AHCCCS Pregnant and Post-Partum Women with Substance Use Disorder Needs Assessment

August 2021

LeCroy & Milligan
ASSOCIATES, INC.

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About LeCroy & Milligan Associates, Inc.:

Founded in 1991, LeCroy & Milligan Associates, Inc. (LMA) is a consulting firm specializing in social services and education program evaluation and training that is comprehensive, research-driven, and useful. Our goal is to provide effective program evaluation and training that enables stakeholders to document outcomes, provide accountability, and engage in continuous program improvement. With central offices located in Tucson, Arizona, LMA has worked at the local, state, and national level with a broad spectrum of social services, criminal justice, education, and behavioral health programs. The LeCroy & Milligan Associates project team included Darcy McNaughton, MBA, Steve Wind, PhD, Darlene Lopez, MA, Craig LeCroy, PhD, Skyler LeCroy, BA, and Natalie Long, MSW, with contributions from Dr. Natasha Mendoza, Arizona State University School of Social Work and Valaura Imus-Nahsonhoya, Hongwungsi Consulting.

Our organization would like to thank the Arizona Health Care Cost Containment System for their support of this work and significant efforts in engaging key stakeholders.

Suggested Citation:

LeCroy & Milligan Associates, Inc. (2021). AHCCCS Pregnant and Post-Partum Women with SUD Needs Assessment. Tucson, AZ.

This publication was made possible by SAMSHA Grant number 6H79TI083173-01M002. The views expressed in these materials do not necessarily reflect the official policies or contractual requirements of the Arizona Health Care Cost Containment System (AHCCCS) or the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

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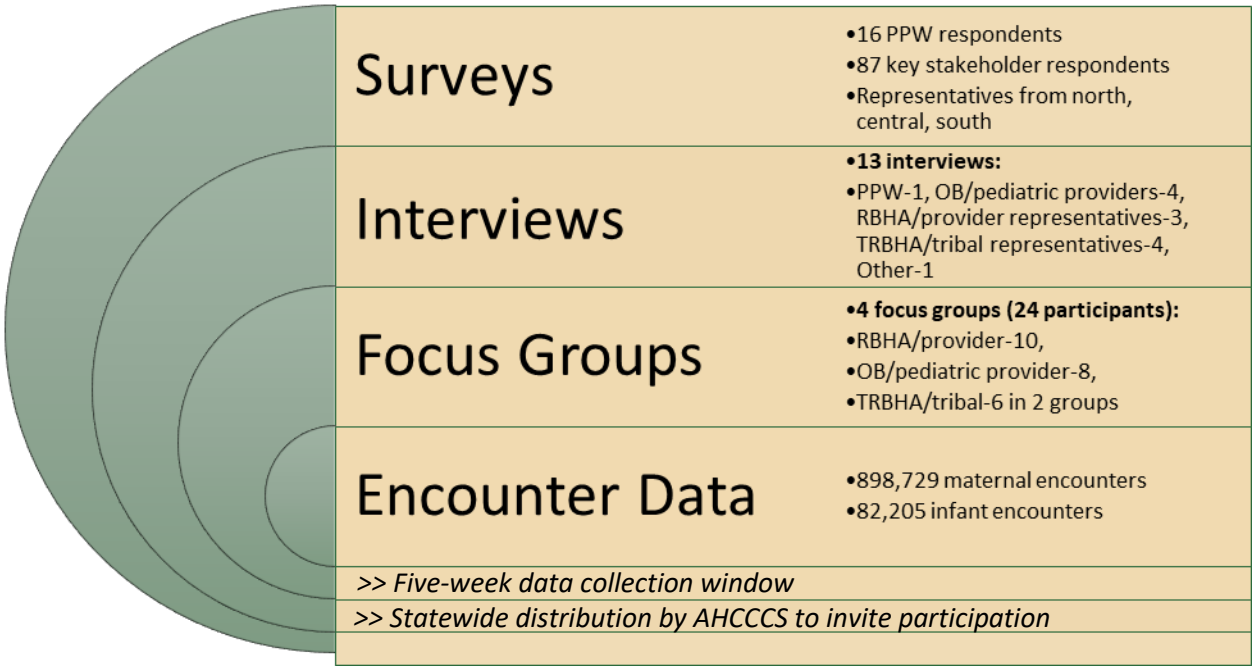
Executive Summary

This needs assessment for Arizona Health Care Cost Containment System (AHCCCS) was contracted to LeCroy & Milligan Associates in June 2021, with the goal of better understanding, and ultimately improving, the system of care for pregnant and post-partum women (PPW) with a substance use disorder or opioid use disorder (SUD/OUD) and their children (often who have Neonatal Abstinence Syndrome - NAS). The needs assessment was conducted within a short (three-month) timeline to meet Substance Abuse and Mental Health Service Administration (SAMHSA) requirements. Data collection methods included interviews, focus groups, two online surveys (one for PPW and one for key stakeholders), analysis of AHCCCS encounter data, and a brief literature review.

Summary of Data Collection



Key themes from across the data that was collected are highlighted in this section and detailed in the remainder of this report.

I did not get to hold my son when he was born. He was taken to the NICU. I knew he would probably be born with substances in his system… I wanted to do everything right, so I divulged to the doctor the truth. ~PPW

The overall complexity of working with this population and their varying needs is clear across the feedback collected, from challenges with homelessness and multi-generational trauma, to other children placed in foster care. Women with lived experience highlighted the service fragmentation and stigma they have often experienced. Findings suggest there is a great deal of variability in what services are offered, who is aware of the services, and how the communication and coordination of services occur. There is a need for more resources and training on what services/programs are available for this population, and how to best meet their needs.

While many general services exist (e.g., behavioral health treatment or primary care), they do not appear well-connected, integrated, or specifically suited to this population. Women and their children receive services from different providers at different times, and often this happens too close to when the baby is born rather than during prenatal planning and services. Many participants emphasized the importance that services available are responsive, compassionate, and family-focused for both the mother and child.

Data shows that some hospitals, in conjunction with the Arizona Department of Child Safety (DCS), separate mother and baby when the baby is cared for in the Neonatal Intensive Care Unit (NICU), in the interest of protecting the child and under a medical model of treatment. Respondents suggest that other emerging practices may be preferable, such as helping the infant stay with the mother, where possible, if they are receiving treatment and/or in recovery and with infant plans of safe care. Stakeholders mentioned the practice of *Eat, Sleep, Console* (Grisham, et al., 2019) and encourage hospitals to consider using these types of practices or refer families to providers who offer them.

Summary of Recommendations

1) Shift the culture:
- Train PPW and providers
- Stigma reduction

2) Expand screening and earlier entry points

3) Enhance the system of care:
- -Specialized comprehensive providers for PPW families
- -Improve referral pathways
- -DCS collaboration
- -Local/culturally responsive programming
- -Extent supports well beyond birth

4) Support the mother-baby dyad and families remaining together (where safe and with DCS support)

5) Navigate billing mechanisms for the mom-baby dyad

6) Improve utilization of evidence-based treatment and continue to research best practices

Competition between providers for funds may impact how changes in practices are perceived. In addition, more research is needed to see if child outcomes are achieved in the long-term. Some providers who are moving in this direction are highly regarded by stakeholders in this study.

Even when these services are in place, key stakeholders mentioned that billing can be a challenge. For example, a hospital may not be able to bill for services for the mother, only for the child while they are in the NICU. Stakeholders also had questions about the use of Substance Abuse Block Grant (SABG) funds. Respondents suggested that health insurance coverage is needed by the mother and child for longer than what may currently be covered by AHCCCS (e.g., a year for PPW with SUD/OUD and their children). Billing coding may not be ideally configured to support wrap-around services, case management/care coordination, and other types of supports, particularly those that cross-agencies and are central to collaboration. Encounter data indicates that services for the child are expensive and outpace those for the mother.

PPW and key stakeholders suggested that education to increase awareness of perinatal mental health and routine screening for all PPW might help as a first step, along with other strategies to increase engagement with services including stigma-reduction campaigns statewide. It is clear that AHCCCS is moving forward to try and address some of these issues, by bringing together stakeholders under this current federal SAMHSA grant (see Appendix B overview) and other initiatives underway.

The specific recommendations from this needs assessment are highlighted below and depicted in the infographic on the previous page.

1) **Shift the culture with stigma reduction campaigns and education for PPW and providers.**

2) **Expand screening and multiple entry points to services for this population and try to reach them earlier in their pregnancy.**

3) **Enhance the system of care to include more specialized providers that can provide housing and full wrap-around support for this population** with specialized staff/training; improve referral pathways where specialized services are not available; work closely with DCS on shared practices/policies; ensure some locally-based programming is available, particularly in tribal communities; and ensure that supports for the PPW extends well past the birth of the baby.

4) **Support the mother-baby dyad through emerging best practices** that promote families remaining together (where safe and with DCS support).

5) **Navigate billing mechanisms for the mom-baby dyad.**

6) **Improve utilization of evidence-based treatment and continue to research best practices for PPW participants.**

Introduction

Best practices in serving women with substance use disorders (SUDs) and their children is a current area of significant focus nationwide. Some of the critical practices and recommendations, in recent publications, are referenced below and were used to inform the remainder of this needs assessment report.[1]

Needs Assessment Context

Who is being impacted and what are the risks?

SUDs impact women from all different backgrounds, racial groups, and geographic locations (Normile et al., 2018). Pregnant and post-partum women (PPW) with an SUD are at an increased risk of continued substance use and have unique barriers related to receiving care such as stigma, lack of insurance coverage, fear of child protective services involvement, and poor access to prenatal care (BSAS, 2018).

PPW with opiate use disorders (OUD) are at an even higher risk of health complications and barriers to care including polysubstance use, significant trauma history, domestic violence, lack of social supports, poor nutrition, unstable housing, and co-occurring mental health conditions (SAMHSA, 2016a; 2016b; 2018). The numbers of OUDs continue to rise exponentially. Between 1999 and 2014, the prevalence of OUDs quadrupled along with a coinciding rise in neonatal abstinence syndrome (NAS), increasing from 1.2 per 1,000 hospital births to 5.8 per 1,000 hospital births between 2000 and 2012 (Normile et al., 2018). The increased rate of babies born with NAS has resulted in an increased use of pharmacological treatment, heightened mortality rates, longer hospital stays, and higher hospital bills (Grisham et al., 2019).

What assessment tools are widely utilized with this population?

Currently, the most widely utilized tool to assess for NAS is the Finnegan Neonatal Abstinence Scale (FNASS), which was created in 1975 and scores babies on a scale of 21 points based on the most common neonatal opioid withdrawal symptoms (Grisham et al., 2019). The score determines the course of treatment for the baby. If the score is 8 or higher, pharmacological treatment is used by giving morphine to the baby to minimize pain from withdrawal, which may have adverse consequences for the baby (Blount et al., 2019). Studies have shown that the FNASS assessment has led to unnecessary opioid treatment for newborns, creating a longer hospital stay and less time for the family to spend with the baby due to an unwelcoming hospital environment (Grisham et al., 2019).

[1]This section is not intended to be a comprehensive literature review. See publications such as Bishop et al. (2017) for more information. SAMHSA also has several publications to provide support on this topic (SAMHSA, 2016a; 2016b; 2018).

What does the emerging research suggest about best practices?

