | People Incorporated        |
|          |                             | 56. | ProgenyHealth Inc.         |
|          |                             | 57. | Providence Behavioral Health Hospital |
|          |                             | 58. | Riverside Community Care   |
|          |                             | 59. | South Bay Community Services |
|          |                             | 60. | South Shore Hospital       |
|          |                             | 61. | Stanley Street Treatment and Resources Steppingstone Inc. |
|          |                             | 62. | Sturdy Memorial Hospital   |
|          |                             | 63. | Thom Early Intervention (Pentucket, Marlboro, and Worcester area) |
|          |                             | 64. | Tufts Health Plan (Non-Public Plans) |
|          |                             | 65. | Tufts Health Plan (Public Plans) |
|          |                             | 66. | Tufts Medical Center       |
|          |                             | 67. | Two Rivers Recovery Center for Women |
|          |                             | 68. | UMass Memorial Medical Center |
|          |                             | 69. | UMass Memorial HealthAlliance Hospital |
|          |                             | 70. | United Healthcare          |
|          |                             | 71. | Women Views                |
|          |                             | 72. | Women’s Addiction Treatment Center |
|          |                             | 73. | Winchester Hospital        |
|          |                             | 74. | Youth Villages Community Based Program |

* Summarized results from each organization can be found in Supplemental Materials
Survey Responses
- Survey distributed on 12/09/16
- 93 survey responses were submitted
- Of the 93 responses, **75 unique organizations were represented**

### Geographic Region*
- Northeastern (Essex and Middlesex) 17%
- Boston area (Norfolk and Suffolk) 17%
- Southeastern (Bristol and Plymouth) 15%
- Cape & Islands (Barnstable, Dukes, and Nantucket) 16%
- Central (Worcester) 17%
- Pioneer Valley (Franklin, Hampshire, and Hampden) 11%
- Western (Berkshire) 13%

### Target Population*
- Pregnant women (with SUD/OUD) 18%
- Mothers 16%
- Newborns/Infants 19%
- Older Children 7%
- Other Caretakers 9%
- At-risk Parents 13%
- Providers 7%
- Women of childbearing age 11%

*Some survey submissions listed multiple geographic regions and target populations
Summary of Inventory Survey

*Some survey submissions listed multiple intervention stages and funding sources
Identification of Gaps

Component #2 of State Plan: Identify gaps in available services and programs
Determination of Gaps in Services and Programs

1. **Gaps Summary (based on 93 completed Inventory Surveys)**
   - Staff compiled the gaps by intervention stage and organized them by theme (e.g. education, training, etc.).

2. **Advisory Council Review**
   - At the third Task Force meeting, Advisory Council members reviewed the gaps at all intervention stages and provided additional suggestions.

3. **Revision**
   - Using the feedback from the Advisory Council, staff revised the gaps and developed a list of overarching gaps, as well as specific details related to them, for each intervention stage.

4. **Gaps → Recommendations**
   - Staff aligned the Advisory Council members’ proposed recommendations with the revised list of gaps.
1. Lack of centralized data collection across intervention stages
   • Lack of defined key metrics for tracking outcomes
   • Lack of mechanism for centralized data collection of key metrics

2. Inconsistent sharing of information for clinical care coordination
   • Lack of mechanism for centralized data collection of key metrics
   • Real and perceived barriers regarding patient privacy/confidentiality that impede information sharing
Overarching Gaps:
Pre-Pregnancy/ Prenatal Stage

3. Inconsistent knowledge among providers
   - Lack of knowledge about substance use disorder (SUD) and NAS/SEN among OB/GYN providers
   - Lack of knowledge/training about pregnancy and NAS/SEN among SUD providers

4. Inconsistent protocols and practices for screening and referral
   - Inconsistency of screening
   - Lack of resources for responding to a positive screen

5. Lack of individualized Plans of Safe Care for NAS/SEN infants and families

6. Inconsistent access to effective treatment and services
   - Inconsistent provision of individualized, comprehensive, and coordinated approach to treatment
   - Lack of specialized support services for perinatal substance use
   - Inconsistent access to medication-assisted treatment (MAT) programs
7. Inconsistent education for patients and families
   • Lack of public education about the impact of SUD on pregnancy and infancy
   • Inconsistent pre-pregnancy and prenatal education for patients suffering from SUD about what will happen during pregnancy, at birth, and beyond

8. Inconsistent education about and access to birth control
   • Inconsistent education about birth control (pre-pregnancy, prenatally, at birth, and postnatally)
   • Inconsistent access to effective birth control

9. Inconsistent practices for screening, assessing and reporting newborns with NAS/SEN
   • No standardized protocol for testing infants
   • No standardized shared definition of NAS/SEN or protocol for diagnosing NAS/SEN
   • Inconsistent practices with regard to reporting to DCF

10. Inconsistent treatment/support in the hospital
     • Inconsistent approach to mother-infant bonding
     • Inconsistent in-hospital treatment, education, and support services specifically tailored to SUD and NAS/SEN
11. Lack of specialized training/education for providers
   
   Many postnatal practitioners are not NAS/SEN-specific, and therefore don’t have the specialized training/education to care for NAS/SEN babies and families.

12. Inconsistent intervention, treatment, and support

   Inconsistent referrals to supports such as early intervention (EI), home visiting, treatment, etc.
   
   Lack of targeted treatment and support for NAS/SEN babies and families
   
   Lack of long-term treatment, sober housing, and support
   
   Inconsistent coordination between services for families with a NAS/SEN and DCF
   
   Lack of NAS/SEN-specific resources and training in foster care system including contracted foster care providers
Interagency Plan for Collecting Data, Developing Outcome Goals, and Ensuring Quality Service

Component #4 of State Plan: Develop an interagency plan for collecting data, developing outcome goals and ensuring quality service is delivered
1. Prevalence of NAS/SEN in the Commonwealth
   • What does the existing data tell us?
   • What can we learn about gaps in needed services, access to existing services and quality of care?
   • How can data direct the Commonwealth to those areas of greatest need?
   • What does the existing data tell us about access to quality of services?

2. Statewide Plan on Data:
   • What should a unified statewide plan on data look like?
   • What appropriate data-sharing or provider-to-provider transitions across intervention stages are not occurring but should?
   • What gaps in data collection and sharing of data are identified by the Inventory Survey?
   • What are the recommendations to achieve a state plan on data?
The rate of reported prenatal opiate exposure in Massachusetts rose from **2.6 per 1,000 hospital births in 2004 to 14.7 in 2013, an increase of more than 500%**

However, based on hospitalization figures, researchers estimated a higher rate: that **more than 1,300 Massachusetts babies or about 17.5 per 1,000 hospital births** were born with heroin and other opioids in their system in 2013.

