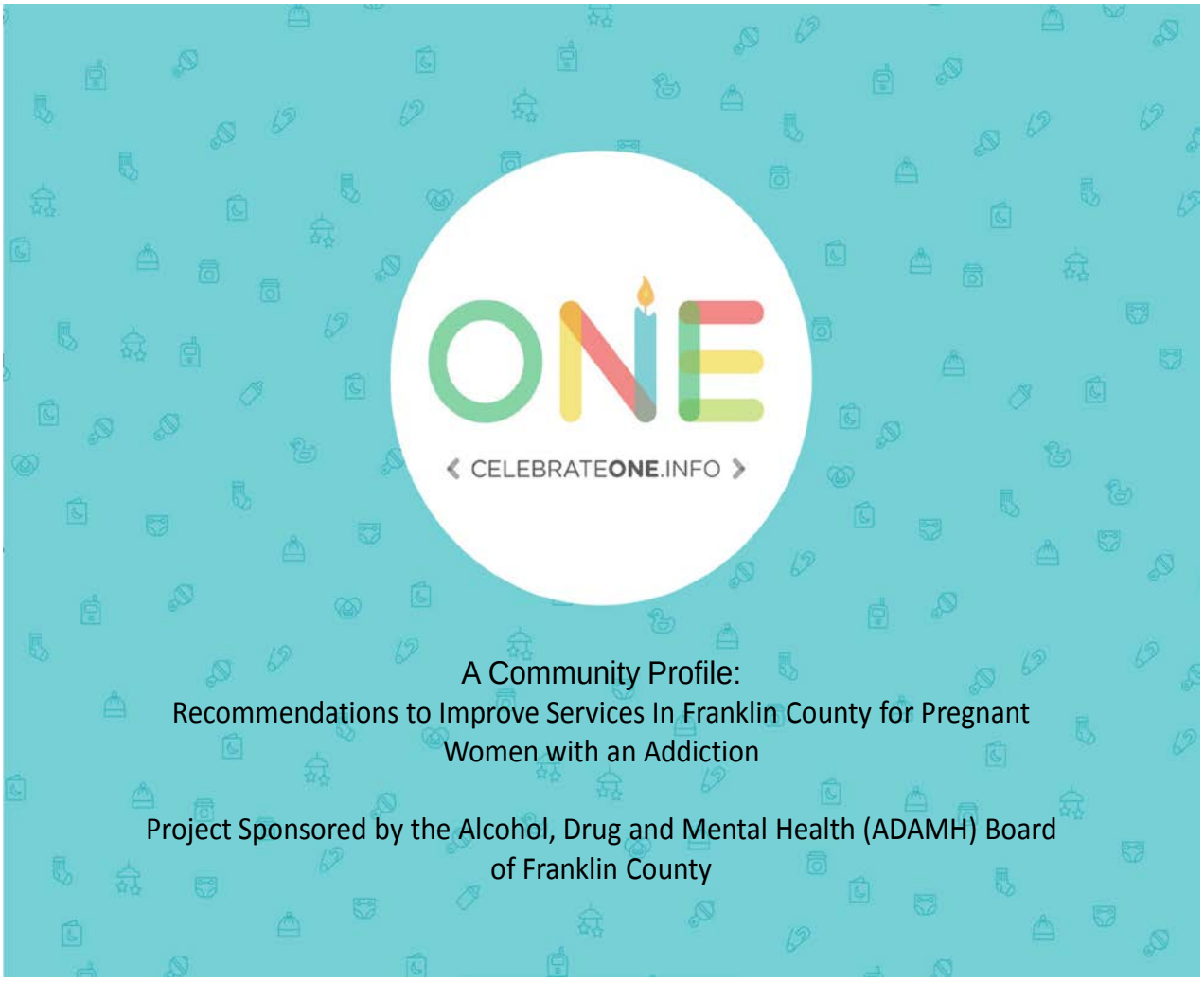

A Community Profile:
Recommendations to Improve Services In Franklin County for Pregnant Women with an Addiction

Project Sponsored by the Alcohol, Drug and Mental Health (ADAMH) Board of Franklin County

Date Submitted: December 08, 2017

CELEBRATEONE

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EXECUTIVE SUMMARY

CelebrateOne, in partnership with the Alcohol, Drug Addiction and Mental Health Board (ADAMH) of Franklin County and its partners, recently completed a high-level community profile of the barriers to positive health and birth outcomes facing pregnant women with the disease of addiction. The short-term project was designed to build on community work to mitigate infant mortality as well as the recently developed Franklin County Opiate Action Plan.

The community profile was defined in three distinct phases:

Phase 1: Defining the Need

Profiling the target population need will be completed by the ADAMH program and a data team of associated partners and public agencies. Utilizing data from key partners in the addiction and medical community, the profile will include the potential demand for care for Franklin County pregnant women with addiction.

Phase 2: Identifying Existing Community Capacity and Barriers

Through community discussions, key informant interviews, surveys, etc., CelebrateOne (or its designee) will assess the current availability of services in Franklin County for pregnancy, opiate-addicted women. Key barriers that are interfering with women receiving the addiction services and prenatal and post-partum services during their pregnancies will be identified.

Phase 3: Finding Solutions

CelebrateOne (or its designee) will develop recommendations for how Franklin County can increase its capacity to serve pregnant women with opiate addiction during and after their pregnancies. Recommendations may include possible models to address the comprehensive needs of high-risk women.

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) says 4.7 percent of women of child-bearing age are addicted to opiates. This extrapolates to approximately **900** pregnant women with addiction in Franklin County may be misusing opiates at any one point in time. There is no solid local data on the size of the target population.

The project's charge fits within Franklin County's broader mission of preventing adverse birth outcomes and infant mortality (CelebrateOne) and its four overarching goals to aggressively confront opiate misuse and addiction (Franklin County Opiate Action Plan). The challenges associated with the current opiate epidemic have been well-documented by experts and are currently being utilized to inform broader initiatives. This project's charge was to develop attainable recommendations to assist addicted, pregnant women with appropriate prenatal and immediate post-partum care, treatment, and support. Given its limited scope, the project did not fully explore prenatal drug misuse or abuse for all types of drugs. Alcohol and tobacco misuse were not part of the project's scope.