Emerging research indicates that maintaining the mother-baby dyad by keeping them in the same room and increasing nonpharmacologic interventions, such as skin-to-skin placement, swaddling, and a calming environment, shortened hospital stays and improved patient outcomes (Blount et al., 2019). One method following these suggestions is the *Eat, Sleep, Console (ESC)* model, which assesses critical areas of functioning in newborns. This model includes monitoring how much the infant is eating and sleeping, and if they can be consoled within 10 minutes (Blount et al., 2019). If the infant is inconsolable after 10 minutes, then pharmacologic treatment may be utilized as a last resort (Blount et al., 2019). Grossman's study using ESC found a reduction of average inpatient days from 22.4 to 5.9, a reduction in the number of infants treated with morphine from 98% to 14%, and a reduction in the cost of care by $34,535 (Grossman et al., 2018).

Research also suggests that a comprehensive care model is necessary to care for the complex needs of this population (Meinhofer et al., 2020). The treatment team should include staff who are specially trained in areas such as mental health, SUD treatment, prenatal care, housing, and any other applicable service providers (Meinhofer et al., 2020). Medication-Assisted Treatment (MAT), using methadone or buprenorphine, is the standard of care for pregnant women with OUD, and leads to improved birth outcomes, including higher birthweight, reduced incidence of NAS, and shorter hospital stays for the infant (Bishop, et al., 2017).

What are other barriers identified in the research?

Studies have shown that pregnant women may be fearful to seek substance use help due to stigma and concerns about Child Protective Services becoming involved (Syvertsen et al., 2020). Women experience structural stigma from healthcare professionals when seeking MAT, as some insurance policies do not cover MAT while pregnant, and many providers require patients to pay for MAT with cash out of pocket (Syvertsen et al., 2020). Some women have been dismissed from MAT care once they became pregnant, and some are placed on unreasonable waitlists for treatment, further removing the care that they need. In some cases, women resort to buying buprenorphine off the street to self-treat (Syvertsen et al., 2020). Suggestions to work on reducing stigma for this population includes providing training for providers, using a stepped care approach to begin engagement in some level of services, and a multisystemic approach to increase care coordination for these women (Syvertsen et al., 2020).

While there are many barriers for PPW with OUD and SUD, research indicates that comprehensive and integrated care, along with maintaining the mother-baby dyad, are demonstrating positive outcomes for families, such as less pharmacological treatment for infants and reduced costs for insurance providers.

AHCCCS PPW SUD/OUD Needs Assessment Overview

This AHCCCS Pregnant and Post-Partum Women with Substance Use Disorder (PPW SUD/OUD) Needs Assessment was contracted to LeCroy & Milligan Associates in June 2021, with the goal of better understanding, and ultimately improving, the system of care for PPW with an SUD/OUD and their children in Arizona. This needs assessment was conducted in a three-month timeline to meet Substance Abuse and Mental Health Service Administration (SAMHSA) requirements.

This statewide needs assessment reflects the Center for Substance Abuse Treatment's (CSAT's) Comprehensive Treatment Model for Alcohol and Other Drug-Abusing Women and Their Children, which emphasizes the interrelated elements of clinical treatment services (i.e., services to address medical and biopsychosocial issues of addiction), clinical support services (services that assist clients in their recover), and community support services (i.e., services and community resources outside of treatment but within a community that serve as fundamental supports for recovery). This needs assessment also focuses on multiple perspectives and service components, and their inter-connectivity (SAMHSA, 2016a).

This needs assessment will ultimately support the AHCCCS State Pilot Grant Program for Treatment for Pregnant and Postpartum Women (PPW-PLT) that increases the integration of treatment and wrap-around services for PPW with SUD/OUD and their children, and their family members. It will as also serve as a baseline for other statewide efforts to improve services for this population in Arizona.

NEEDS ASSESSMENT DEFINITIONS

Women/mothers – Language used is in reference to the female biological sex able to give birth to a child, rather than gender preference.

Mother-baby dyad – Pair of mother and her newborn infant. This is also referred to as mother-infant dyad or maternal-infant dyad. This term is often referenced related to ways to serve both parties together to improve outcomes.

Key stakeholders/providers – Includes all the different types of organizations providing services to this population. Not specific to one sector (e.g., behavioral health) unless specified.

Pregnant and post-partum women (PPW) – Includes women who are pregnant and/or have had children recently (with a focus on 4th trimester). Sometimes PPW are referenced as participants in this assessment.

Methodology

This needs assessment followed the steps outlined in the illustration below. This collaborative process required working closely with AHCCCS to distribute information about the needs assessment, develop the data collection tools, and review results. A statewide advisory group was also convened and had the opportunity to speak to the process and the key findings included in this report.

The research questions of this needs assessment and primary data collection methods/sources are shown in Exhibit 1 and described in further detail in subsequent pages.

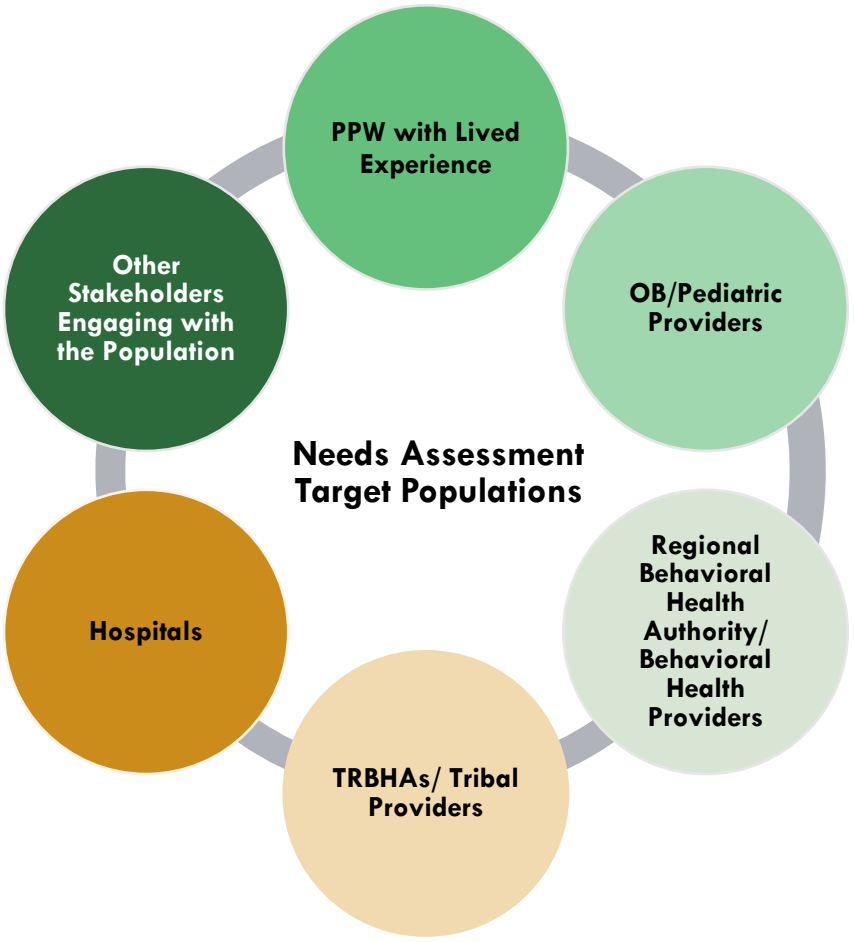
Exhibit 1. Research Questions and Data Collection Methods/Sources

Research Question in Task Order	Data Collection Method/Source
5.5.1: Where are the gaps in the system that are most often encountered by Arizona women seeking treatment and recovery support?	AHCCCS preliminary needs assessment; secondary data (e.g., ADHS SUD/OUD related encounter data); all primary data sources.
5.5.2: For participating tribal nations, what are the system gaps and challenges that American Indian/Alaska Native (AI/AN) women seeking SUD treatment within the healthcare delivery system encounter?	Focus group and informant interviews with representatives Tribal Regional Behavioral Health Authorities (TRBHAs) and Tribal Nations providing services to PPW with SUD/OUD.
5.5.3: What challenges do treatment providers experience in connecting their clients to community-based services?	All primary data sources.
5.5.4: Which hospitals are implementing labor and delivery practices that support Substance Exposed Newborn (SEN)/NAS newborns staying with their mothers, and mothers providing all infant care? What protocols are used to ensure standardization of these practices in their hospital?	Brief landscape analysis of hospitals in AZ implementing practices and protocols (hospital form was method identified).
5.5.5: What data is available to illustrate this model's effectiveness in the length of stay and health of newborns and mothers? What other metrics are collected to inform this practice?	Literature on best practices; secondary data.

Research Question in Task Order	Data Collection Method/Source
5.5.6: Where in Arizona are the following sectors exhibiting awareness of, support for, and implementation of Infant Plans of Safe Care (e.g., Probation, Dependency Courts, Department of Child Safety, OB/GYN, pediatricians, SUD/OUD treatment providers, foster parents)?	Survey of treatment and community-based services providers; key informant interviews
5.5.7: Based on findings, what strategies are recommended to strengthen Arizona's statewide system of support for pregnant and postpartum women with substance use disorder and their children?	Triangulation of data and facilitated discussion with subject matter expert to identify strategies based on findings
5.5.8: What are PPW experiencing as they engage with this system? How could this be improved?	PPW experiencing SUD/OUD focus group and survey

Populations of particular interest for inclusion in this needs assessment are shown in Exhibit 2.

Exhibit 2. Target Populations for Needs Assessment



Primary Data Collection and Measures

Instruments and Measures

The specific methods and measures used for this needs assessment are shown in Exhibit 3.

Exhibit 3. Data Collected, Purpose, and Analysis Method Summary

Data/Instrument*	Purpose	Analysis Method
PPW Interview Protocol	Learn about detailed experiences from the lens of PPW regarding accessing/engaging in this system of care.	Qualitative analysis
OB/Pediatric Provider Focus Group/Interview Protocol	Learn specifically from the OB/pediatric providers on their work with this population, including gaps, training needs, collaboration.	Qualitative analysis
Regional Behavioral Health Authority (RBHA)/Provider Focus Group/Interview Protocol	Learn specifically from the RBHAs/BH provider on their work with this population, including gaps, training needs, collaboration.	Qualitative analysis
Tribal Regional Behavioral Health Authority (TRBHA)/ Tribal Nation Focus Group/ Interview Protocol	Learn specifically from the TRBHA/tribal providers on their work with this population, including gaps, training needs, collaboration.	Qualitative analysis
Stakeholder Survey	Learn from a broad array of stakeholders that engage with this population regarding access, services, knowledge/attitude in working with this population, sector collaboration, gaps, training needs.	Qualitative/ quantitative analysis
PPW Survey	Learn from a sample of PPW to learn more about statewide gaps in services and stigma experienced.	Qualitative/ quantitative analysis
Hospital Form	Collect specific quantitative and descriptive information about hospital practices related to serving women with PPT and their children	Qualitative/ quantitative analysis

*All measures were developed and implemented by LeCroy & Milligan Associates for this project, including the hospital form.