Nationally, the figure is **five babies out of every 1,000 births**

The New England region (of which Massachusetts is the most populous) has the **second highest rate of prenatal exposure in the nation** (13.7 per 1,000), after the East/South Central region.

The average length of stay in Massachusetts for an infant requiring treatment for NAS is **19 days, with an average cost (2013) of $30,000**


Franca et al. 2016, ibid.
Rural and Urban Differences in Neonatal Abstinence Syndrome and Maternal Opioid Use, 2004 to 2013

A. Neonatal abstinence syndrome

B. Maternal opioid use

No. per 1000 HospitalBirths

Time, y


No. per 1000 HospitalBirths

Time, y


Rural  Urban

Prevalence of NAS/SEN in the Commonwealth

NAS is increasing more rapidly in Massachusetts than nationally.

### National vs. Massachusetts trends in NAS births (2011-2013)

![Graph showing NAS rates per 1,000 births from 2011 to 2013 for national and Massachusetts data. The graph indicates a 29% increase for the national data and a 23% increase for Massachusetts data.](image)

**Notes:**

NAS discharges were identified using ICD-9-CM diagnosis code 779.5 (drug withdrawal syndrome in a newborn).
NAS increased significantly in Massachusetts between 2011 and 2015

Source: HPC analysis of Center for Health Information and Analysis, Inpatient Discharge Database 2011-2015
Notes: NAS discharges were identified using ICD-9-CM diagnosis code 779.5 (drug withdrawal syndrome in a newborn).
Rate of NAS discharges per 1,000 live births, by HPC region, in 2015

Source: HPC analysis of Center for Health Information and Analysis, Inpatient Discharge Database 2015
Notes: NAS discharges were identified using ICD-9-CM diagnosis code 779.5 (drug withdrawal syndrome in a newborn).
Key Department of Public Health Data Reporting Related to NAS/SEN
Opioid-related deaths in MA increased more than 350% from 2000 to 2015

Opioid-Related Deaths, Unintentional/Undetermined
Massachusetts: 2000-2015

Rate of Unintentional/Undetermined\(^1\) Opioid\(^2\)-Related Deaths
Massachusetts Residents: 2000-2015
Chapter 55 Opened the Door to New Data Analytics

• Massachusetts Chapter 55 Legislation, signed into law in August 2015, provided a number of benefits for researchers, including:
  o Providing a legal basis for cross-agency collaboration
  o Requiring a comprehensive report to the state Legislature
  o Fostering cross-agency collaboration for the first time
  o Requiring the examination of trends in opioid-related deaths and the addressing of seven specific questions
  o Eliminating legal barriers for use of some data for the first time

• One goal of the new analytics was to develop reliable estimates of the burden of the opioid crisis (including NAS) for all 351 communities in Massachusetts.

• A primary assumption of the analysis is that multiple data sources capturing different aspects of the opioid crisis, when combined, will produce a more reliable estimate.
Chapter 55 Data Mapping

All Doors Opening

- Significant coordination within DPH
- Financial and technical support from MassIT’s Data Office
- Center for Health Information and Analysis (CHIA) takes on role as linking agent
- Coordination across agencies (legal and evaluation)
- Volunteer analytic support from academia and industry

Type of Data Sources (2013-2014)

- Fatal opioid overdoses
- In hospital non-fatal opioid overdoses
- Narcan enrollments (layperson request for training) by community
- Infants born with Neonatal Abstinence Syndrome

System Attributes

- Data encrypted in transit & at rest
- Limited data sets unlinked at rest
- Simplified structure using summarized data
- Linking and analytics “on the fly”
- No residual files after query completed
- Analysts can’t see data
- Automatic cell suppression
- Possible resolution to issues related to 42 CFR part 2
This type of analysis is important as it will help the state target resources to those communities of greatest need.
Interagency Plan on Data

Component #4 of State Plan: Develop an interagency plan for collecting data, developing outcome goals and ensuring quality service is delivered
1. Lack of centralized data collection across intervention stages

2. Inconsistent sharing of information for clinical care coordination
## Data Collection/ Quality Improvement

**Gap #1: Lack of centralized data collection across intervention stages**

<table>
<thead>
<tr>
<th>Details</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of defined key metrics for tracking outcomes</td>
<td>Develop key metrics across intervention stages</td>
</tr>
<tr>
<td>Lack of mechanism for centralized data collection of key metrics</td>
<td>1. Create a statewide “dashboard” of key metrics to monitor progress on aspects of care for families impacted by perinatal substance use</td>
</tr>
<tr>
<td></td>
<td>2. Develop protocols for data reporting across the NAS/SEN care continuum</td>
</tr>
</tbody>
</table>

### Current State-Level Initiatives*
- Neonatal Quality Improvement Collaborative (NeoQIC) NAS project
- Health Policy Commission’s Mother and Infant Focused NAS Interventions
- Chapter 55 Initiative

*Full list of “Current State-Level Initiatives” can be found in Supplemental Report Materials*
Data Collection/ Quality Improvement

Gap #2: Inconsistent sharing of information for clinical care coordination

Lack of reimbursement and accountability for care coordination

Details

Recommendations

1. Encourage insurance reimbursement for care coordination

2. Build upon the care coordination approach to support information sharing across a patient’s entire care team

3. Create provider accountability for the transition from one level of care to the next, ensuring efficient and effective care coordination

Current State-Level Initiatives: MassHealth 1115 Waiver

Aligned with the Recommendations of the Governor’s Opioid Working Group
Gap #2: Inconsistent sharing of information for clinical care coordination

Details

Real and perceived barriers regarding patient privacy/confidentiality that impede information sharing

Recommendations

1. Identify and address barriers (in regulations/statutes or in practice) that impede appropriate, necessary, and timely information sharing for care coordination

2. Create a unified EOHHS privacy policy and implement a process for sharing confidential data with guidance to providers about best practices for information sharing for purposes of care coordination

_aligned with the Recommendations of the Governor’s Opioid Working Group_
### Example of Possible Statewide Plan for Data Sharing and Quality Improvement

1. **Create a statewide “dashboard” of key metrics to monitor progress on aspects of care for families impacted by perinatal substance use**