To complete its charge, the project:

- Convened key data experts from local programs/systems to discuss and define the scope of the issue;
- Engaged key stakeholders and hosted client focus groups to define current conditions, major barriers, resource needs, and ideas to better serve the target population;
- Utilized a collaborative, cross-system planning team to identify potential recommendations; and
- Present findings to the staff of the ADAMH Board of Franklin County.

The project's process yielded numerous insights and findings. For some topics, the input shed light on complex topics. For others, it provided clarification of a service gap or validation on models that are working. Overall, Franklin County is home to service models that work for the target population. The

overarching issue is immediate access and availability to critical care and treatment. Real-time access matters because clients reported that pregnancy is a pivotal moment for many women with addiction that leads to a "readiness for treatment" which can be lost while waiting for an appointment. Building real-time access requires a sustainable funding model that supports increased provider capacity. To encourage pregnant women to access needed services requires a more effective community "intake" process and fostering an environment with less stigma and fear of reprisal. This approach should be based on the belief that addiction is a chronic disease that affecting women before, during and after their pregnancies.

Key project findings:

1. There appears to be no systemic lead or approach for this target population. No systemic entity manages a system of care for this chronic disease population toward positive general health and addiction treatment outcomes.
2. The lack of a systemic lead creates a strategic void that magnifies the lack of systemic ownership for data, funding, current-state issues, and future-state solutions.
3. A complete system of care addresses health care needs, addiction/psychological treatment, and social supports. All three components require capacity building for real-time access, standardized referral protocols, and client education.
4. More collaborative discussions are needed regarding how best to increase and/or leverage hospital systems (emergency departments and labor and delivery units) and public health systems to provide target population services.

The prioritized project recommendations are:

A. For the target population of women with the disease of addiction who are pregnant, designate a lead entity to address their needs. Define the lead entity's roles and responsibilities. Consider establishing a position similar to the Franklin County Opiate Action Plan's Senior Policy Analyst to be responsible for convening strategic partners across systems. At a minimum, leverage the infrastructure that has been developed through the Treatment Action Group.

B. ADAMH or the Treatment Action Group of the Franklin County Opiate Task Force should send out a survey to existing providers to determine the current capacity of the treatment system. There is no current set of accurate data that demonstrates the comprehensive service capacity in our community. The Planning Team for this project felt that having an entity with expertise in addiction send the survey would yield better results. Sample questions were drafted by the Planning Team and provided in Addendum A.

C. Begin a process to simplify the target population's entry into prenatal care and addiction treatment. Consider expanding StepONE services, or a similar entity, to provide individuals and referring partners with real-time, access information and referrals to a provider with capacity to meet the individual needs of the client. Recognize that StepONE may require resources to enhance technology and to routinely monitor provider capacity.

D. Identify sustainable, system-of-care models for the target population inclusive of health care, addiction/psychological treatment and supports, social supports, and the necessary care coordination mechanisms required to help the individual navigate the system and achieve positive outcomes. In the short-term, consider investing in workforce expansions to the current programs to help address the social supports that may increase the success rate for treatment.

By illuminating some attainable short-range and longer-term proposals, the profile was designed to help establish priorities for the target population within the overall missions of county and community health care, addiction treatment, and support service organizations that serve pregnant women and families with young children. In forwarding these recommendations, the partners involved in their formulation recognize it will require their ongoing individual and collective commitment, as well as the efforts of the community, to make certain that recommended actions are executed for results.

As with any report, planners caution not to take its information, findings, or recommendations out of context. Given the high-level nature of the process that generated this report, additional, more complete data most likely will be needed to fully inform detailed planning and action steps.

The CelebrateOne project recommendations will now be taken under the advisement of the staff of the ADAMH Board of Franklin County and the Franklin County Opiate Task Force to best determine the path forward.

For more information, please visit the following websites:

- Celebrate One: http://celebrateone.info
- ADAMH of Franklin County: https://adamhfranklin.org
- Franklin County Opiate Action Plan: https://octf.franklincountyohio.gov/CRNR-OCTF-website/media/Documents/2017%20Opiate%20Action%20Plan/2017-Opiate-Action-Plan-Web.pdf

The Charge & Background

This profile provides the recommendations to improve positive health and birth outcomes for pregnant women with the disease of addiction and their babies. CelebrateOne, in partnership the Alcohol, Drug Addiction and Mental Health Board (ADAMH) of Franklin County, recently completed a high-level profile that outlines the barriers to positive health and birth outcomes facing pregnant women with the disease of addiction. The short-term project was designed to build on community work to mitigate infant mortality as well as the recently developed Franklin County Opiate Action Plan.

The community profile was defined in three distinct phases:

Phase 1: Defining the Need

Profiling the target population need will be completed by the ADAMH program and a data team of associated partners and public agencies. Utilizing data from key partners in the addiction and medical community, the profile will include the potential demand for care for Franklin County pregnant women with addiction.

Phase 2: Identifying Existing Community Capacity and Barriers

Through community discussions, key informant interviews, surveys, etc., CelebrateOne (or its designee) will assess the current availability of services in Franklin County for pregnancy, opiate-addicted women. Key barriers that are interfering with women receiving the addiction services and prenatal and post-partum services during their pregnancies will be identified.

Phase 3: Finding Solutions

CelebrateOne (or its designee) will develop recommendations for how Franklin County can increase its capacity to serve pregnant women with opiate addiction during and after their pregnancies. Recommendations may include possible models to address the comprehensive needs of high-risk women.

The project's charge fits within Franklin County's broader mission of preventing adverse birth outcomes and infant mortality (CelebrateOne) and its four overarching goals to aggressively confront opiate misuse and addiction (Franklin County Opiate Action Plan). The challenges associated with the current opiate epidemic have been well-documented by experts and are currently being utilized to inform broader initiatives. This project's charge was to develop attainable recommendations to assist addicted, pregnant women with appropriate prenatal and immediate post-partum care, treatment, and support. Given its limited scope, the project did not fully explore prenatal drug misuse or abuse for all types of drugs. Alcohol and tobacco misuse were not part of the project's scope.

The project received consultative support from Jacqueline Romer-Sensky of The JRS Group, Ltd.

The Project Process

The components of the community profile were conducted and completed in the fall of 2017. To complete its charge, the project:

- Convened key data experts from local programs/systems to define the scope of the issue. Represented entities in the data discussion included: ADAMH of Franklin County, CelebrateOne, Central Ohio Hospital Council, Columbus Public Health, Franklin County Children Services, Franklin County Public Health, Nationwide Children's Hospital.