Communications/Distribution Methods

AHCCCS staff engaged numerous stakeholders across Arizona working with this population by building connections as part of the PPW-PLT grant. Thus, communications regarding participating in the needs assessment were focused on outreach via established AHCCCS

channels including, but not limited to: AHCCCS PPW-PLT advisory group, AHCCCS PPW-PLT stakeholder distribution list (100+ contacts), and AHCCCS social media. Participating organizations are shown in Appendix A. PPW were engaged through a snowball method where contacted providers were encouraged to share information with their clients regarding the PPW survey and opportunity to complete an interview. Numerous key stakeholders distributed the information to their own networks (e.g., Health Start, Arizona Statewide Task Force on Preventing Prenatal Exposure to Alcohol and Other Drugs) and LMA disseminated information to contacts in the behavioral health field. Dissemination included multiple communications and flyers at various points in the project (see examples in Appendix B). Tribal contacts (i.e., TRBHAs and other tribal providers) were specifically outreached via the AHCCCS Tribal Liaison.

Data Analysis

Qualitative data from focus groups and open-ended survey responses were coded and analyzed for key themes. All quantitative data was analyzed across all respondents and also with some sub-analyses by region (North, Central and Southern). The key stakeholder survey data included zip-code data that was used to group the respondents into three regions, mirroring approximately the three geographic service areas used for the AHCCCS Complete Care System including Northern (Mohave, Coconino, Yavapai, Navajo, Apache, and Gila Counties); Central (Maricopa County); and Southern (La Paz, Yuma, Pima, Santa Cruz, Cochise, Pinal, Graham and Greenlee Counties).[2] Analyses of some survey items were conducted by region and compared. All of the data were analyzed for descriptive statistics as well as averages by survey item, where applicable. Open-ended items were analyzed for key themes. The case study presented in the section on women with lived experience was summarized and slightly modified for clarity and confidentiality, but it was based heavily upon one interview with a woman with lived experience.

AHCCCS Utilization Data

Data was received from AHCCCS for women with SUD ICD-10 diagnoses during the perinatal period women (week 22 of pregnancy to 1 week post birth) and for infants with NAS and other substance-exposure. AHCCCS provided three Excel files containing encounter data labeled as substance use treatment, substance use diagnosis, and infant data. Data was provided for state fiscal years 2017 to 2021, covering July 1, 2016 to May 30, 2021. The data for state fiscal year 2021 was incomplete, and should be viewed with caution, as encounters can be submitted well after the encounter date has passed. In addition, identifying information was not included in the files, so individual clients may have multiple encounter records. The results presented in this report provide information on encounters and not on individual clients. Both the treatment file and the diagnosis file contained data on maternal encounters. Due to the small number of records in the treatment file, and similar data being available in the diagnosis file, data from the

[2] https://www.azahcccs.gov/Members/BehavioralHealthServices/

treatment spreadsheet is not included in this report. Data was reviewed by year to determine any potential trends over time. All data is presented as a statewide aggregate and by county where possible. There are several counties where there were no records meeting the above-mentioned inclusion criteria during a specific year. This could indicate that funding was unavailable, services were unavailable in those counties during those years, or there were issues with coding services, rather than there being no clients with substance use diagnoses.

Limitations

A number of limitations impacted this needs assessment, with the primary limitation being the timeline. The overall project needed to be completed in 11 weeks, which required an approximate 5-week data collection window and limited the time available for extensive data analysis (e.g., by sub-population). The goal of the needs assessment was to accomplish as much as possible during the timeline, with recognition by both AHCCCS and LMA that additional work would likely be needed.

The evaluation team was not able to conduct additional or targeted outreach beyond what AHCCCS provided through their extensive existing networks. Thus, the overall sample likely over-represents stakeholders that are engaged or connected with the work happening at AHCCCS. Stakeholders could also have participated in more than one type of data collection (i.e., surveys, interviews, and focus groups were conducted), which could possibly lead to over-representation. Surveys were intentionally anonymous, so there is no way to determine if participants also completed a survey. Thus, the overall data should not be assumed to be fully reflective of the diversity of Arizona providers.

The number of PPW who participated was particularly limited, and it is clear that additional information should be collected from those most intimately involved in this experience and services. Engaging PPW in how to build upon these recommendations is suggested. Additionally, there was limited data received directly from hospitals regarding the number of PPW and children with NAS/OUD that they serve. A survey was sent out by AHCCCS to direct hospital contacts, but because only a handful of responses were received, this information was not included in this report for statewide comparison. AHCCCS encounters data provides some of this information.

Despite these limitations, overall, this needs assessment provides more information than was previously available regarding the needs, services, and potential areas for further exploration and possible systems change going forward in Arizona for PPW.

Results

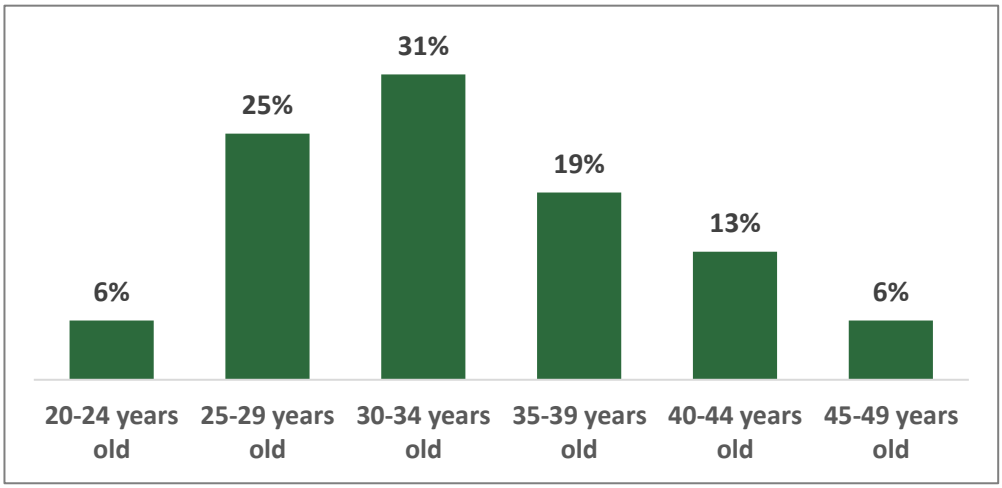
Pregnant and Post-partum Women with SUD Survey Data

This section details findings from the PPW Survey, including respondent demographics, services received, stigma, and recommendations for system improvement.

Survey Demographics

Of the 16 survey respondents, almost a third (31%, n=5) were less than 30 years of age and 31% (n=5) were between the ages of 30-34 years (Exhibit 4). Survey respondents reported living in 14 zip codes across Arizona, representing north, central, and southern parts of the state.

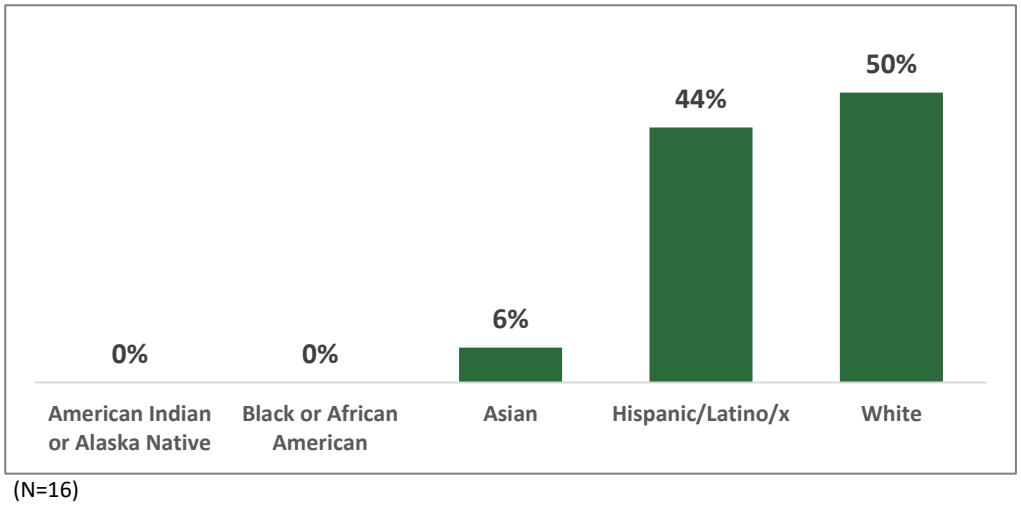
Exhibit 4. Age Distribution of PPW Survey Respondents



(N=16)

Half of the respondents (50%, n=8) identified as White and 44% (n=7) reported they were Hispanic/Latino/x (Exhibit 5).

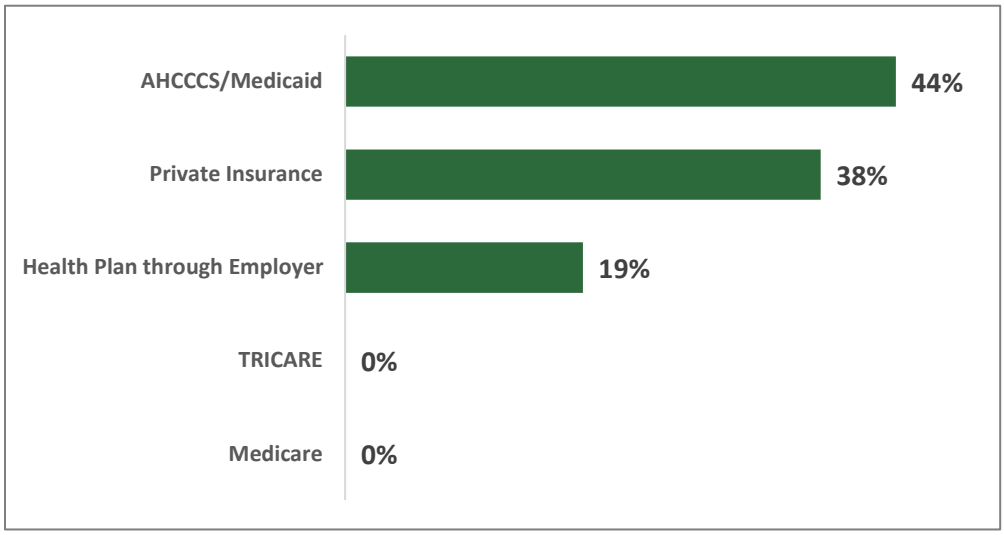
Exhibit 5. Race/Ethnicity of PPW Respondents



(N=16)

Almost half (44%, n=7) off the PPW respondents had health insurance coverage through AHCCCS (Medicaid), followed by 38% (n=6) who had private insurance (Exhibit 6).