<table>
<thead>
<tr>
<th>Pre-pregnancy/Prenatal</th>
<th>Birth/Inpatient/Neonatal</th>
<th>Postnatal/Post-Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Perinatal substance use incidence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Maternal use of MAT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Timeliness of Prenatal Visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Frequency of ongoing prenatal care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- NAS incidence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Average LOS for infants with NAS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Inpatient therapy for NAS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Breastfeeding in infants with NAS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Readmissions for infants with NAS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Enrollment in EI for infants with NAS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Timeliness of Postpartum Visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Childcare visits in first 15 months</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. **Create provider accountability for the transition from one level of care to the next, ensuring efficient and effective care coordination**

<table>
<thead>
<tr>
<th>Outpatient clinics</th>
<th>PCP Offices</th>
<th>Community Health Centers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birthing hospitals</td>
<td>Acute hospitals</td>
<td>Other birthing centers</td>
</tr>
<tr>
<td>Outpatient clinics</td>
<td>PCP Offices</td>
<td>Community Health Centers</td>
</tr>
</tbody>
</table>

3. **Create a unified EOHHS privacy policy for sharing confidential data with guidance to providers about best practices for care coordination**

1. Review all existing state and federal patient confidentiality and data-sharing protections (HIPPA, 42 CFR Part 2, Chapter 224, 105 CMR.140 and others) to understand what information can be shared among treating clinicians across the care continuum
2. Identify barriers and challenges (existing in regulations/statutes or in practice) that limit appropriate, necessary and timely care coordination
3. Develop a list of recommendations for needed regulatory or statutory changes as well as state-directed guidance clarifying what information (under what circumstances) is currently permissible to be shared
State Plan for the Coordination of Care and Services for NAS and SEN

Component #3 of State Plan: Formulate a plan to address identified gaps
Across all intervention stages, the Commonwealth should look for ways to encourage:

1. *Plans of Safe Care* for all newborns with neonatal abstinence syndrome and substance-exposed newborns (NAS/SEN) and their families

2. Shared responsibility for patient well-being that results in coordinated, multi-disciplinary care

3. Referrals and warm hand-offs, as appropriate, across the entire care continuum for pregnant women, new moms, and infants

4. Treatment and care as early as possible for both pregnant and postpartum women as well as substance-exposed infants
5. Models of support that bridge intervention stages (e.g. recovery coaches, case management)

6. Reducing stigma regarding NAS/SEN and SUD and/or its treatment during pregnancy and post-partum

7. Trauma-informed and strength-based practices

8. Services that address the whole family, not just the infant

9. Initiatives to publish and disseminate best practices, resources, and services for evidence-based prevention, intervention, and care

10. Ways to address social determinants of health (e.g. access to transportation, affordable housing, food security, child care) to ensure the long-term well-being of families who are at risk or in recovery
Pre-Pregnancy/Prenatal Stage
3. Inconsistent knowledge among providers

4. Inconsistent protocols and practices for screening and referral

5. Lack of individualized Plans of Safe Care for NAS/SEN infants and families

6. Inconsistent access to effective treatment and services

7. Inconsistent education for patients and families

8. Inconsistent education about and access to birth control
Pre-Pregnancy/Prenatal Stage

Gap #3: Inconsistent knowledge among providers

Details

Lack of knowledge about SUD and NAS/SEN among OB/GYN providers

Recommendations

1. Support comprehensive statewide training on SUD and addiction (and how to treat them during pregnancy) to all providers and frontline staff who care for pregnant women

2. Raise awareness among prenatal providers and staff to increase training about: screening, intervention, and care for women with a substance use disorder

Current State-Level Initiatives: BSAS Webinar Series for Prenatal Providers; MA Maternal Mortality and Morbidity Review Committee (BSAS); Moms Do Care Initiatives; BFHN Title V work on Substance Use Among Women of Reproductive Age; MA Fetal Alcohol Spectrum Disorders (FASD) Task Force

Aligned with the Recommendations of the Governor’s Opioid Working Group
Pre-Pregnancy/Prenatal Stage

Gap #3: Inconsistent knowledge among providers

Details

Lack of knowledge/training about pregnancy and NAS/SEN among SUD providers

Recommendations

Publish and train MAT and other SUD providers on best practices regarding perinatal substance use including:

• Referring women of child-bearing age to family planning and/or primary care providers, and furnishing them with information about options for contraception

• Providing information to pre-pregnant and pregnant women about the impact of SUD on pregnancy and the importance of prenatal care

Current State-Level Initiatives: BSAS Webinar Series for Prenatal Providers; BSAS Website; BSAS Pregnant Women’s Working Group
Pre-Pregnancy/Prenatal Stage

Gap #4: Inconsistent protocols and practices for prenatal screening and referral

**Details**

**Inconsistency of screening**

**Recommendations**

1. Promote statewide, universal prenatal screening using a verified screening tool (including Emotional Health, SUD and Intimate Partner Violence)
2. Identify and train providers on best practices for prenatal screening
3. Consider ways to encourage and/or require insurance reimbursement for prenatal screening

**Current State-Level Initiatives:** DPH Guidelines for Community Standard for Maternal and Newborn Screening For Alcohol/Substance Use (released May 2013)

Aligned with the Recommendations of the Governor’s Opioid Working Group
Pre-Pregnancy/Prenatal Stage

Gap #4: Inconsistent protocols and practices for screening and referral

Lack of resources for responding to a positive screen

Details

Recommendations

1. Develop materials and train OB/GYN providers and frontline staff on best practices for responding to a positive screen, including:
   - Education for screened patient
   - Protocols for drug testing
   - How to make appropriate referrals
   - How to follow up on referrals/coordinate care

2. Support a centralized database of appropriate referrals/community resources and mechanism for making referrals quickly and easily

Current State-Level Initiatives: MA Child Psychiatry Access Project (MCPAP) for Moms; Moms Do Care initiatives; MA Substance Use Helpline Call Center and Website

Aligned with the Recommendations of the Governor’s Opioid Working Group
**Pre-Pregnancy/Prenatal Stage**

**Gap #5: Lack of individualized Plans of Safe Care for NAS/SEN infants and families**

**Details**

Lack of individualized Plans of Safe Care for NAS/SEN infants and families

**Recommendations**

1. Develop a template and standard protocols for *Plans of Safe Care*. Key questions these protocols shall address include:
   - What must be incorporated into a Plan of Safe Care?
   - When is the Plan of Safe Care implemented and by whom?
   - Who must be involved in a Plan of Safe Care and what is the follow up?
   - What data must be collected on a Plan of Safe Care?