- Engaged key stakeholders (13 individual, 30-minute interviews) and hosted client focus groups (four groups with 16 participants) to define current conditions, major barriers to positive outcomes, resource needs, and ideas to better serve the target population.

  Interviewees represented perspectives from public health, obstetrics/family health physicians, major hospital systems, addiction treatment providers, social support programs for pregnant women and women with young children, referral services, opiate misuse experts, and ADAMH. One-hour focus groups were hosted by Columbus Public Health, CompDrug, Moms2B, and Stable Cradle at Maryhaven. Focus group participants received refreshments and a nominal gift card for sharing their experiences and insights for improvement.

- Utilized a collaborative, cross-system planning team to identify potential recommendations. Team members are listed below.

Planning Team Members			
Nancy Bechtel *Columbus Public Health* Erika Clark Jones *CelebrateOne* Krisanna Deppen *Ohio Health* Wanda Dillard *Stable Cradle, OSU / Maryhaven*	Tonya Fulwider *Mental Health America of Franklin County* Debbie Helldoerfer *Columbus Public Health* Katie Higgins *Nationwide Children's Hospital / Ohio Better Birth Outcomes Collaborative* Jeff Klingler Central Ohio Hospital Council	Kelly Knight *Franklin County Children Services* Alicia Leatherman *CelebrateOne* Alex Meyer *CompDrug* Amy O'Grady *Columbus City Council / City of Columbus*	Mona Prasad *Mount Carmel Health System* *STEPP Clinic, OSU* Christine Sander *Nationwide Children's Hospital / Ohio Better Birth Outcomes Collaborative* Twinkle Schottke Moms2B Vince Sabino *ADAMH Franklin County*

- Presented findings to the staff of the ADAMH Board of Franklin County.

The combined experiences, perspectives and commitment of planning team participants, stakeholders, and clients helped ensure that pragmatic, results-oriented recommendations were generated.

The Phase 1: Defining the Need

Understanding the current-state of the system of care for pregnant women with an addiction and the operating environment was critical to making solid judgments regarding what actions to prioritize. For most partners involved in developing recommendations, their day-to-day working knowledge of the issue meant not all baseline or foundational data needed to be reviewed to begin dialogue. A brief, far from inclusive, summary of data reviewed through the planning process follows. As with any process, the context reflects a point-in-time scan.

- **The Target Population**

Pregnant Women with Addiction

SAMHSA says 4.7 percent of women of child-bearing age are addicted to opiates. This extrapolates to approximately 900 pregnant women with addiction in Franklin County who may be misusing opiates at any one point in time. There is no solid local data on the size of the target population. Local data discussion was able to illuminate that:

- Through early November 2017, ADAMH of Franklin County providers report treating 100 pregnant or postpartum women.
- Through October 2017, 7% of StepONE pregnant callers self reported "drug use" (179 women)
- In 2016, City of Columbus medics documented administering Narcan to 7 pregnant women and 2 children under age one. Through August 2017, Narcan has been administered to 5 pregnant women and no children under age one.
- In 2016, Franklin County Children Services reported 907 (76%) of screened-in cases of child abuse or neglect mention opiate use. The majority of these cases screen in at birth when mom or newborn infant tested positive.

Babies- Neonatal Abstinence Syndrome (NAS)

A NAS diagnosis means an infant tests positive for certain drugs and is treated by the health care system. NAS infants are more likely than all other hospital births to have low birthweight or respiratory complications. (SAMHSA, Journal of the American Medical Association)

- In 2016, 627 Franklin County resident babies born in Ohio hospitals had a diagnosis code for exposure to opioids and hallucinogens. Not all babies were screened for noxious substances, so the number likely reflects an underestimate. (Ohio Hospital Association)
- From June 2016 through July 2017, Columbus Public Health reports 166 NAS infants were treated in, and were residents of, Franklin County.
- From 2015 through 2017, only one percent of Franklin County babies diagnosed with (NAS), with a complete data history, were born less than 32 weeks gestational age. (Billable Medical Codes ICD9: 779.5; ICD10: P96.1)
- 55-94 percent of babies born to women using opiates experience signs of withdrawal, usually within 72 hours of birth, although some experience symptoms later. Many infants who may be NAS are discharged prior to the onset of withdrawal symptoms and may not be captured in current data. (American Academy of Pediatrics)
- NAS is treatable, and has not been associated with long-term adverse consequences. (International Drug Policy Consortium, 2013)
- However, data on long-term development outcomes related to NAS are limited. (American Academy of Pediatrics)

From June 2016 through July 2017, Columbus Public Health reports **166** Neonatal Abstinence Syndrome (NAS) infants were treated in, and were residents of, Franklin County.

- **Understanding The Medical Issues**

Pregnant Women

Providing appropriate care and support to a pregnant woman with the disease of addiction requires service involving multiple medical, addiction and social support specialties. For example, those involved with this project developed these recommendations by fully recognizing that addiction to drugs or alcohol is a disease of the brain. Opiate addiction is a chronic disease. Even with treatment, the brain may require months or even years to reverse the changes caused by the drugs.

Opiates work by overwhelming the endorphin receptors to produce euphoria, analgesic relief, and respiratory depression. Common opiates include heroin, oxycodone *(Percocet, Percodan, OxyContin),* hydrocodone *(Vicodin, Lortab, Norco),* fentanyl, hydromorphine *(Dilaudid),* buprenorphine *(Subutex, Suboxone),* doceine, methadone, morphine, and tramadol *(Ultram).*

Opioid use during pregnancy can result in complications affecting the unborn fetus and include fetal growth restriction, placental abruption, and even fetal death. Opiate withdrawal during pregnancy increases the risk of fetal distress, miscarriage, and premature labor. According to the American College of Obstetricians and Gynecologists, chronic untreated opioid addiction during pregnancy also increases the risk of pregnancy complications, namely by way of engagement in high-risk health behaviors that may expose women to infections, violence, or legal issues. Additionally, women addicted to opioids tend to avoid medical settings during pregnancy, limiting the ability to diagnose and care for complications traditionally identified during prenatal care.