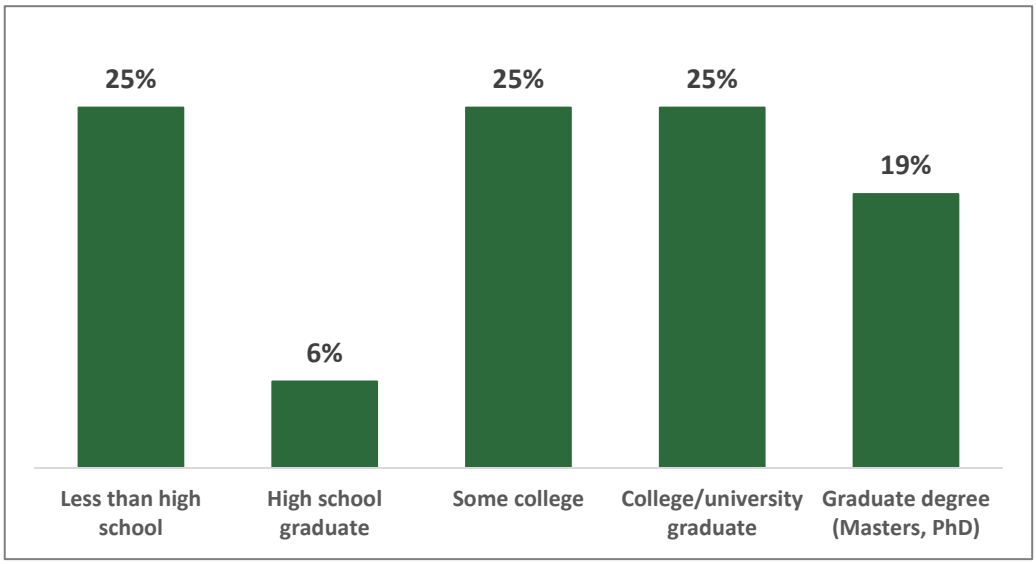
Exhibit 6. Health Insurance Coverage of PPW Respondents



(N=16)

The education level of the PPW was relatively evenly spread across the education continuum from less than high school competition to having a graduate degree (Exhibit 7).

Exhibit 7. Education Level of PPW Respondents



(N=16)

More than half (56%, n=9) of the PPW Survey respondents reported they had a child in the past 12 months. Two of the sixteen respondents (13%) indicated they were pregnant when they completed the survey. The total number of children under age 18 that respondents had ranged from one to four, with 44% (n=7) having three or four children in that age range. None of the respondents had grandchildren living with them (Exhibit 8).

Exhibit 8. Parenting and Pregnancy Demographics of PPW Respondents

Characteristic	Percentage and Number by Response
Have had a child within past 12 months	Yes (56%, n=9) No (44%, n=7)
Total number of children have under age 18 (not including any currently pregnant with)	1 child (31%, n=5) 2 children (25%, n=4) 3 children (19%, n=3) 4 children (25%, n=4)
Have children older than 18 living with them	Yes (25%, n=4) No (75%, n=12)
Have grandchildren living with them	Yes (0%, n=0) No (100%, n=16)
Are currently pregnant	Yes (13%, n=2) No (88%, n=14)

(N=16)

Substance Use

Only three of the PPW respondents (23%) reported using prescription pain medication during their pregnancy, with two of them indicating they used that medication in a larger amount or more often than their doctor had prescribed (Exhibit 9).

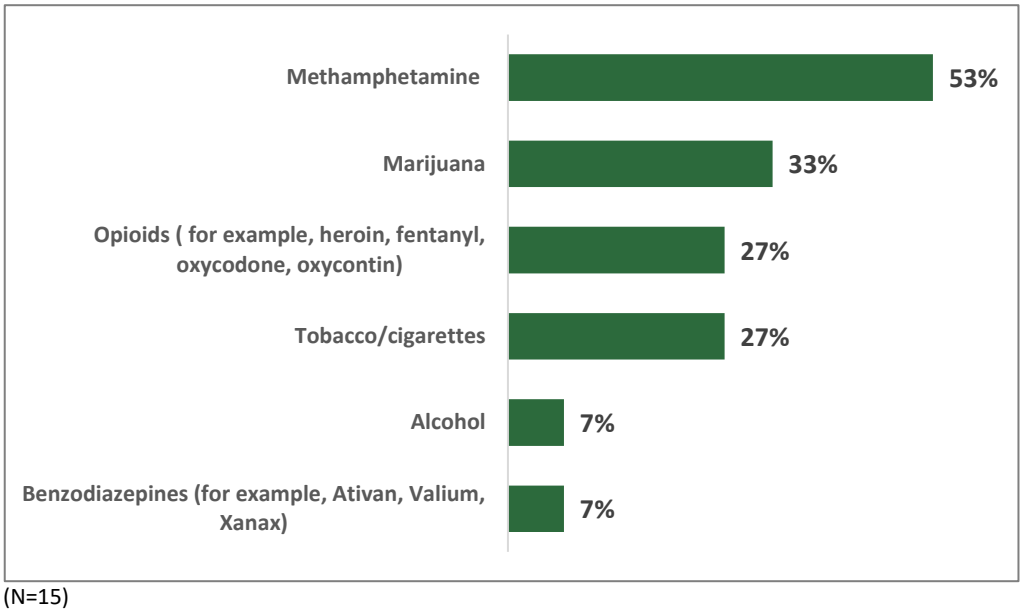
Exhibit 9. Prescription Pain Medication Use During Pregnancy

Type of Usage	Percentage (Number)
Women using Prescription Pain Medications During Pregnancy	Yes (23%, n=3) No (77%, n=10)
Women who Used Pain Medications in Larger Amount or More Often than Doctor Prescribed During Pregnant	Yes (15%, n=2) No (85%, n=10)

(N=13)

The drug most commonly used by the PPW Survey respondents was methamphetamine (53%, n=8), followed by marijuana (33%, n=5) (Exhibit 10).

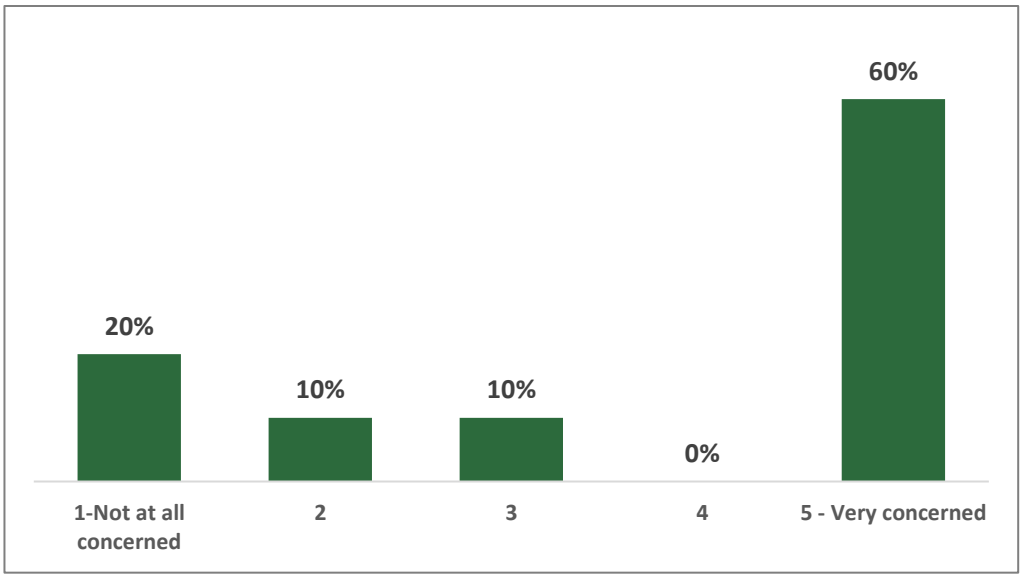
Exhibit 10. Types of Substances Used During Pregnancy



(N=15)

While 60%(n=6) of the PPW respondents reported they had been very concerned about substance use during their pregnancy, 40% (n=4) indicated they had a low or neutral level of concern at that time (Exhibit 11).

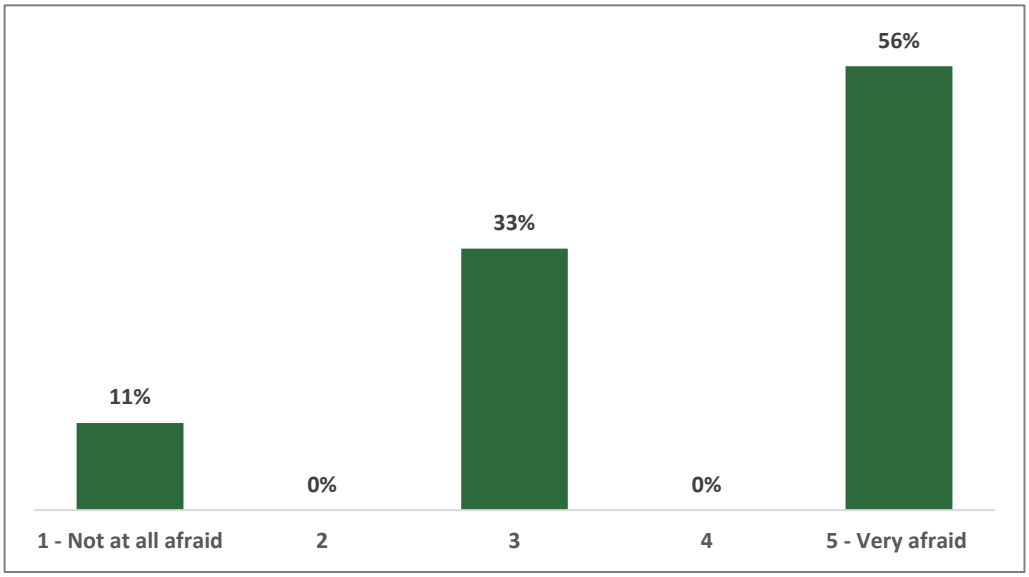
Exhibit 11. Level of Concern About Substance Use During Pregnancy



(N=10)

More than half (56%, n=5) of the PPW respondents were very afraid their drug use would be found out during their pregnancy while a third of the respondents appeared to be more neutral about having such fear at that time (i.e., a rating of 3) (Exhibit 12).

Exhibit 12. Level of Fear that Substance Use Would be Found Out



(N=9)

Substance Use Treatment

A total of 78% (n=7) of participants who responded to the item about substance use treatment stated that they received substance use treatment while pregnant and 22% (n=2) did not. The two greatest barriers to getting substance use treatment during pregnancy reported by the PPW respondents were thinking they did not need treatment (31%, n=5) and not having transportation (31%, n=5) (Exhibit 13).

Exhibit 13. Substance Use Treatment Barriers

Barriers	Percentage (Number)
I did not think I needed treatment.	31% (5)
I did not have transportation.	31% (5)
I could not find a treatment provider who would see me.	19% (3)
I was concerned that getting treatment or counseling might cause my neighbors or community to have a negative opinion of me.	6% (1)
I was concerned that getting treatment or counseling might cause my neighbors or community to have a negative opinion of me.	6% (1)
Someone encouraged me not to get treatment while pregnant.	6% (1)

Barriers	Percentage (Number)
There was no availability at local treatment providers.	6% (1)
I did not have insurance or a way to pay for it.	0% (0)
There are no treatment providers in my area.	0% (0)

(N=16)

A total of 31% (n=5) of the PPW Survey respondents indicated that they had been given information about medication options related to substance use during pregnancy. A total of 18% (n=3) had received this information and 50% (n=8) did not respond to this question. Those who received information got it from a doctor, OB/GYN, or while in jail. Respondents were asked to indicate if they were prescribed medication to treat SUD/OUD during pregnancy. Only half of the women responded to this question and they were equally split between stating they had or had not been prescribed medication during pregnancy.

Choices During Pregnancy

The two actions during pregnancy that PPW respondents most commonly reported, of the options provided, were being honest with their doctor (38%, n=6), and being worried they might get reported to DCS or go to jail because of their substance use (31%, n=6) (Exhibit 14).