2. Ensure all appropriate members of the care team are included to offer individualized, multi-disciplinary support and care coordination consistent with *Plans of Safe Care* across all intervention stages

**Current State-Level Initiatives**: Policy Academy to Improve Outcomes for Pregnant and Postpartum Women with Opioid Use Disorders, and Their Infants, Families and Caregivers
Pre-Pregnancy/Prenatal Stage

Gap #6: Inconsistent access to effective treatment and services

Inconsistent provision of individualized, comprehensive, and coordinated approach to treatment

**Details**

**Recommendations**

1. Leverage and increase community-based perinatal support coalitions where local organizations coordinate the care of pregnant women with SUD

2. Encourage care coordination that empowers women to build a team of support for pregnancy and beyond

3. Encourage and support reimbursement for patient navigation and care coordination (by social workers, peers, community health workers, etc.)

4. Incentivize and support providers to develop and test innovative prenatal SUD treatment approaches

**Current State-Level Initiatives:** Peer Mothers in Recovery Learning Collaborative; MassHealth 1115 Waiver; MA Opioid Abuse Prevention Collaborative (MOAPC); Substance Abuse Prevention Collaborative (SAPC)

- Aligned with the Recommendations of the Governor’s Opioid Working Group
## Pre-Pregnancy/Prenatal Stage

### Gap #6: Inconsistent access to effective treatment and services

<table>
<thead>
<tr>
<th>Details</th>
<th>Recommendations</th>
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</thead>
<tbody>
<tr>
<td>Lack of specialized support services for perinatal substance use</td>
<td>Leverage and increase resources for support including recovery coaching, group prenatal care, telemedicine, support groups, home visiting services, parenting classes, etc.</td>
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</table>

**Current State-Level Initiatives:** MassHealth 1115 Waiver; Moms Do Care Initiatives

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<tr>
<th>Details</th>
<th>Recommendations</th>
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<tbody>
<tr>
<td>Inconsistent access to MAT programs</td>
<td>1. Increase awareness of and access to MAT programs among patients and providers across all intervention stages 2. Increase certification of MAT providers to include obstetricians, certified nurse midwives, primary care physicians, nurse practitioners, and physician’s assistants</td>
</tr>
</tbody>
</table>

**Current State-Level Initiatives:** Moms Do Care Initiatives; Health Policy Commission’s Mother & Infant Focused NAS Interventions; MA Perinatal Quality Collaborative

*Aligned with the Recommendations of the Governor’s Opioid Working Group*
Gap #7: Inconsistent education for patients and families

**Details**

Lack of public education about the impact of SUD on pregnancy and infancy

**Recommendations**

Create a public awareness campaign specific to NAS/SEN to educate, reduce stigma, and encourage prevention and early care, similar to the “State Without StigMA” campaign

**Aligned with the Recommendations of the Governor’s Opioid Working Group**
**Gap #7: Inconsistent education for patients and families**

**Details**

*Inconsistent pre-pregnancy and prenatal education for patients suffering from SUD about what will happen during pregnancy, at birth, and beyond*

**Recommendations**

1. Develop/identify and distribute patient-centered and culturally-sensitive educational materials specific to perinatal SUD and NAS/SEN
2. Train and encourage OB/GYN providers and staff to educate pregnant SUD patients about treatment options and what to expect
3. Consider ways to educate patients about DCF involvement after birth
4. Consider whether/how EI might offer consultation to patients prenatally
5. Support prenatal hospital visits for patients with SUD to discuss what to expect at birth

**Current State-Level Initiatives:** Journey Project; Early Intervention/NAS Workgroup; Early Intervention/NAS Pilot Group; Early Intervention Partnerships Program; DCF Family Recovery Project; Moms Do Care Initiatives
Pre-Pregnancy/Prenatal Stage

Gap #8: Inconsistent education about and access to birth control

**Details**

- Inconsistent education about birth control (pre-pregnancy, prenatally, at birth, and postnatally)
- Inconsistent access to effective birth control

**Recommendations**

1. Train SUD providers to educate pre-pregnant and pregnant women about birth control
2. Encourage patient education about contraception at preconception and postpartum periods (as well as prenatally as part of birth plan)

1. Preserve access to effective birth control without a co-pay
2. Ensure long-acting birth control is available and fully reimbursable both immediately post-partum in the hospital and in the outpatient office setting
Birth/Neonatal Stage
Overarching Gaps: Birth/Neonatal Stage

9. Inconsistent practices for screening, assessing and reporting newborns with NAS/SEN

10. Inconsistent treatment/support in the hospital
**Gap #9: Inconsistent practices for screening, assessing and reporting newborns with NAS/SEN**

**Details**

- No standardized protocol for testing infants
- No standardized shared definition of NAS/SEN or protocol for diagnosing NAS/SEN

**Recommendations**

1. Require or encourage universal maternal screening
2. Require or encourage universal testing of infants of mothers with positive screen and/or positive testing
3. Identify and promote best practices for testing infants

Publish and provide training on best practices for how to assess symptoms and properly diagnose NAS/SEN

**Current State-Level Initiatives:** Health Policy Commission Mother and Infant-Focused NAS Interventions

*Aligned with the Recommendations of the Governor’s Opioid Working Group*
**Birth/Neonatal Stage**

*Gap #9: Inconsistent practices for screening, assessing and reporting newborns with NAS/SEN*

<table>
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<th>Details</th>
<th>Recommendations</th>
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</thead>
</table>
| Inconsistent practices with regard to reporting to DCF | 1. Consider whether legislative and/or regulatory changes are needed to clarify NAS/SEN reporting to DCF  
   2. Work with health care providers to establish protocols and guidance for communication including additional training for reporting to DCF, when reporting is appropriate and what information should be provided from the outset |

**Current State-Level Initiatives:** DCF Intake Policy, DCF Guidance on 51A Reports Regarding Substance-Exposed Newborns

Aligned with the Recommendations of the Governor’s Opioid Working Group
Gap #10: Inconsistent treatment/support in the hospital

Inconsistent approach to mother-infant bonding

**Details**

**Recommendations**

1. Identify and disseminate best practices for mother-infant bonding, including rooming-in, when possible.
2. Support in-hospital services for mothers (meals, MAT therapy, counseling, etc.) so they can stay at the hospital with the baby.
3. Identify and disseminate best practices and provide training for lactation support for NAS/SEN, when not contraindicated.