For pregnant women with addiction misusing opiates, SAMHSA recommends the use of Medication-Assisted Treatment (MAT), in combination with counseling and behavioral therapies, and access to a range of supportive services, such as housing and employment services, to assist the mother in achieving a more stable life. Beginning MAT late in a pregnancy may not be medically feasible.

- **Services & Support**

Pregnant women with addiction seek prenatal care throughout the medical system. Access challenges arise with the need to combine prenatal care with addiction treatment. There are currently a limited number of Board-certified, addiction-medicine specialists and MAT-certified physicians in Central Ohio who also provide prenatal care.

Comprehensive prenatal care with MAT is available at the STEPP (Substance Abuse, Treatment, Education and Prevention Program) Clinic affiliated with the Ohio State University hospital system, within the OhioHealth system, and at individual medical practices treating obstetric patients. For many obstetric physicians, referrals must be made to other physicians certified to prescribe MAT. The number of patients with opiate addiction that can be treated within known prenatal care practices is limited.

A comprehensive view of Franklin County addiction treatment capacity for pregnant women with addiction is currently unavailable. Currently, documented capacity includes:

- Outpatient comprehensive treatment with MAT for pregnant women offered at Amethyst, CompDrug, Maryhaven, Netcare Access, OhioGuidestone, STEPP Clinic at OSU;
- Maryhaven offers residential treatment program for *pregnant* women, women, and women with children; and
- Amethyst offers supportive housing for women and children.

Depending upon economic indicators or neighborhood-of-residence, pregnant women with the disease of addiction may also be receiving social supports from a home-visiting program and/or Moms2B.

Connection with CelebrateOne Mission and Affiliated Services

CelebrateOne and its partners aggressively pursue a mission of preventing adverse birth outcomes and infant mortality. Many CelebrateOne partners provide services and supports to pregnant women and women of childbearing age.

Partners who committed to reducing the infant mortality rate are often asked about the opiate epidemic and the impact on infant mortality. While opioid use during pregnancy is a very serious concern *(See Understanding the Medical Issues above)* and is impacting the social conditions in Franklin County neighborhoods, it has not been shown to contribute directly to infant deaths or higher rates of extreme prematurity. Instead, opiate use has been associated with babies that die before birth (fetal death) which are not captured in infant mortality rates.

Prenatal opioid addiction has been associated with an increased risk of preterm birth – one of the leading causes of infant mortality in Frankly County. Fortunately, though, extreme prematurity as a result of prenatal opioid use is not common. In fact, billable medical codes from 2015 through 2017 indicate only one percent of Franklin County babies diagnosed with NAS were born less than 32 weeks gestational age. Notably, other environmental or parental behavioral factors are more common among those addicted to opioids, posing as secondary risk factors for infant death.

In Franklin County, African American babies are 3.0 times more likely to die before their first birthday . For this reason, CelebrateOne is very focused on decreasing the racial disparities evident in Franklin County prematurity and infant mortality rates. The corresponding Black-White racial disparity is not reflected locally among mothers whose babies are diagnosed with NAS. During the last two-and-a-half years, 88 percent of mothers whose babies are diagnosed with NAS report their race as White.

Additional information is needed to understand how babies are exposed to substances, effective treatment, and the subsequent impact on their mental and physical development. While this collection of evidence occurs, CelebrateOne recognizes a need to intentionally focus on the root causes of Black infant mortality in Franklin County, a rate that is disproportionately higher than the White rate.

Overall, a woman who is healthy before pregnancy has the best chance of delivering a healthy baby. CelebrateOne and its sponsored services and supports remain focused on partnering to lower rates of drug abuse and misuse among pregnant women and women of child-bearing age to ensure better health outcomes.

Phase 2: Identifying Existing Community Capacity and Barriers

Beyond a review of system data, the Planning Team sought insights from key stakeholders and from clients. Thirteen key stakeholders participated in 30-minute interviews. Interviewees represented perspectives from public health, obstetrics/family health physicians, major hospital systems, addiction treatment providers, social support programs for pregnant women and families with young children, referral services, opiate misuse experts, and ADAMH. Key insights from stakeholder interviews follow.

Key Stakeholder Interviewee Insights
Current-State Strengths • Local recognition of the issue and the passion to pursue solutions for the target population. • Quality programs are available for the target population, i.e. STEPP Clinic & Stable Cradle, CompDrug, OhioHealth, StepONE referral system, Moms2B, POEM Program, home-visiting. • Lessons to build upon from MOMS project, i.e. co-location, coordinated care works. • Mentors / Community Health Workers / Care Coordinators / Home Visitors are key positions within the system that provide critical linkages to the target population. • The addiction treatment provider community is open to prioritizing target population access. • Pregnancy can be an opportunity to treat this chronic disease.

Current-State Challenges

- Access. Limited capacity in current model programs exists for women who often need routine prenatal medical care *and* MAT as well as a lack of providers that accept Medicaid or insurance.
  - Prevalence of one-time funds for programs curtails investment in ongoing capacity.
  - Prenatal-appointment-first model creates challenges for providing addiction treatment at a time when women are ready to seek addiction treatment.
  - Widespread misperception that only two central Ohio physicians who provide prenatal care are certified to prescribe MAT to pregnant women.
  - Appropriateness of referring women to abstinence-only treatment per SAMHSA guidance.
- Clients and providers must navigate a maze of programs, eligibility standards, wait lists and referral protocols that complicates access. No system hub or technological navigation tool exists.
- Treating pregnant women who do not seek care until the third-trimester of pregnancy or receive no prenatal care. Curtails treatment options and compromises birth outcomes.
- Lack of a systemic approach or coordinated infrastructure that recognizes addiction as a chronic disease and treats it accordingly
- Peripheral engagement of major hospital systems in a major public health epidemic. General health care marketplace turmoil. Medicaid reimbursement levels and some patient referral protocols complicate engagement.
- Lack of co-located programs or enough models in each hospital system with co-located supports.
- Lack of residential programs or supported housing.
- Limited postpartum and first-year-of-life follow up / support available.
- Inability to make needed social service connections.
- Client fear of reprisal for seeking care and concerns regarding stigma.
- Client treatment choices which often complicate access and service.
- Lack of universal, prenatal toxicology screening to inform treatment and systemic investment.
- Children Service worker knowledge of disease of addiction and how this impacts women/families.
- Mission-drift concern regarding Celebrate One which focuses on infant mortality and needs to maintain its focus. Opiates probably not a primary driver of adverse infant mortality outcomes.