Exhibit 14. Actions During Pregnancy

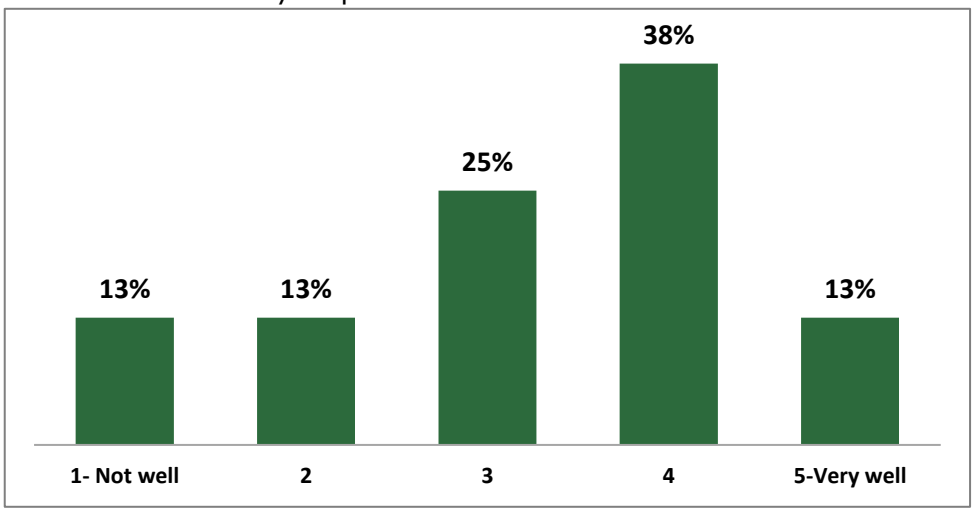
Area	Percentage (Number)
Was honest with my doctor about my substance use	38% (6)
Worried I might get reported to DCS or go to jail because of my substance use	31% (5)
Avoided family and friends	19% (3)
Trusted my doctor with information about my substance use	19% (3)
Talked with a pediatric provider about the potential impact on my child from substance use	13% (2)
Timed prenatal appointments to avoid substance use detection	13% (2)
Skipped doctor appointments because I was worried about my substance use	6% (1)
Hid the pregnancy from others	6% (1)

(N=16)

Hospital Care

Participants were asked to comment on how well they were treated by hospital staff. Exhibit 15 indicates that over a quarter did not feel that they were well treated.

Exhibit 15. Treatment by Hospital Staff



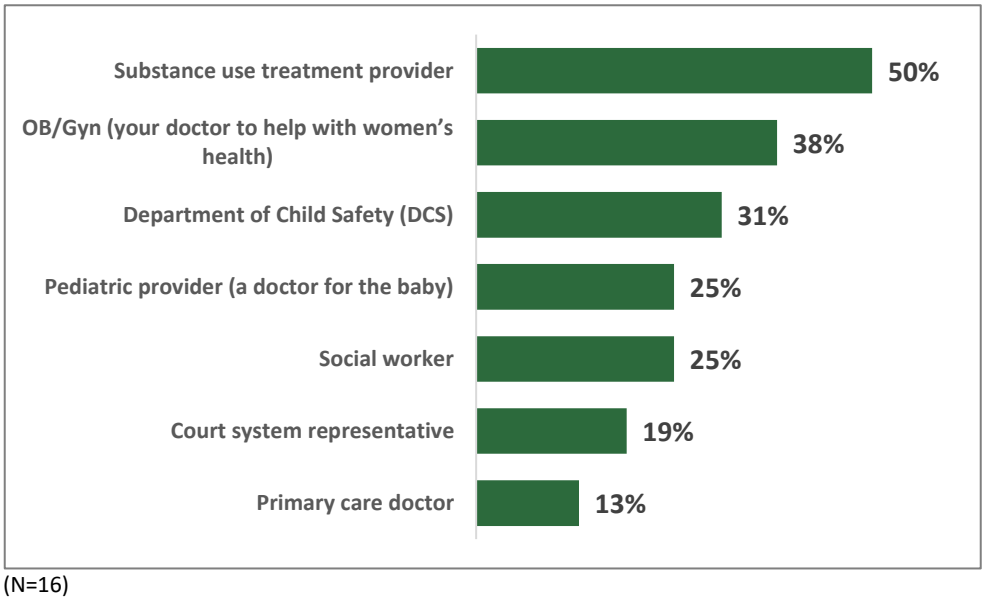
N=8

The amount of time women reported their baby was in the hospital ranged from 1 day to 30 days (n=8). Three participants (38%) indicated their child was in the hospital 22 days or longer.

Supports and Other Services

Of the professionals in various sectors that the PPW Survey respondents had involvement with during their pregnancy, the largest proportions reported contact with a substance use treatment provider (50%, n=8), OB-GYN (38%, n=6), and DCS staff (31%, n=5) (Exhibit 16).

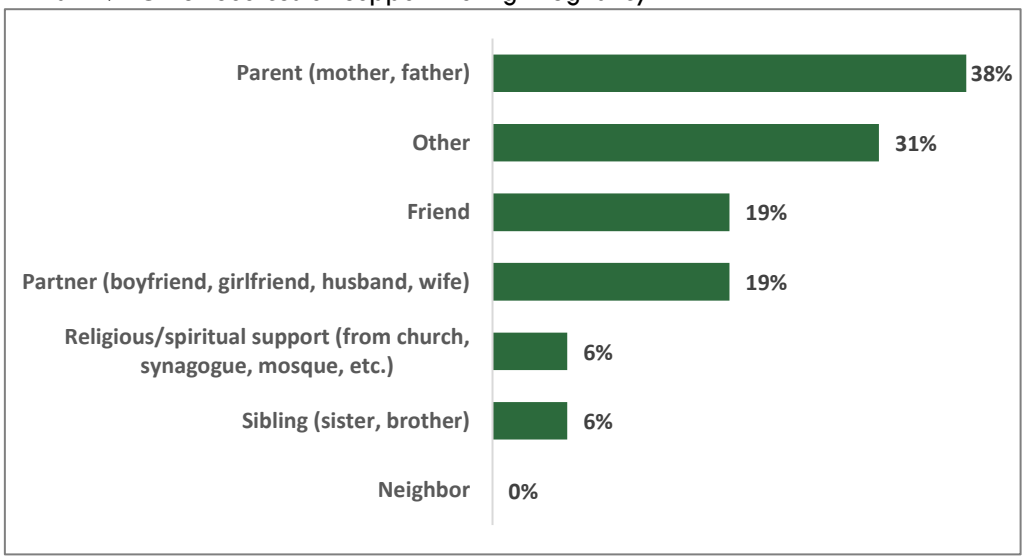
Exhibit 16. People Involved with Respondent and Their Baby During Pregnancy



(N=16)

More than a third of the PPW Survey respondents (38%, n=6) stated their parents served as another source of support during pregnancy. The varied sources of support indicated by the "Other" choice (31%, n=5) included the Arizona Women's Recovery Center, a grandmother, Hushabye Nursery, peer support, and probation officer) (Exhibit 17).

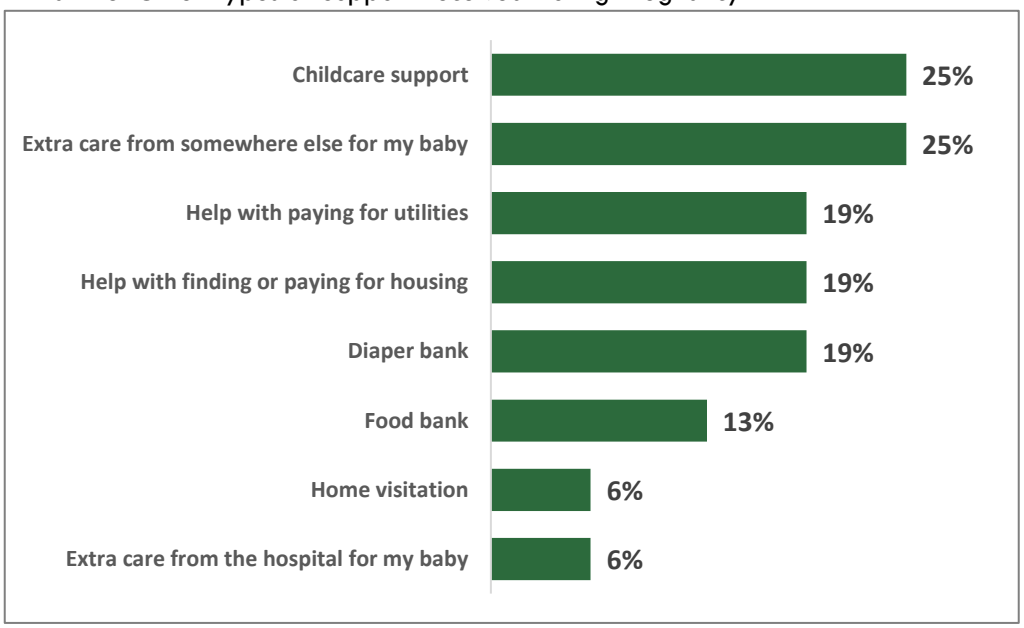
Exhibit 17. Other Sources of Support During Pregnancy



(N=16)

Only half (50%, n=8) of the women responded positively to the question about whether they received prenatal care while pregnant. Interestingly, all others left this item blank. In addition, the PPW respondents received a wide range of supports during their pregnancy including Childcare, extra baby care, utility payment, housing assistance, and free diapers (Exhibit 18).

Exhibit 18. Other Types of Support Received During Pregnancy

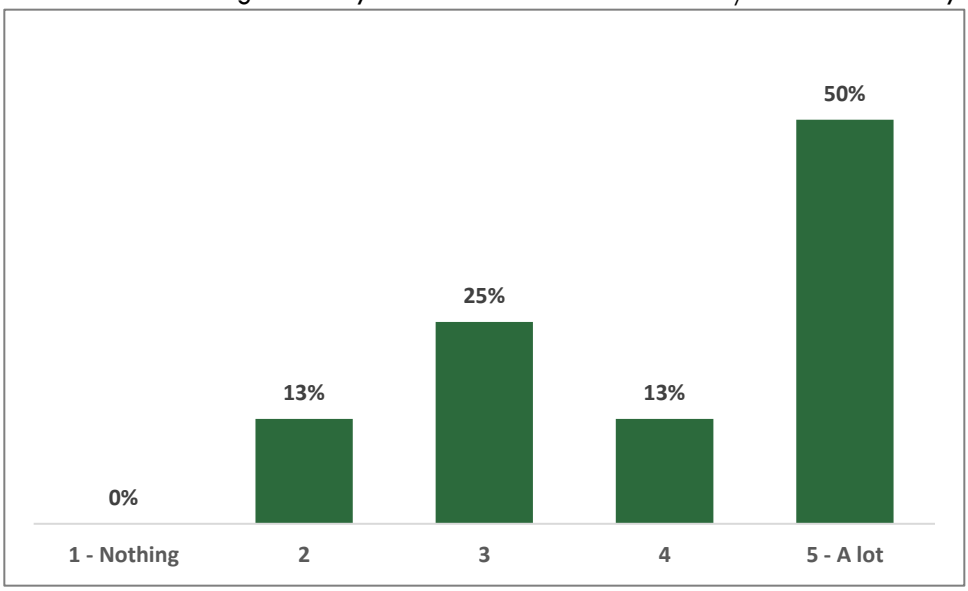


(N=16)

Knowledge

Half (50%, n=4) of the PPW Survey respondents reported having a lot of knowledge during their pregnancy about the medical needs and/or withdrawal symptoms their baby might have after they were born. In contrast, 38% (n=3) indicated they'd had little or only a modest amount knowledge (i.e., a rating of 2 or 3) about those potential health issues of their baby (Exhibit 19).