**Current State-Level Initiatives**: Health Policy Commission Mother and Infant-Focused NAS Interventions
Gap #10: Inconsistent treatment/support in the hospital

Inconsistent in-hospital treatment, education, and support services specifically tailored to SUD and NAS/SEN

**Recommendations**

1. Promote comprehensive training for neonatal providers about the recognition and treatment of NAS/SEN at birth (e.g. establish a CME program and consider integration into the credentialing requirement for nursery privileges)

2. Encourage the availability of in-hospital parenting classes, support groups, counseling, and other supports

3. Promote in-hospital referrals to SUD treatment options, EI, home visiting, and other postpartum treatment/supports

**Current State-Level Initiatives:** Health Policy Commission Mother and Infant-Focused NAS Interventions; MA Perinatal Quality Collaborative

*Aligned with the Recommendations of the Governor’s Opioid Working Group*
Postnatal Stage
11. Lack of specialized training/education for providers

12. Inconsistent intervention, treatment, and support
Gap #11: Lack of specialized training/education for providers

Many postnatal practitioners are not NAS/SEN-specific, and therefore don’t have the specialized training/education to care for NAS/SEN babies and families.

Recommendations:

1. Provide specialized training for postnatal practitioners including EI, home visiting, DCF, Early Head Start, and child care
2. Identify and disseminate best practices for postnatal practitioners working with NAS/SEN babies and families
3. Develop resource of available training and education opportunities for postnatal practitioners
4. Support targeted referrals to specially trained practitioners for NAS/SEN

Current State-Level Initiatives: Moms Do Care Initiatives; Early Intervention/NAS Workgroup; Early Intervention/NAS Pilot Group; Early Intervention Partnership Program; Bureau of Family Health and Nutrition Postpartum Depression Trainings; MA Fetal Alcohol Spectrum Disorders (FASD) Task Force; Maternal Child Home Visiting Program (DPH with Children’s Trust)
Gap #12: Inconsistent intervention, treatment, and support

**Details**

*Inconsistent referrals to supports such as EI, home visiting, treatment, etc.*

**Recommendations**

1. Develop and disseminate guidelines for postnatal referrals and support better referral mechanisms
2. Work with health care providers to strengthen the EI referral system among providers and encourage consistent practice of referring to EI

**Current State-Level Initiatives:** Health Policy Commission Mother and Infant-Focused NAS Interventions

*Aligned with the Recommendations of the Governor’s Opioid Working Group*
Gap #12: Inconsistent intervention, treatment, and support

Details

Lack of targeted treatment and support for NAS/SEN babies and families

Recommendations

1. Extend automatic EI eligibility to three years (not just one year) for all SENs
2. Support priority access for treatment to new moms with SUD
3. Support specialized, intensive, outpatient or day treatment options for new moms with SUD, with wrap-around services to support parenting while in recovery
4. Support increase in in-patient mother-child treatment beds
5. Support specialized home visiting services for parents with SUDs that focus on parenting capacity, substance use recovery, and care coordination

Current State-Level Initiatives: Early Intervention/NAS Workgroup; Early Intervention/NAS Pilot Group; Early Intervention Partnership Program; DCF Family Recovery Project; Maternal Child Home Visiting Program (DPH with Children’s Trust)
## Gap #12: Inconsistent intervention, treatment, and support

### Details

- Lack of long-term treatment, sober housing, and support

### Recommendations

1. Increase access to and availability of long-term family-focused services that reflect addiction as a chronic disease

2. Increase capacity and access to safe, stable, long-term sober housing for families, especially programs that include a case management component

3. Develop long-term pregnancy/postpartum recovery coach track with specialized training and supervision, available through treatment programs, recovery centers, and community-based organizations

4. Incentivize and support providers to develop and test innovative postnatal treatment approaches for infants and mothers

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**Current State-Level Initiatives:** Peer Mothers in Recovery Learning Collaborative; MassHealth 1115 Waiver

- Aligned with the Recommendations of the Governor’s Opioid Working Group
Gap #12: Inconsistent intervention, treatment, and support

Details

Inconsistent coordination between services for families affected by NAS/SEN and DCF

Recommendations

1. Encourage communication between DCF and treatment and community-based providers to facilitate/coordinate follow-up services for newborns and their families.

2. Increase access to community-based services, such as Recovery Coaching for DCF families.

Current State-Level Initiatives: DFC Intake Policy, DCF Guidance on 51A Reports Regarding Substance-Exposed Newborns
Gap #12: Inconsistent intervention, treatment, and support

**Details**

Lack of NAS/SEN-specific resources and training in foster care system including contracted foster care providers

**Recommendations**

1. Undertake a Continuous Quality Improvement (CQI) process to review current resources and training in the foster care system, including contracted foster care providers.

2. Develop NAS/SEN-specific resources and trainings for foster care and support specialized foster homes equipped to care for NAS/SEN infants
Summary of 12 Overarching Gaps

Data Collection and Quality Improvement

1. Lack of centralized data collection across intervention stages
2. Inconsistent sharing of information for clinical care coordination

Pre-pregnancy/Prenatal Stage

3. Inconsistent knowledge among providers
4. Inconsistent protocols and practices for screening and referral
5. Lack of individualized Plans of Safe Care for NAS/SEN infants and families
6. Inconsistent access to effective treatment and services
7. Inconsistent education for patients and families
8. Inconsistent education about and access to birth control

Birth/Neonatal Stage

9. Inconsistent practices for screening, assessing and reporting newborns with NAS/SEN
10. Inconsistent treatment/support in the hospital

Postnatal Stage

11. Lack of specialized training/education for providers
12. Inconsistent intervention, treatment, and support
Overview of Task Force
Task Force Members

- Secretary of Health and Human Services or a designee (Co-Chair)
  - Secretary Marylou Sudders

- Attorney General or a designee (Co-Chair)
  - Judge Gail Garinger, designated by Attorney General Maura Healey

- Commissioner of Children and Families or a designee
  - Kim Bishop-Stevens, designated by Commissioner Linda Spears

- Commissioner of Mental Health or a designee
  - Beverly Presson, designated by Commissioner Joan Mikula

- Commissioner of Public Health or a designee
  - Ron Benham, designated by Commissioner Monica Bharel

- Executive Director of the Health Policy Commission or a designee
  - Executive Director David Seltz
Task Force Meeting Schedule*

Task Force meeting #1 – November 7, 2016

Task Force meeting #2 – December 19, 2016

Task Force meeting #3 – January 18, 2017

Task Force meeting #4 – February 15, 2017

Report of Task Force findings due to General Court - March 2017

*Task Force Meeting Agendas can be found in the Appendix
Task Force Public Awareness and Transparency

- All Task Force meetings complied with the Open Meeting Law
- A dedicated webpage was created to support awareness of the Task Force deliberations to the community
- All agendas, materials and approved minutes for the meetings are posted to the Task Force website
NAS Task Force Advisory Council
The co-chairs shall establish an advisory council to assist in developing a unified statewide plan.