Sixteen women, who were pregnant or who had recently become mothers, participated in facilitated, focus group sessions hosted by Columbus Public Health, CompDrug, Moms2B, and Stable Cradle at Maryhaven. Key themes from client input follows.

Client Input: Key Themes

1. Current mechanisms for accessing prenatal care and addiction treatment are largely working. Clients shared they know how to gain access/referral to prenatal care; they generally called a known physician or worked through Medicaid system. Some contacted StepONE.
   - Clients shared they know how to gain access/referral to prenatal care; generally called known physician or worked through Medicaid system options or called StepONE.
   - Clients shared that access/referral to addiction treatment and MAT happens via phone calls, physician referral, or court referral. From their perspective, the MAT referral is a relatively smooth process. All reported their physicians knew how to gain MAT.
   - Some clients struggled with transportation; one-stop locations would mitigate issues.
   - Some clients voiced concern about losing Medicaid coverage if working.

2. Stigma and fear of the child welfare system prevents many clients from seeking prenatal care or addiction treatment earlier in their pregnancy. Professionals in fields of care may need additional training. Clients said…
   - Stigma is amplified when a woman with addiction becomes pregnant which leads to a delay in seeking treatment/care.
   - Many health care providers and children services personnel do not recognize they have a "disease" and are also pregnant. They report feeling disrespected, judged, and stigmatized.
   - Children Services prolongs involvement beyond "the issue." However, many clients voiced support for strong measures when a woman is not cooperating with Children Services

3. Pregnancy is a pivotal moment for many women with addiction. This time of reflection and self-awareness regarding their addiction often leads to "readiness for treatment" requiring real-time access.
   - Women who seek treatment need real-time access to addiction treatment or the opportunity moment is lost. Wait lists or appointments several days out don't work. For many, seeking treatment requires housing support for themselves and their other children.
   - Clients stressed this is not just about addiction to opiates, other drugs are being misused/abused and these women also need help for their addictions.

4. Residential treatment and/or Housing Support is lacking.
   - Clients report true difficulty in securing safe housing options when in treatment and striving to remain "clean." More research is needed to ascertain if the need is for a residential level of treatment or if the issue is about safe housing in a new environment that breaks negative lifestyle cycles or both.

5. Target population clients need more information for how to obtain a continuum of assistance, including social supports, when they are ready to pursue treatment. When individuals recognize they want treatment, they:
   - May be fairly clear on how and where to obtain prenatal care and addiction treatment, but they have little to no idea how to obtain supportive services for themselves or their children.
   - Need more up-front clarity on the ramifications of selecting methadone, suboxone or other MAT.
   - Services need to take into consideration that the women is part of a family, likely with older children, and accommodations need to be made for housing options, transportations, child care, etc.

Bear in mind that focus group participants were women in care and treatment. The insights of focus group participants may be different from those women who are not receiving prenatal care or addiction treatment. It's also important to note that some of the positive attributes of the current system, such as ease in finding prenatal care, may change if more women sought care or more women sought care earlier.

Overall Key Stakeholder Findings
1. There appears to be no systemic lead or approach for this target population. No systemic entity manages a system of care for this chronic disease population toward positive general health and addiction treatment outcomes. 2. The lack of a systemic lead creates a strategic void that shows up as a lack of systemic ownership for data, funding, current-state issues, and future-state solutions. 3. A system of care addresses health care needs, addiction/psychological treatment, and social supports. All three components require capacity building for real-time access, standardized referral protocols, and client education. 4. More insight is needed regarding how best to increase and/or leverage hospital systems and public health systems to provide target population services.

The inputs and findings from the stakeholder process shed light on complex topics. In some cases, the words of stakeholders and clients provided clarification of a suspected service gap or validation that current models are working. Overall, Planning Team members expressed appreciation for the willingness and time that participants generously gave to the process.

Finally, thoughts from the stakeholder input process must be kept in context. The input was gleaned from an informed, but relatively small, number of people. Participants recognized that solutions to the issues discussed were complicated and potential solutions could be difficult to implement. One person was responsible for conducting the interviews and focus groups and for analyzing and synthesizing the results which can result in unintentional bias.

Phase 3: Finding Solutions

Planning Team members were charged with developing recommendations for improvement that would help establish priorities for the target population within the overall missions of county and community health care, addiction treatment, and support service organizations that serve pregnant women and mothers with young children.

To meet the project charge, Plan Team members reviewed available data and stakeholder and client input- including recommendation proposals. Plan Team members then undertook their own decision process. Planners shared their impressions for how best to serve the target population given their program/system knowledge, subject expertise, and overall experience. Planners then generated a list of recommendation proposals for final group discussion and prioritization.

As would be expected, some recommendation proposals lend themselves to short-range implementation while others may require longer-term, system effort. For the purposes of this project, planners emphasized short-range recommendations. Planning Team members requested that its full proposal brainstorm list and the list of ideas generated during the Stakeholder process be included in the project report, so that many of these solid ideas could be pursued in a more systemic and/or long-term fashion. The list of all recommendation ideas is included as Addendum A.

As with any planning process, the dialogue behind each recommendation decision was robust. Final recommendation language rarely, if ever, captures the depth and breadth of the thinking behind its selection. Nonetheless, selected recommendations were chosen with an eye toward producing a positive, and potentially cascading, impact upon the system, the local community, and the population being served.

The prioritized project recommendations are:

A. For the target population of women with the disease of addiction who are pregnant, designate a lead entity to address their needs. Define the lead entity's roles and responsibilities. Consider establishing a position similar to the Franklin County Opiate Action Plan's Senior Policy Analyst to be responsible for convening strategic partners across systems. At a minimum, leverage the infrastructure that has been developed through the Treatment Action Group.

B. ADAMH or the Treatment Action Group of the Franklin County Opiate Task Force should send out a survey to existing providers to determine the current capacity of the treatment system. There in no current set of accurate data that demonstrates the comprehensive service capacity in our community. The Planning Team for this project felt that having an entity with expertise in addiction send the survey would yield better results. Sample questions were drafted by the Planning Team and provided in Addendum B.