Exhibit 19. Knowledge of Baby's Potential Medical Needs and/or Withdrawal Symptoms After Birth



(N=8)

Recommendations

Only five participants responded with recommendations for improving this system going forward. These are included in Exhibit 20.

Exhibit 20. Recommendations from PPW Respondents

"Getting help before the baby comes will help you tremendously, and after baby comes you have a lot of support that can help with resources that you need."

"Make sure they are well educated about treatment centers with a non-judgmental tone. Also keep them updated with good sources for MAT services with in-patient treatment centers where you can be treated for substance abuse as well as have parenting classes for your child(ren) while your there as well as them being in your care."

"Just going into treatment into a rehab and getting all the help that is there for you and your baby."

"To be honest with everybody about your substance use."

"Hospital staff need to be more educated and the stigma needs to be broken."

PPW Case Study*

My drug of choice was heroine, and I was living on the street with my baby's daddy. On the street there was more stigma doing drugs as a pregnant woman than after I came in for services. People did not want to sell me drugs, use drugs with me, would not even allow me in the door anymore. I was pushed into recovery in that way. And I decided I did not want to be sick for myself and baby.

I called an OB/GYN, but they could not get me in for a few weeks. I felt bad, but I went to the hospital claiming I was in labor, so I could get checked out. I got a wonderful doctor at the hospital who I saw the last few weeks of my pregnancy.

I was not clear on what insurance I needed for rehab. There was a lot of conflicting information. Eventually I called them [a rehab facility] because I did not have more money—they came to get me that same day. I would have had to wait outside for intake during Covid. The driver took the long way as they saw I was pregnant, just so I did not have to wait outside so long. I was onboard from that moment on, and I knew I would stay longer than detox.

This was about 2 months before my baby was born. I did not know the sex of my baby yet. I thought that sharing I was a pregnant woman, who was not getting services until as late as I was, would be an issue. It never seemed to be one. Everyone seemed supportive. I felt that if I got there [through rehab] before I have the baby, then that is a win. Looking back, I wish I had done it earlier, rehab earlier, OB/gyn earlier. All the things I was scared about, once I got on Suboxone, things fell into place, and things that I thought would be issue were not, once I no longer was so focused on the drug.

I left rehab just a couple days before my son was born. They did not have the services focused for baby and mom together there at rehab. Luckily, I had parents to go to. The rehab place was adamant about making sure I had a safe place to go before I left. I felt really cared for in that moment.

For the birth, I wanted a C-section. The baby was in distress, so that is what happened, even though I did go into labor. Nobody was allowed to be there with me. The baby's father tried to come back, but his priorities were not there, and he did not come back. I was there by myself.

I did not get to hold my son when he was born. He was taken to the NICU. I knew he would probably be born with substances in his system. I knew I was drug-free, but not him. I waited a long time to hear those results from the NICU. I wanted to do everything right, so I divulged to the doctor the truth. I was happy to not go through the stress of lying anymore. CPS had already come to see him in the NICU. I decided I did not want to live on the street anymore.

During the several weeks he was in the hospital, I had to leave because of COVID. I had to get tested. I only got to come see him two days before he left. On the days I was at the hospital, I had to get my Suboxone from my outside provider. They let my mom get it from my provider and drop it off for me at the hospital.

In the NICU, there was the overall feeling of judgement from the nurses there. I felt they gossiped about me. It was hard to go visit him there. If I was upset, they asked me what was wrong. What is wrong is nobody was there, and it was my first kid, and I was scared! They would ask and then leave. Empathy but I feel more care was needed. I don't think I was the normal person they interact with. Maybe that is my own stigma too. I felt like they assumed I was a drug addict without any resources.

With COVID, I was not able to stay there as at very end in what they call mom-and-me room. I was told that the day before you leave, you stay with your child in a room and see what you are in-store for with

your baby. I would have loved to do that. More one-on-one time without nurses, babies, everyone. Time to just be us. I was looking forward to that one day. Without COVID, I was told I would have had that.

I was able to connect with my parents during this time. They were so excited to have me come home and live with them after many years. My son got to be third party released to my mom's home with me there. I got the best of CPS workers. I had to meet with a mediator and other people I had never met while he was at the hospital. They challenged me on many different things. They thought I was lying and hiding something. A DCS worker came forward, and said I was telling the truth. The mediator should have not taken a side in it. My case is closed now.

AHCCCS has been great not having to renew my KidsCare and that he will be covered until 18 no matter what. Right now, I could make $15/hour where I work, but don't, as I need the health insurance and my job will not provide it. I take a pay hit. I would love to know the differences in coverage and, if it is a matter of paying out of pocket for medications, how much that would cost, so I could decide. Maybe losing my insurance would be offset by making more money. I would want to know before I make that change. I tried to apply for cash benefits. I am smart and dedicated and the process was very confusing. It took almost two months through application, appeal, getting answers back, understanding what they said, and finally it should have been approved. But it was not. I have a job now and am self-sufficient. Many things I have learned by asking questions—nobody explained to me all this.

I had a default pediatrician assigned to my son and had to follow-up with them days after he left the hospital. He was not in the office that day, but another doctor was able to see him since it was a community of doctors in office. I liked her and switched to her. It was not an issue with changing doctors within that practice. I wish they had looked at zip-code when assigned a pediatrician though, so they could have made it a little closer to home. I have to travel far now, and I don't have a car.

My life is so much more together now than it ever was before.

*This case study is based on interview data from a woman with lived experience and other information provided by PPW. Some details were changed/reordered for confidentiality and clarity.

Key Stakeholder Survey Results

Stakeholder Respondent Demographics

Exhibit 21 shows that respondents to the Stakeholder Survey were from all three regions of the state, representing 56 zip codes. The regional breakdown below is described in the Methodology section and aligns closely with the AHCCCS Geographic Service Areas (GSAs).

Exhibit 21. Region and Zip code Demographics of Stakeholder Respondents

Region	Number of Zip codes Represented by Region	Percentage (Number) in Region
North	17	29% (25)
Central	22	44% (37)
South	17	27% (23)

(N=85)

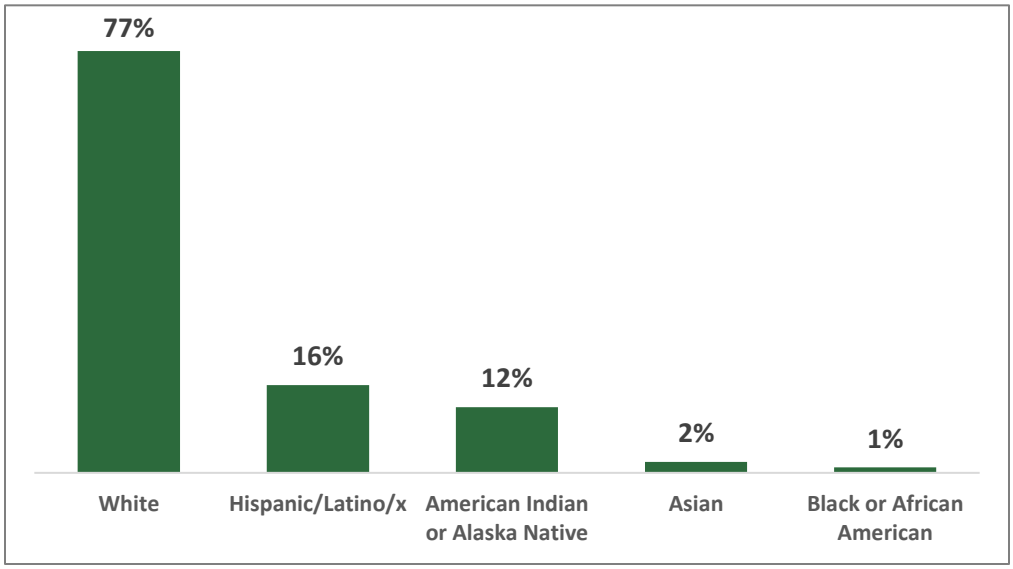
Respondents were from 9 of the 15 counties in Arizona, as shown below, with the largest percentages coming from Maricopa, Pima, Coconino, and Yavapai counties (Exhibit 22).

Exhibit 22. County Demographics of Stakeholder Survey Respondents

County	Percentage (Number)
Maricopa	44% (37)
Pima	22% (19)
Coconino	12% (10)
Yavapai	9% (8)
Navajo	4% (3)
Apache	2% (2)
Mohave	2% (2)
Pinal	2% (2)
Yuma	2% (2)

Over three-fourths (77%, n=67) of the stakeholder respondents self-identified as White (Exhibit 23). Other races/ethnicities with significant representation include Hispanic/Latino (16%, n=14) and American Indian/Alaskan Native (12%, n=10). Just under 90% (n=77) of the participants were female and almost 11% (n=9) were male.

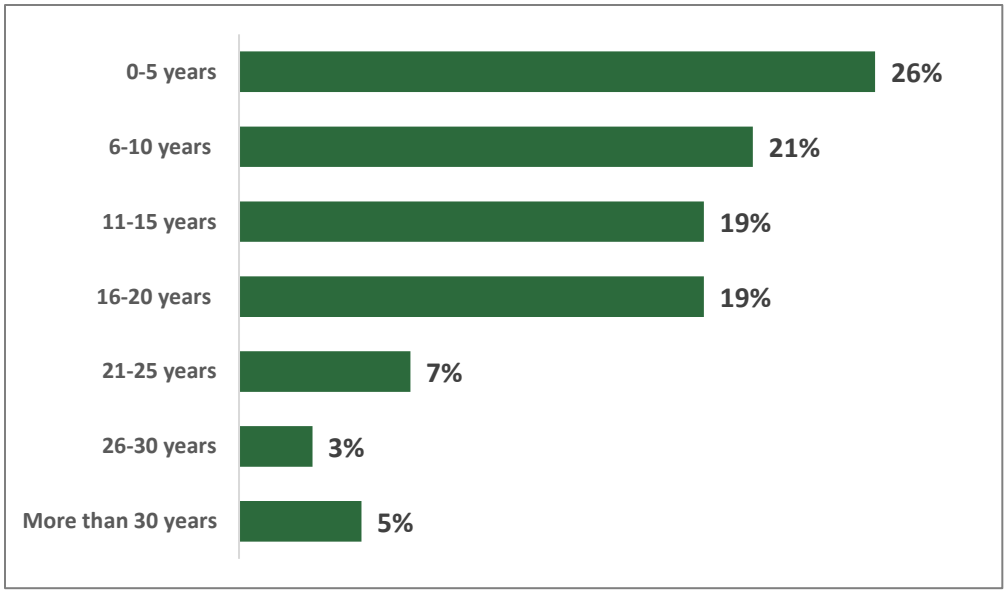
Exhibit 23. Stakeholder Respondents' Race/Ethnicity



(N=56)