By statute, the advisory council may include hospitals, non-profit entities and community-based organizations with demonstrated expertise in the health, care and treatment of mothers with substance use disorders, newborns with neonatal abstinence syndrome or substance-exposed newborns, infants and children.

The Task Force shall seek input from other experts in the field to develop a unified statewide plan.
Role of Advisory Council

- **The Advisory Council shall:**
  - Provide direct input from the field
  - Contribute subject matter expertise
  - Review identified gaps and potential recommendations
  - Draft content as necessary for the final report

- **Subgroups will be created to review results of inventory exercise and make specific recommendations for:**
  - Filling gaps in available services
  - Improving the coordination of services
  - Collecting data and developing outcome goals
Advisory Council Recommendation Process

- **Recruitment and Application Process**
  - Task Force developed *Notice of Opportunity* and *Advisory Council Application Form*.
  - Application materials posted on CommBuys.
  - Task Force members and other stakeholders distributed the application materials to contact lists via email.
  - Request for Response (RFR) posted on 11/15/16.
  - Original deadline of 11/28/16 was extended to 12/02/16.

- **Evaluation and Recommendation Process**
  - The Evaluation Committee, composed of Judge Gail Garinger, Abigail Taylor, Michael Kelleher and Vivian Pham, reviewed all applications on 12/05/16.
  - The Evaluation Committee recommended all 41 applicants for Advisory Council membership to the Task Force.
Advisory Council Members: Full Geographic Representation and Broad Expertise

Geographic Region*

- Western (Berkshire), 8
- Pioneer Valley (Franklin, Hampshire, and Hampden), 15
- Central (Worcester), 11
- Cape and Islands (Barnstable, Dukes, Nantucket), 10
- Northeastern (Essex and Middlesex), 13
- Boston area (Norfolk and Suffolk), 22
- Southeastern (Bristol and Plymouth), 12

Area of Expertise*

- Best Practices in prevention, screening and treatment: 33
- Screening and intervention protocols: 24
- Referral and support services: 20
- Provider training and staff development: 13
- Data collection and reporting: 24
- Quality and outcome reporting: 9
- Alternative payment models/Provider: 2

Some applicants listed multiple geographic regions and areas of expertise
Advisory Council Members Represent Numerous Stakeholders Across the Care Continuum

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<td>Child welfare advocate or expert</td>
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<td>Consumer advocacy organizations</td>
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<td>Social services provider for children</td>
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*Some applicants indicated more than one perspective and intervention stage focus
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<tr>
<td>Nichole</td>
<td>Aguiar</td>
<td>March of Dimes</td>
<td>Director of Advocacy &amp; Government Affairs</td>
</tr>
<tr>
<td>Marilyn</td>
<td>Augustyn</td>
<td>Boston Medical Center</td>
<td>Division Director, Developmental and Behavioral Practices</td>
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<tr>
<td>Debra</td>
<td>Bercuvitz</td>
<td>Department of Public Health, Bureau of Family Health and Nutrition</td>
<td>Coordinator, Perinatal Substance Use Initiative</td>
</tr>
<tr>
<td>Marjorie</td>
<td>Bloom</td>
<td>Baystate Medical Center</td>
<td>Medical Social Worker, Labor and Delivery</td>
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<td>Anenery</td>
<td>Brown</td>
<td>Baystate Medical Center</td>
<td>Medical Social Worker</td>
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<td>Kathleen</td>
<td>Charette</td>
<td>Hudson Public Schools</td>
<td>Central Regional School Nurse Consultant</td>
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<tr>
<td>Jennifer</td>
<td>Childs-Roshak</td>
<td>Planned Parenthood League of Mass.</td>
<td>President &amp; CEO</td>
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<tr>
<td>Sharyl</td>
<td>Costa</td>
<td>Department of Children and Families</td>
<td>Social Worker</td>
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<td>Mara</td>
<td>Coyle</td>
<td>Women &amp; Infants Hospital</td>
<td>Neonatologist; Professor of Pediatrics</td>
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<tr>
<td>Jonathan</td>
<td>Davis</td>
<td>The Floating Hospital for Children at Tufts Medical Center</td>
<td>Vice-Chair of Pediatrics and Chief of Newborn Medicine</td>
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<td>Susan</td>
<td>Elsen</td>
<td>Massachusetts Law Reform Institute</td>
<td>Child Welfare Advocate; lawyer</td>
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<tr>
<td>Norma</td>
<td>Finkelstein</td>
<td>Institute for Health and Recovery</td>
<td>Executive Director</td>
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<tr>
<td>Maryanne</td>
<td>Frangules</td>
<td>Massachusetts Organization for Addiction Recovery</td>
<td>Executive Director</td>
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<td>Mark</td>
<td>Friedman</td>
<td>Community Catalyst</td>
<td>Volunteer; retired pediatrician</td>
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<td>Munish</td>
<td>Gupta</td>
<td>Beth Israel Deaconess Medical Center; Neonatal Quality Improvement Collaborative (NeoQIC)</td>
<td>Chair, Neonatal Quality Improvement Collaborative, Neonatologist</td>
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<td>Cynthia</td>
<td>Horgan</td>
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<td>Executive Director; Family Support Coordinator</td>
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<td>Ronald</td>
<td>Iverson</td>
<td>Boston Medical Center</td>
<td>Physician</td>
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<td>Linda</td>
<td>Jablonski</td>
<td>Baystate Franklin Medical Center</td>
<td>Assistant Nurse Manager of the Birthplace; Co-Chair of Franklin County Perinatal Support Coalition</td>
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<tr>
<td>Leslie</td>
<td>Kerzner</td>
<td>Mass. General Hospital</td>
<td>Associate Medical Director Special Care Nursery; Director of Newborn Developmental Follow-up Clinic; Director of NAS Program</td>
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<td>Georganna</td>
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<td>Claudette</td>
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<td>Jennifer</td>
<td>Lee</td>
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<td>Associate Medical Director; Neonatologist</td>
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<td>Erin</td>
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<tr>
<td>Mary</td>
<td>McGeown</td>
<td>Massachusetts Society for the Prevention of Cruelty to Children</td>
<td>Executive Director</td>
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<td>Amy</td>
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<td>Kristy</td>
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<td>Executive Director</td>
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<td>Clinical Coordinator for Pregnant and Postpartum Women</td>
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<td>Karen</td>
<td>Pressman</td>
<td>Department of Public Health, Bureau of Substance Abuse Services</td>
<td>Director, Planning and Development</td>
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<td>Julian</td>
<td>Robinson</td>
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<td>Chief, Obstetrics</td>
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<td>Christina</td>
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<td>Davida</td>
<td>Schiff</td>
<td>Boston Medical Center</td>
<td>Pediatrician</td>
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<tr>
<td>Nicole</td>
<td>Sczekan</td>
<td>Lahey Beverly Hospital; Essex County OB/GYN Association</td>
<td>Certified Nurse Midwife; Co-Director of Maternal Behavioral Health Integrative Program</td>
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<tr>
<td>Robert</td>
<td>Sege</td>
<td>Health Resources in Action</td>
<td>Chief Medical Officer</td>
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<td>Jeffrey</td>
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<td>Chief of Newborn Medicine; Professor of Pediatrics</td>
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<td>Rachana</td>
<td>Singh</td>
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<td>Medical Director, NICU; Associate Professor of Pediatrics</td>
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<td>Shannon</td>
<td>Snyder</td>
<td>Department of Children and Families</td>
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<td>Julie</td>
<td>Thompson</td>
<td>Baystate Franklin Medical Center; Pioneer Women's Health</td>
<td>OB/GYN; Chair of Obstetrics</td>
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<tr>
<td>Deborah</td>
<td>Sweet</td>
<td>Department of Children and Families</td>
<td>Foster Parent; Foster Parent Ambassador</td>
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<td>Marianne</td>
<td>Valle</td>
<td>St. Luke's Hospital</td>
<td>RN (Maternal Child Health Nurse)</td>
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<td>Elisha</td>
<td>Wachman</td>
<td>Boston Medical Center</td>
<td>Assistant Professor of Pediatrics; Neonatologist</td>
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Four Subgroups