C. Begin a process to simplify the target population's entry into prenatal care and addiction treatment. Consider expanding on StepONE services, or a similar entity, to provide individuals and referring partners with real-time access information and referrals to a provider with capacity to meet the individual needs of the client. Recognize that StepONE may require resources to enhance technology and to routinely monitor provider capacity. Sample process maps have been developed to reflect the current system of intake. See Addendum C.

D. Identify sustainable, system-of-care models for the target population inclusive of health care, addiction/psychological treatment and supports, social supports, and the necessary care coordination mechanisms required to help the individual navigate the system and achieve positive outcomes. In the short-term, consider investing in workforce expansions to the current programs to help address the social supports that may increase the success rate for treatment.

In forwarding these recommendations, the partners involved in their formulation recognize it will require their ongoing individual and collective commitment, as well as the efforts of the community, to make certain that recommended actions are executed for results.

As with any report, planners caution not to take its information, findings, or recommendations out of context. Given the high-level nature of the process that generated this report, additional, more complete data most likely will be needed to fully inform detailed planning and action steps.

Next Steps

The CelebrateOne project recommendations will now be taken under the advisement of the staff of the ADAMH Board of Franklin County and the Franklin County Opiate Action Plan Central Steering Committee to best determine the path forward.

For more information, please visit the following websites:

- Celebrate One: http://celebrateone.info
- ADAMH of Franklin County: https://adamhfranklin.org
- Franklin County Opiate Action Plan: https://octf.franklincountyohio.gov/CRNR-OCTF-website/media/Documents/2017%20Opiate%20Action%20Plan/2017-Opiate-Action-Plan-Web.pdf

Addendum A: Full List of Generated Recommendation Proposals

The table below lists all recommendation proposals generated through brainstorming discussion during the Planning Team meeting, stakeholder individual interviews, and client focus groups. For ease of discussion, the proposals were categorized by major issue groups. The proposals are not listed in any priority order. The ID # is utilized to facilitate reference during discussion. The Plan Team, Stakeholder, and Client columns show an "X" to demonstrate who articulated an idea or if it was articulated in more than one forum. The "X!" distinction made in the Client column for ideas #8 & 9 reflect the overwhelming emphasis and frequency that these ideas were articulated by clients (virtually every client focus group member articulated this as the primary need.)

ID	Brainstorm List of Recommendation Proposals	Plan Team	Stake-holder	Client
Access / Capacity				
1	Expand model capacity by hiring one FTE support each for Drs. Prasad & Deppen • Potentially an Advanced Practice Nurse or Physician Assistant	X	X	X
2	Identify programs that could expand the system's programs current reach.	X		
3	Fund a specialized clinic for each major hospital system in at least one target neighborhood.		X	
4	Launch a Board-certified, addiction treatment physician fellowship program to gain prenatal health care capacity.	X	X	
5	Provide financial incentives for OB/family physician practices to become MAT sites.		X	
6	Hire additional mentors/community health workers/care coordinators, per program model.	X	X	X
7	Increase access to mentors.	X		
8	Leverage community health care workers to connect pregnant women in treatment, United Way Care Coordination Network.	X		
9	Decrease wait times by utilizing nurse practitioners, physician assistants within the system.	X		
10	Expand STEPP model to include post-partum care relationship through baby's first year.		X	
11	Create a post-delivery stabilization unit for women that incorporates their babies. A "rooming" unit.		X	X
12	Test home-visiting MAT program during a newborn's four-weeks to accommodate mother's needs and baby's immune system while linking to ongoing supports.		X	
13	Fund a dedicated residential addiction treatment program for pregnant women.		X	X!
14	Expand safe, recovery housing options for pregnant women and women with children.		X	X!
15	Expand StepONE to better handle referrals for target population with sustainable funding, including capacity to create a technology navigation tool.	X	X	X
16	Determine how FQHC can better assist with this population.			
17	Build capacity for treatment of marijuana and other drug use.	X		
Program Enhancements				
18	Require all central Ohio birthing hospital systems to conduct universal toxicology screenings.		X	
19	Ensure that women with addiction are also screened for mental illness and receive appropriate treatment.			X
20	Establish a protocol to ensure all newborn children of women with addiction are screened and provided supports to ensure optimal child development.		X	
21	Develop a technology platform for providers (health, Tx, supports) showing who is involved with a client and who has a care coordinator to avoid duplication, gaps, and		X	

	client confusion.			
22	Provide a few hours of child care respite each week for a woman in treatment to allow her to focus on her recovery.	X		X
General / Social Service Supports				
23	Ensure target audiences understand the role of Moms2B program and expand program to meet larger need.		X	X
24	Bring clients who are ordered into the treatment system by the Court or child welfare more fully into the system of community supports, i.e. Moms2B, wraparound supports	X		
25	Initiate a PASSPORT program to support pregnant women and moms with obtaining needed supports (reward system to "purchase" necessities).			
26	Increase availability of transportation for prenatal and treatment appointments.			X
27	Place weatherized pantry boxes in appropriate neighborhoods to help homeless women obtain food without judgment or paperwork.			X
Professional Development				
28	Enhance training for health care/birthing hospital professionals regarding sensitivity to addiction as a disease.			X
29	Enhance training for children services professionals regarding sensitivity to addiction as a disease.		X	X
Education & Outreach				
30	Increase education on the impact of alcohol and drugs and mental illness.			X
31	Increase education and outreach aimed at pregnant women on how to seek services and resources.	X		X
32	Develop outreach for those who are being human trafficked; these are women likely to be addicted and become pregnant.			X
System Governance & Resources				
33	Identify a system lead to pursue positive, target population outcomes, and define the role.	X		
34	Establish a Senior Policy Analyst-type position to be responsible for bringing systems together to a build strategic approach and capacity for pregnant women with substance abuse disorders.	X		
35	Examine data sharing processes to better understand and address issues associated with serving this population with models that achieve appropriate outcomes.		X	

Addendum B: Sample Survey Questions

PROVIDER SURVEY

Celebrate One & the Franklin County ADAMH Board are spearheading a short-term project to identify needed strategies to assist pregnant women and new mothers who struggle with addiction in addressing their health issues to ensure their babies are born and stay healthy. To achieve these health goals, those involved know that the women in the target audience need prenatal support to avoid adverse birth outcomes and during the post-partum period. Generated ideas will be shared with the ADAMH Board and those managing the Franklin County Opiate Action Plan.