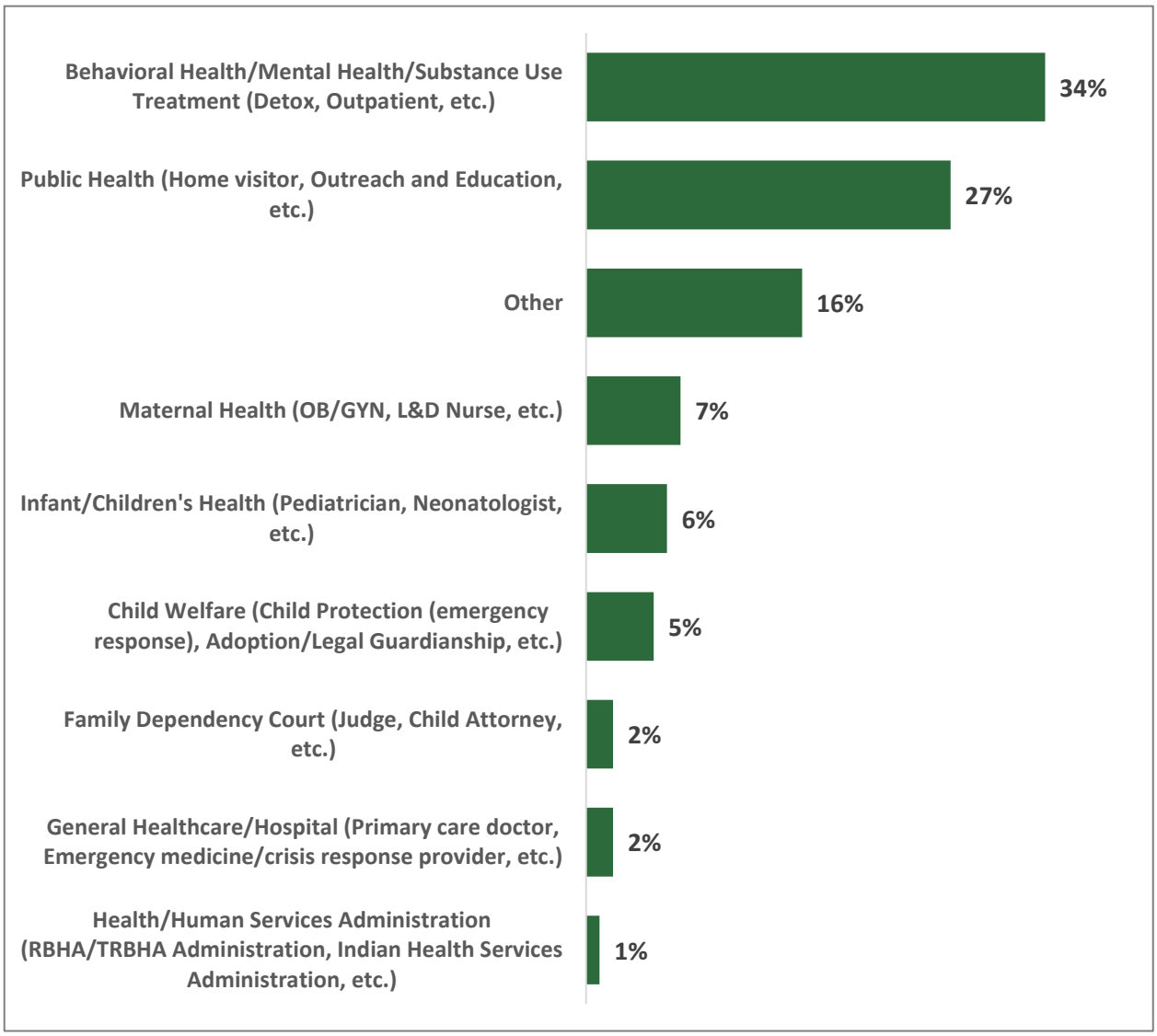
About a quarter (26%, n=15) of the stakeholder respondents have worked with mothers experiencing SUD/OUD or their babies for five years or less although a substantial proportion of them (34%, n=20) have worked with one of these populations for 16 years or longer (Exhibit 24).

Exhibit 24. Number of Years Stakeholder Respondents Have Worked with Mothers Experiencing SUD/OUD or Their Babies



The largest proportion of the stakeholder respondents (34%, n=28) work in Behavioral Health/Mental Health/ Substance Use Treatment, followed by 27% (n=22) who work in public health (Exhibit 25).

Exhibit 25. Category of Work Done by Stakeholder Respondents



(N=83)

Organizations Represented

Almost all (97%, n=84) of the participants reported that their organization works in some way with mothers with SUD/OUD or their babies. The greatest proportion (43%, n=35) of stakeholder respondents identified their organization as being in the Behavioral Healthcare/Mental Health/Substance Use Treatment sector (Exhibit 26).

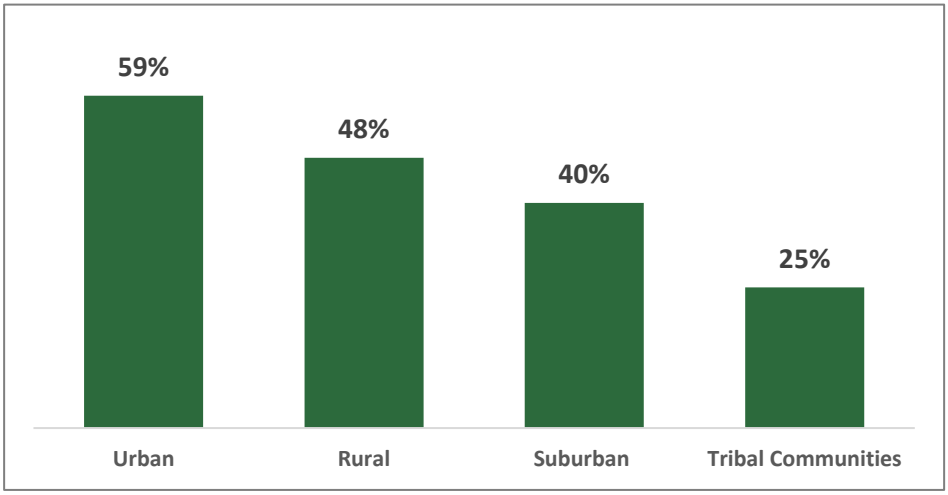
Exhibit 26. Sector of Stakeholder Respondents' Organizations

Sector	Percentage (Number)
Behavioral Healthcare/Mental Health/Substance Use Treatment	43% (35)
Other Social Services	15% (82)
Government	10% (8)
Maternal Healthcare	10% (8)
Infant/Child HealthCare	9% (7)
Child Welfare	6% (5)
Court/Justice System	2% (2)
Emergency/Crisis Responses	1% (1)

(N=82)

Sixteen of the 82 participants (16%) indicated they were affiliated with or part of a tribe. Respondents could also indicate one or more population density areas that they serve including urban, rural, suburban, and tribal communities (Exhibit 27).

Exhibit 27. Areas Served by Stakeholder Respondents' Organizations

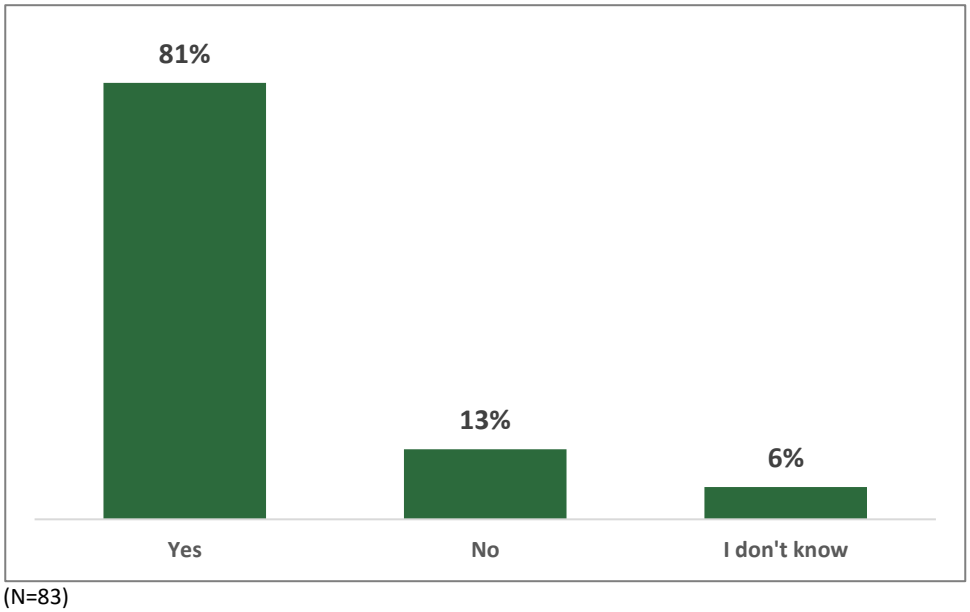


(n=87). Percentages do not total to 100% as respondents could indicate multiple selections.

Services Provided

Sixty-seven of the 83 participants (81%) reported that the services their organization provide to women with SUD/OUD or their babies are reimbursed by AHCCCS (Exhibit 28).

Exhibit 28. Whether the Majority of Services for PPWs with SUD/OUD or their Babies at Stakeholder Respondents' Organizations s are Reimbursed by AHCCCS



(N=83)

Two-thirds (66.3%, n=57) of the respondents' organizations specialize in serving or supporting women with OUD/OUD or their children. Almost three-fourths (74%, n=61) of the participants' organizations provide telehealth services to PPW. Eighty-one percent of the respondents receive reimbursement from AHCCCS for the services they provide to a majority of the PPWs and their babies (Exhibit 29).

Exhibit 29. Characteristics of Stakeholder Respondent's Organizations' Services

Organization Characteristic	Yes	No
Specializes in treating/serving/ supporting PPWs and/ or their babies	59% (49)	41% (34)
Provides telehealth services to PPWs and/or their babies	74% (61)	27% (22)
Services for a majority of PPWs and/or their babies serves reimbursed by AHCCCS*	81% (67)	13% (n=11)

(N=83). This question also had an "I don't know" response option, which 6% (n=5) of the respondents chose.

Descriptions of the services provided suggest that about half of those stakeholders that responded to the survey **focus significantly on serving this population (**PPW with SUD/OUD). Examples of the types of services include:[3]

> "We have a program for pregnant patients with substance abuse specifically designed for pregnant women. This includes 2 maternal fetal medicine [practitioners], (both of whom are skilled in addiction management), a Nurse practitioner, and connections with social services/treatment centers…"

> "[Our hospital] offers a Family Centered NAS Care Program. This program is a NICU-based effort to create better outcomes for infants with NAS. Mom-baby dyads that have been able to go through our program have seen the benefits of decreased length of stay, decreased postnatal morphine use for baby, and an increase in the number of these family units that remain intact with the mandated DCS involvement."

> "Our Women's Health Dept. also runs a Maternity Outreach Mobile Unit (MOMobile)... Depending on the substance, the parent might be referred to MAT programs, detox, in-patient substance abuse treatment if they agree. When the baby is born, and if found to have additional needs (and was in the NICU), post-discharge, the in-patient social worker will refer her to [a grant funded program for additional support]."

> "Maternal Care Managers support pregnant members who are high risk including those with SUD. They educate members and coordinate resources. The health plan contracts with providers who treat SUD. Pediatric Care Managers manage newborns with NAS throughout the NICU stay and post discharge. The health plan contracts with [a specific] Baby Nursery to also treat babies post-delivery to either shorten or prevent a NICU stay."