- Staff divided the selected Advisory Council members into four subgroups based on self-selected area of expertise (as indicated on each application) as well as geographic representation and/or perspective.

- The Four Subgroups (building off the *Five-Point Intervention Framework* described on p. 22-23) are as follows:
  - Pre-pregnancy/ Prenatal
  - Birth/ Neonatal
  - Postnatal
  - Data Collection/ Quality Improvement
Key Federal Legislation Related to NAS/SEN and 2017 Policy Academy
• **Child Abuse Prevention and Treatment Act (CAPTA)** was enacted in 1974
  
  • Provides federal funding to support prevention, assessment, investigation, prosecution, and treatment activities related to child abuse and neglect
  • Provides for minimum definition of child abuse and neglect, child abuse and neglect response and overall confidentiality of these cases
  
  • In 2003, CAPTA was amended by the Keeping Children and Families Safe Act. To receive CAPTA funds, states must have policies and procedures to address the needs of “substance-exposed infants born and identified as being affected by illegal substance use or withdrawal symptoms resulting from prenatal drug exposure”:
    
    • Health care providers must notify child welfare
    • Make appropriate referrals to services to address the needs of infant, including Early Intervention
    • Develop a Plan of Safe Care for affected infants
  
  • In 2010, the CAPTA Reauthorization Act updated the definition to include Fetal Alcohol Spectrum Disorder and added state data reporting requirements.
Comprehensive Addiction and Recovery Act (CARA)

• In 2016, Congress passed the **Comprehensive Addiction and Recovery Act (CARA)** which established a comprehensive, coordinated, balanced strategy through enhanced grant programs that would expand prevention and education efforts while also promoting treatment and recovery.

• Specifically, CARA:
  
  • Clarified the population requiring a *Plan of Safe Care* – “Born with and affected by substance use, withdrawal symptoms or Fetal Alcohol Spectrum Disorder” removing the word “illegal”
  
  • Required the *Plan of Safe Care* to include the needs of both the infant and family/caregiver
  
  • Specified data to be reported by States through the National Child Abuse and Neglect Data System (NCANDS)
  
  • Specified increased monitoring and oversight for States to ensure that Plans of Safe Care are implemented and that families have access to appropriate services

• **The Task Force considered the federal requirements of both CAPTA and CARA in its deliberations and development of the State Plan.**
In November 2016, the Commonwealth applied to the 2017 Policy Academy, sponsored by the Substance Abuse and Mental Health Service Administration and led by the National Center on Substance Abuse and Child Welfare (NCSACW) to support its ongoing work with families affected by NAS/SEN.

In December 2016, the Commonwealth was selected as one of ten states to participate in the 2017 Policy Academy and receive technical assistance.

By participating in the Policy Academy, the Commonwealth team benefitted from:
• Presentations by national experts
• Dialogue with and coaching from sites that have previously received Technical Assistance
• Hearing about the strategies employed by the Mentor Sites, the barriers they faced, and how they resolved them
• Dedicated team time to develop an action plan, governance structure and goals
• Access to a package of technical assistance tools and resources that teams can use in the planning and implementation process
• Six months of follow-up technical assistance from NCSACW to meet each team’s needs
State teams will:

• Develop a state-specific action plan that describes current practices, gaps and barriers.

• Identify potential changes in practices, policies and legislation needed to improve outcomes. Build upon collaborative structure and processes.

• Use the Five-Point Framework (Pre-Pregnancy, Prenatal, Birth, Neonatal, Postnatal) for developing action plans.

• Receive up to six months of follow-up technical assistance towards implementing the state-specific action plan (through August 2017).

Policy Academy Timeline

January 10: Policy Academy webinar

February 7-8: Policy Academy

March-August: Technical assistance

Massachusetts Policy Academy Team Roster

• Co-leader: Kim Bishop-Stevens, DCF
• Co-leader: Karen Pressman, DPH
• Ron Benham, DPH
• Judge Gail Garinger, AGO
• Munish Gupta, MD, Beth Israel Deaconess Medical Center
• Michael Kelleher, EOHHS
• Katherine Record, HPC
• Kevin Wicker, OBH
1. The Task Force recommends:

   • The Commonwealth’s Policy Academy Team, utilizing the Task Force and Advisory Council as needed, work to make each recommendation a reality.
   • The Task Force Report, submitted in March 2017, to become the blueprint for the Policy Academy team, which will develop the operational details.