To generate solid proposals, your help is needed to compile an accurate picture of current, available addiction services and supports. If possible, we would ask that you complete the survey below and return it to >>>>>>> by close of business on Friday, date .

We appreciate that this is a quick turn around. The belief is that this information is primary to your business and should not be difficult to report. If you have any questions, please contact >>>>>>>.

Thank you in advance for assisting us with this important work. The goal is that any recommendations generated in this process benefit the system and the clients you serve.

A. Available services for pregnant women with addiction (excluding alcohol and tobacco).

1. Does your organization provide addiction treatment to pregnant women?
2. If so, are their eligibility parameters on who is accepted? Please describe.
3. For each program available, please describe the service program available, i.e. out-patient, residential, MAT, individual therapy, group supports.
4. Please describe the service capacity of the program. At any one time, how many slots are available/clients can be enrolled?
5. Please share 2016 (annual) admission number.
6. In a typical month, how many individuals are enrolled in your program?
7. In a typical month, how many inquiries does your program receive for access to treatment?
    a. Please describe the source of these inquiries, i.e. "x" percent from women themselves, family members, Medicaid, hospital systems, other community service providers by type. Please share if the percentage is based on hard data or an estimate.
8. Does the organization maintain a waiting list for the program? If so, how many individuals are typically waiting? If so, what is the typical wait?
9. Please share 2016 (annual) average length-of-stay.
10. Does the program provide Medication-Assisted Treatment to those enrolled?
    a. If so, is MAT offered within the organization's program to this population?
    b. If not, please describe if any referral to MAT occurs? If possible, please share a list of providers accepting MAT referrals for pregnant women?
11. Please share how the program ensures enrolled women receive adequate prenatal care?
    a. Share if prenatal care is provided within the program? In-house health care provider or via contract?

b. If parental care is not part of the organization's program, indicate if a referral is made? If relevant, please share a list of providers accepting prenatal referrals?

12. Does the program track the drug misuse by type? If so, please share the drug misuse breakdown.
13. What is the primary source of funding for serving pregnant women with addiction? Does the program accept insurance? Medicaid?
14. Does the program have any protocol for dealing with tobacco usage in alignment with other drug addictions being treated for the target population?

B. General Support for <u>pregnant</u> women with addiction.

1. Does your program provide any type of housing support? If so, please provide a brief description, including capacity.
2. Does your program routinely refer program participants to any other county/city/community-based supports for pregnant women? If so, please list those partners.

C. General Support for <u>women</u> with addiction (excluding alcohol and tobacco) who have babies and young children.

1. Does your organization provide addiction treatment to women with babies and young children?
2. If so, are their eligibility parameters on who is accepted? Please describe.
3. For each program available, please describe the service program available, i.e. out-patient, residential, individual therapy, group supports … a typical patient service continuum.
4. Please describe the service capacity of the program. At any one time, how many slots are available/clients can be enrolled?
5. Please share 2016 (annual) admission number.
6. In a typical month, how many individuals are enrolled in your program?
7. In a typical month, how many inquiries does your program receive for access to treatment?
   a. Please describe the source of these inquiries, i.e. "x" percent from women themselves, family members, Medicaid, hospital systems, other community service providers by type. Please share if the percentage is based on hard data or an estimate.
8. Does the organization maintain a waiting list for the program? If so, how many individuals are typically waiting? If so, what is the typical wait?
9. Please share 2016 (annual) average length-of-stay.
10. Does the program provide Medication-Assisted Treatment to those enrolled?
    a. If so, please describe the process for MAT within the program?
    b. If not, please describe if any referral to MAT occurs?
11. Please share how the program provides any specific post-partum supports?
12. Does the program track the drug misuse by type? If so, please share the drug misuse breakdown.
13. What is the primary source of funding for serving women with addiction? Does the program accept insurance? Medicaid?
14. Does the program have any protocol for dealing with tobacco usage in alignment with other drug addictions being treated for the target population?

D. General support for <u>new</u> mothers with addiction.

1. Does your program provide any type of housing support? If so, please provide a brief description, including capacity.
2. Does your program routinely refer program participants to any other county/city/community-based supports for women with young children? If so, please list those partners.
3. Does your program routinely refer program participants to any other county/city/community-based supports for young children to ensure their optimum development? If so, please list those partners.