2. It is the Task Force’s expectation that the Policy Academy team will:

   • Use the report as the starting point for each recommendation
   • Assemble ad-hoc working groups, as needed, to operationalize each recommendation
   • Engage all necessary stakeholders
   • Create an action plan for each recommendation (i.e. 3-, 6- and 9-month goals)
   • Define clear measures to monitor progress for each recommendation
Supplemental Report Materials
The following documents shall be considered as part of this Task Force Report for the coordination of care and services for newborns with neonatal abstinence syndrome and substance-exposed newborns:

1. *Health Policy Commission Investments in NAS*

2. *NAS Task Force Inventory Survey Summary Report*

3. *Current State-Level Initiatives*
Appendix
• Establishment of Interagency Task Force
• Task Force Members
• Schedule of Task Force
• Five Components of Final Report
• Role of Advisory Council
• What Are Neonatal Abstinence Syndrome (NAS)/ Substance-Exposed Newborns (SEN)?
• Prevalence of NAS/SEN in the Commonwealth
• Benefits of Early Identification and Treatment
• Challenges of NAS/SEN Services and Support
• Inventory of NAS/SEN Services, Initiatives and Programs
• Key Components of Inventory Exercise
• Entities/Organizations/Initiatives to be Reviewed
• 2017 Policy Academy Application
• Next Steps & Action Items
Task Force Meeting #2 – December 19, 2016
10-12pm  Meeting Agenda

• 2017 Policy Academy Update
• Advisory Council Recommendation
• Inventory of Existing NAS/SEN Services, Programs, & Initiatives
• Health Policy Commission Investments in NAS (separate PPT)
• Three Pillars of Data Review
  • Picture of NAS/SEN: What does it tell us?
  • Data Mechanics: What is currently collected?
  • What could a Statewide Plan on data look like?
• Action Items & Next Steps
• Welcome of Task Force
• Welcome of Advisory Council and Composition
• Overview of Task Force
• 2017 Policy Academy
• Prevalence of NAS/SEN in the Commonwealth
• Advisory Council Role and Subgroups
• Review of Inventory Exercise
• Breakout Sessions
• Action Items & Next Steps
• Welcome & Review of Third Meeting Minutes

• Policy Academy Update

• Advisory Council Subgroup Presentations to Task Force and Q&A

• Subgroup 1: Pre-pregnancy/ Prenatal

• Subgroup 2: Birth/ Neonatal

• Subgroup 3: Postnatal

• Subgroup 4: Data Collection/ Quality Improvement

• Review Action Items and Next Steps
NAS & SEN Services, Programs and Initiatives Inventory

In order to have a full inventory and identify gaps in available services and programs, the Task Force is collecting information on the services, programs and initiatives available in the Commonwealth to serve newborns with neonatal abstinence syndrome and substance exposed newborns along with their mothers and caregivers.

1. Contact Information
Name of person completing survey:
Email:
Phone:
Relationship to organization:

2. Organization (and if applicable, name of service/program/initiative)

3. Organization/Program Description as it Relates to NAS/SEN

4. Geographic Region Served (please select all that apply).
   - Northeastern (Essex and Middlesex)
   - Boston area (Norfolk and Suffolk)
   - Southeastern (Bristol and Plymouth)
   - Cape and Islands (Barnstable, Dukes, and Nantucket)
   - Central (Worcester)
   - Pioneer Valley (Franklin, Hampshire, and Hampden)
   - Western (Berkshire)

Please indicate whether the entire region(s) selected is served, or whether you operate within a smaller geographical area within the region(s).

5. Intervention Stage (please select all that apply)
   - Pre-pregnancy
   - Prenatal
   - Birth
   - Neonatal
   - Postnatal (Throughout Childhood and Adolescence)

6. Type of Intervention (please provide a description for all that apply)
   - Prevention/Education/Outreach
     If applicable, please describe in detail. For example: educational materials and programming, media campaigns
   - Screening/Testing/Assessment
     If applicable, please specify the type of screening/testing/assessment provided and indicate the instrument/tool that is used. For example: prenatal self-report, interviews, or clinical observations screenings; name of scoring systems; type of assessment to determine need and match to services
   - Treatment
     If applicable, please describe the type of treatment and care provided, length of treatment, how patient costs are covered, and other relevant information. For example: pharmacological, non-pharmacological, inpatient, outpatient, services available in languages other than English, ASAM (American Society of Addiction Medicine) level of care, etc.
   - Social Services
     If applicable, please describe what social services are provided and if applicable, what the eligibility criteria is. For example: early intervention, home visiting, housing, childcare, income assistance, etc.
   - Training
     If applicable, please describe who receives/provides the training, type of training, length of training, and other relevant information
   - Data Collection
     If applicable, please describe in more detail collection methodology and data type. For example: The federal Treatment Episode Data Set (TEDS) track trends on the percentage of women who are pregnant at treatment admission, drug of choice, number of substances used, prior treatment admissions, primary source of referral, etc.
   - Quality Improvement
     If applicable, please describe what measures are in place for monitoring and improving quality of care. For example: The Health Policy Commission’s “delivery to discharge” QI Initiative addresses scoring reliability, pharmacologic and non-pharmacologic intervention protocols, multidisciplinary rounds, NICU transition protocols, staff training, and follow-up care coordination protocols.
   - Other
     Please describe other relevant interventions that were not listed above
7. **Target Population** (please select all that apply)
   - Women of childbearing age
   - Pregnant women (with SUD/OUD)
   - Mothers
   - At-risk parents
   - Other caretakers
   - Newborns/infants
   - Older children
   - Providers

8. **Capacity**
   Please describe how many individuals or patients this initiative serves annually (i.e. the # of patients treated, screening, counseling or other interventions provided). Additionally, please provide a number for those who are not served due to lack of resources and the program utilization rate against the supply of services (we understand this % to be an estimate).

9. **Funding Source and Duration** (please select all that apply)
   - State appropriation
   - Grant (federal or state)
   - Private
   - Payer reimbursement
   - Other

   Please also provide information about the amount of annual funding and duration of funding. For example: $250,000 state grant for 1 year, with possibility of renewal in 2017.

10. **Gaps in Services and Programs**
    If you are aware of particular gaps in needed services and programs for NAS/SEN-affected families, please identify those gaps here. Please be as specific as possible (i.e. identify the specific types of services and programs that are needed, who those programs/services should be serving, and whether the gap(s) is/are specific to particular regions or state-wide).