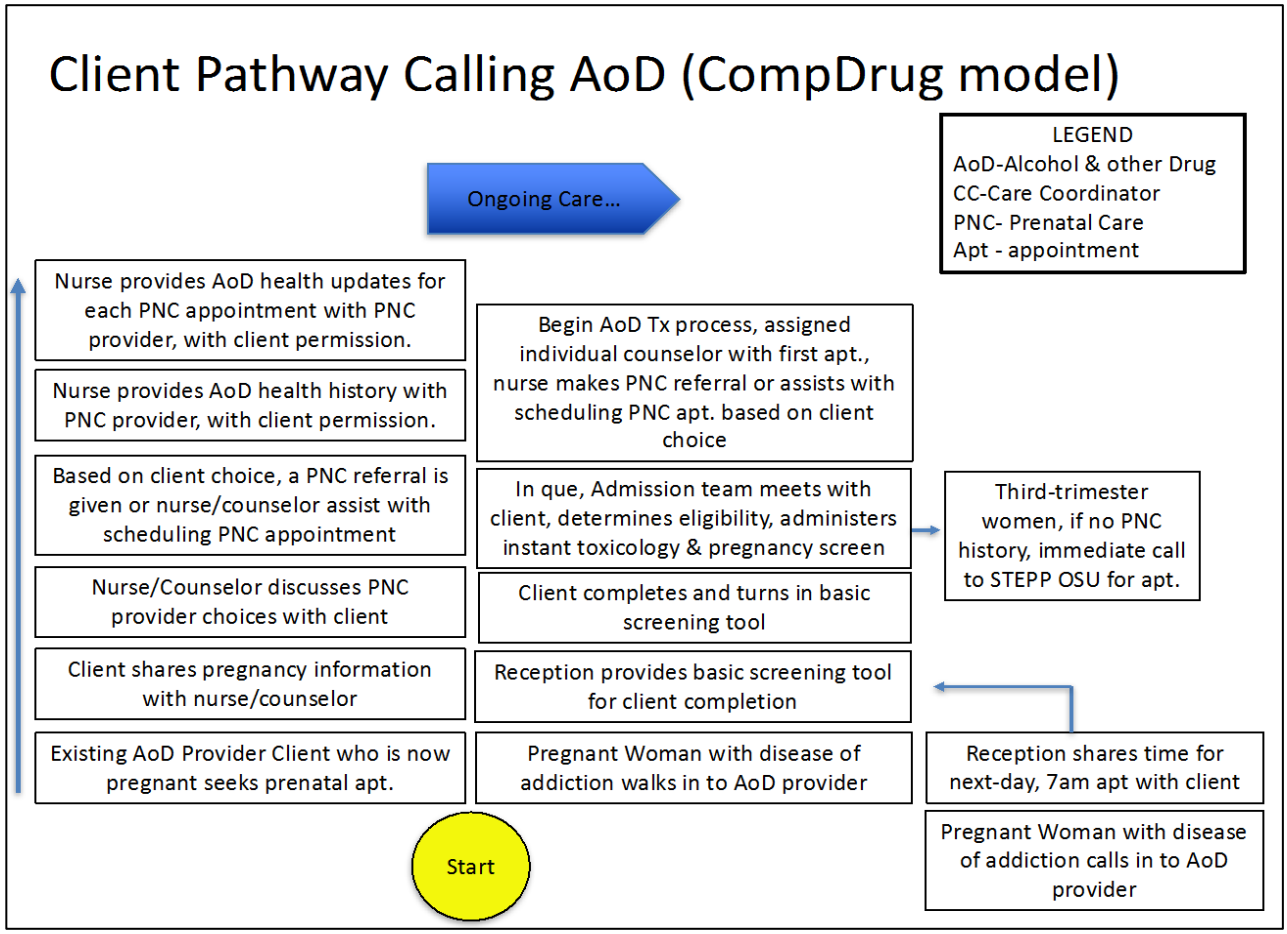
E. Recommendation Proposal

1. Given the organization's experience and expertise, what one proposal would you put forth to better serve the target population in meeting the goal of healthy mothers and healthy babies.

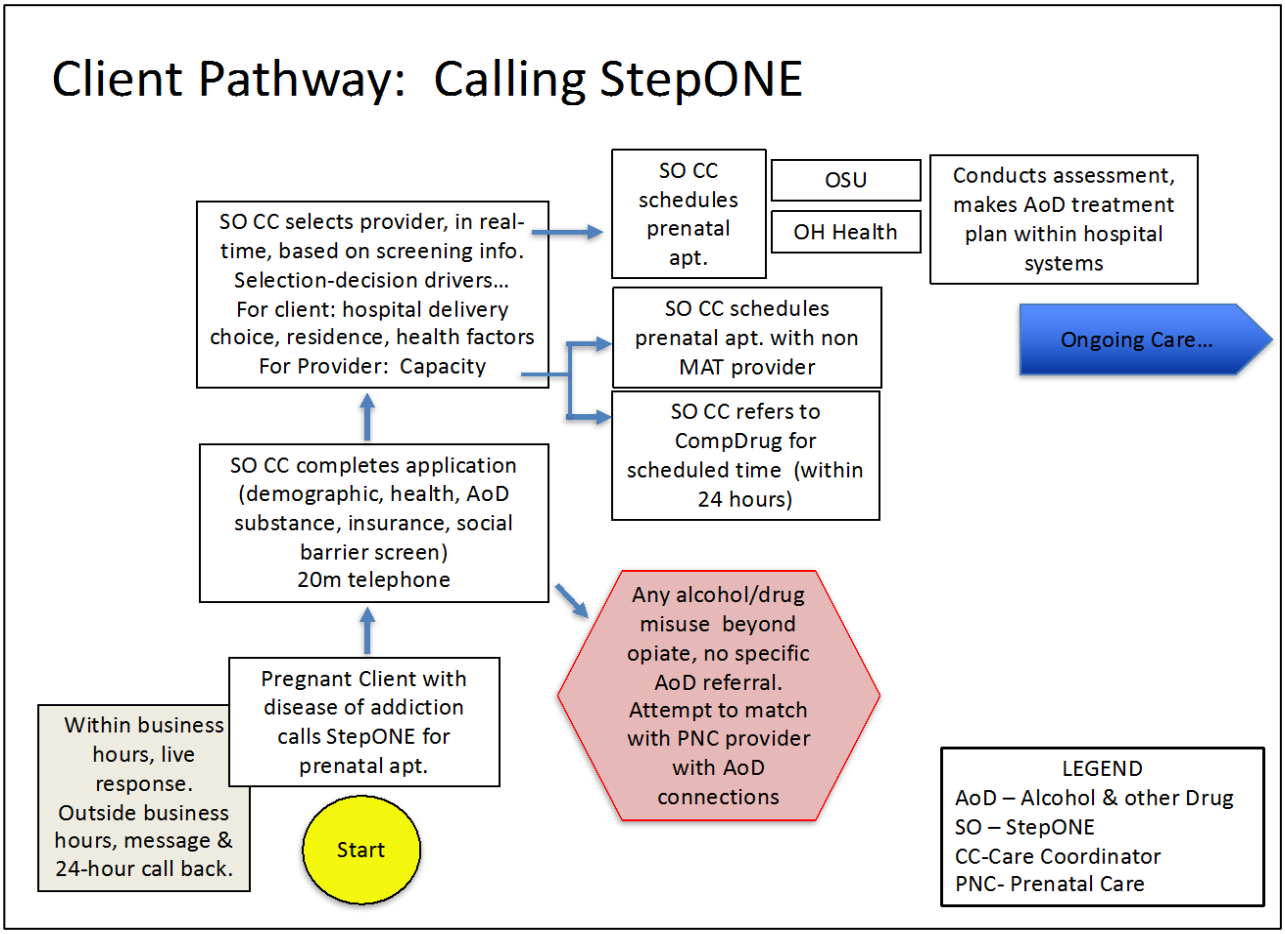
Addendum C: Intake Process Maps

The following charts provide a draft depiction of the step-by-step processes some pregnant women with addiction follow when seeking to enroll in prenatal care and addiction treatment. These two sample process flows can be refined and additional flows depicting other entrance points can and should also be charted to fully represent the "current state." These flows help illustrate where processes work for clients and where modifications can be made for easier access.

Process for enrolling in care when a woman contacts CompDrug



Process for enrolling in care when a woman contacts StepONE

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