> "[We offer] residential substance use utilizing Native American traditional healing practices, trauma informed care, using Hazelton's Living in Balance Curriculum, and Native specific parenting, domestic violence and White Bison & Read Road to Recovery. [We] specialize in treating pregnant and parenting SUD using women, with their dependent children, couples and families – keeping the family together in treatment."

> "[Our] outpatient program provides services to women and pregnant women and post-partum woman. Infants are welcome to join mom in the program."

[3] A comprehensive analysis of all providers serving this population was not conducted, and thus, this should not serve as a complete list of those services available. In addition, only some responses added the name of their organization. These were removed to not over-emphasize the work of any one provider with out a review of the type/quality of services they provide. This description is intended to capture the array of service types occurring in Arizona for this population.

"The nurses provide in home (now virtual) visits to all babies that have a NAS diagnosis or have been in the NICU for greater than 5 days. The nurse supports these families with health and developmental education and community resources that they may qualify for."

"We use a Peer Model to deliver services to pregnant and post-partum women with substance use disorders . We have peers who have received advanced training to become Doulas birth coaches to meet the needs of pregnant / pregnant women with SUD. This is what we consider our area of expertise as many of us have spent our careers working with the population…"

The other half of the responses were from **more general providers that may also come across some members of this population** in their standard care. Some focus their work with PPW but not *specifically* with those experiencing SUD/OUD, while others serve those experiencing SUD/OUD but not *specifically* PPW. Examples of this type of response include:

"We work with mothers who are breastfeeding or providing breast milk to their infants. I also facilitate groups for families…."

"[Our] home visitation program serves pregnant and new mothers. Many of our participants had experienced substance abuse in their life, and others have a substance abuse addiction, and they are struggling with rehabilitation."

"We serve this population, but we have no specialized services."

"We provide services for expectant moms and dads. A significant number of the women we work with are using substance or have experienced addiction in their past. We provide decision making counseling, parenting support, and adoption planning in our pregnancy counseling program. We also serve at risk parents…This program is focused on preventing kids from going into care by providing a safe space for children to go while the family is in crisis. Some of the women and men we work with are experiencing addiction or have experienced addiction in the past…"

"[We offer] Medication Assisted Treatment; Counseling and Drug treatment intervention."

"[We are an] integrated care community health center"

"[We provide] dependency support, parenting classes, CASA volunteers, visit coaching."

Some also described their organization's role as primarily one of **linking PPW to services** through screening, referrals, or case planning. Examples of this type of response include:

> "[We provide] behavioral health services provided to incarcerated pregnant women, and release planning for incarcerated pregnant women."

> "Linking this population to home visitation supports…"

> "My organization does home visitation services. A program for all parents, prenatal mothers, and their children birth to 5yrs of age. [This program] offers the following services: Personal visits: two scheduled visits per month; developmental screenings: Two scheduled screenings per year, includes vision, hearing screening; Referrals to resources: Connect families with local programs according to their needs or request; Group connections: Monthly parent trainings/family activities, and cultural nights."

> "Prenatal care – serve small population through contracted prenatal care; many high-risk pregnancies are transferred out. We do try to link moms with SUD with our integrated behavioral health provider and with our behavioral health services on site."

> "Screening with Edinburgh, as well as working with medical providers (Obs., neonate practitioners, etc.) to identify, link, and coordinate services. Also looking at…additional screening tools. Provide [home visitation] that is also coordinated with local mental health and MAT providers.

Resources Available

The stakeholder respondents identified leadership, technology, and staffing as being the resources their organizations had the greatest sufficiency in for serving PPWs experiencing SUD/OUD and their babies (Exhibit 30).

Exhibit 30. Sufficiency of Resources at Organizations for Serving PPW with SUD/OUD and Their Babies

	Not at All Sufficient 1	2	3	4	Very Sufficient 5	I Don't Know
Leadership	5%	5%	14%	17%	**52%**	7%
Technology	10%	5%	10%	29%	**40%**	5%
Staffing	7%	9%	26%	17%	**33%**	9%
Physical Space/ Wards/Beds	30%	5%	11%	9%	**23%**	21%
Financial Resources	17%	9%	26%	21%	**21%**	7%

Fifty-eight participants answered for all of the characteristics except Physical Space, for which 56 answered.

Physical space/wards/beds were the resource area that notable proportions of stakeholder respondents in all regions rated as being not at all sufficient, with North most indicating this gap. Almost a third of the stakeholder respondents from the South (31%, n=5) also indicated financial resources were not at all sufficient in their region (Exhibit 31).

Exhibit 31. Percent of Stakeholder Respondents Indicating Resources ***Not at All Sufficient*** by Region

	North N=14	Central N=25	South N=16	Overall N=58
Leadership	7%	7%	0%	5%
Technology	14%	4%	19%	17%
Staffing	7%	7%	6%	7%
Physical Space/Wards/Beds	43%	24%	31%	30%
Financial Resources	21%	7%	31%	17%

Fifty-eight participants answered for all of the characteristics except Physical Space, for which 56 answered.

Participants were also asked to describe any significant resource gaps. The 36 stakeholders who responded indicated some of the primary gaps include housing and/or residential services for this population, availability of specialty providers (e.g., behavioral health provider serving mothers, physicians) and adequate staffing, funding challenges (e.g., billing that allows parent/child to stay together, review use of SABG, need longer treatment timeline), and challenges with cross-sector collaboration/referrals (e.g., close-looped referrals, whereby the initiating organization is also informed of the outcome of the referral).

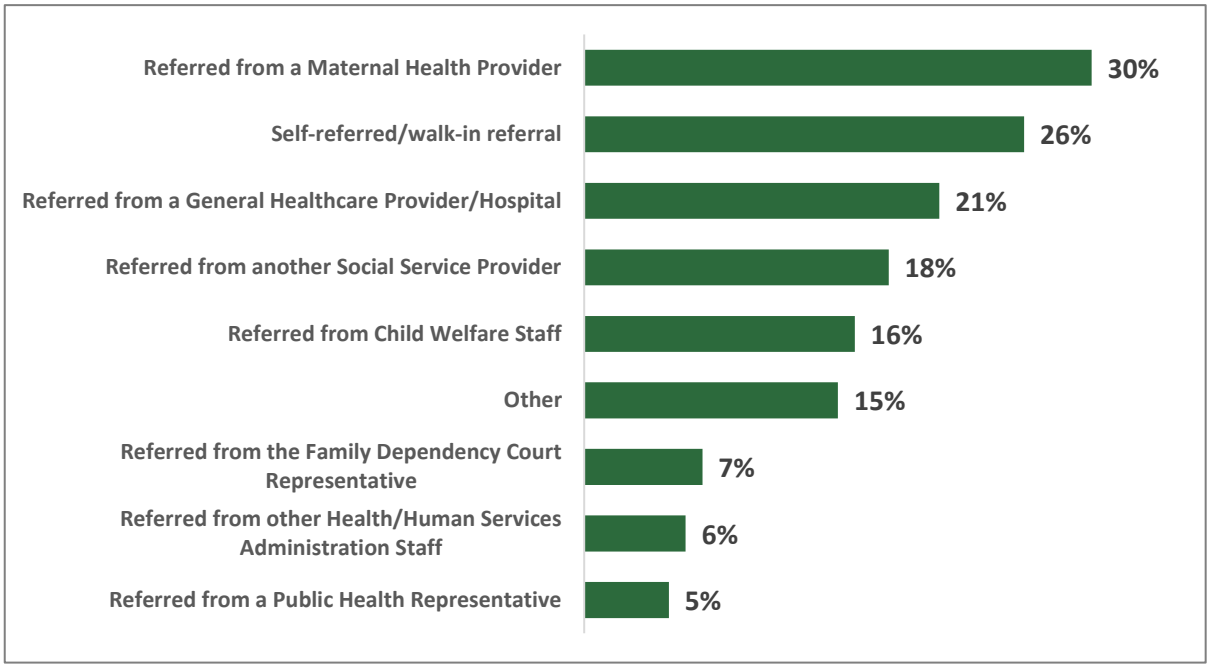
There is a serious gap between the needs of pregnant/postpartum women, their very young children, and the number of providers available & trained to deliver quality mental health services. While [our organization] has rich and comprehensive programming, the demand quickly outpaces the staffing system wide. Additionally, the rates provided do not adequately cover competitive salaries for skilled practitioners creating turn over and burn out…

Investment in trauma informed care and the value of keeping mothers and babies together would also be a game changer for the DCS system.

Connectivity/Communication Across the System

Participants' organizations most commonly receive referrals from a maternal health provider (30%) and self-referrals (26%) (Exhibit 32). "Other" responses included jails, MAT facilities, probation, pregnancy resource centers, health plans, and judicial agencies.

Exhibit 32. Common Referral Sources



(N=87)

The largest proportion of stakeholder respondents (53%, n=28) were very confident they would be able to successfully refer a PPW experiencing SUD/OUD or their baby to a hospital serving such populations, followed closely by 50% (n=27) of the respondents who felt similarly confident that they could secure a referral with a maternal health provider (Exhibit 33).

Exhibit 33. Confidence in Securing a Referral for PPWs Experiencing SUD/OUD or Their Babies

Referral Destination	Not at All Confident 1	2	3	4	Very Confident 5
A hospital that serves this population. (n=53)	6%	11%	11%	19%	**53%**
A Maternal Health Provider that serves this population. (n=53)	4%	13%	15%	19%	**50%**
A Behavioral Health/Mental Health/Substance Use treatment provider that serves this population. (n=54)	6%	11%	20%	15%	**48%**
An Infant Health Provider that serves this population. (n=53)	8%	15%	19%	19%	**40%**
An appropriate Crisis Response Provider (n=54)	15%	9%	15%	22%	**39%**

More than half of the stakeholder respondents rated their level of knowledge of how other sectors work PPWs and their babies as being moderate or high (i.e., 4 or 5) with the exception of the court/justice system, government, and other social services. They were most knowledgeable of how the behavioral healthcare/mental health/substance use treatment sector works with this population (Exhibit 34).

Exhibit 34. Knowledge of How Other Sectors Work with PPWs and Their Babies

Sector	Know a Little 1	2	3	4	Know a Lot 5
Healthcare – Maternal	4%	8%	**30%**	**30%**	28%
Healthcare – Infant/Child	6%	4%	**32%**	28%	30%
Healthcare – All Others Including Hospitals	4%	4%	**34%**	30%	28%
Emergency/Crisis Response	8%	11%	23%	**38%**	21%
Behavioral Healthcare/Mental Health/Substance Use Treatment	4%	9%	13%	36%	**38%**
Court/Justice System	8%	19%	**38%**	26%	9%
Child Welfare	4%	8%	**29%**	37%	23%
Government	8%	15%	**55%**	15%	8%
Other Social Services	2%	15%	**40%**	29%	14%

(N=-87)

The largest proportions of stakeholder respondents reported having "a lot" of opportunities collaborating with the various population-specific and more general healthcare sectors – maternal, infant/child, and "others" including hospitals as well as behavioral healthcare/ mental health/substance use treatment. A notable proportion of the respondents had also collaborated with the child welfare moderately or a lot (i.e., at the 4 or 5 levels) (Exhibit 35).

Exhibit 35. Opportunity to Collaborate with Other Sectors

Sector	Not at All 1	2	3	4	A lot 5
Healthcare – Maternal	4%	19%	23%	21%	**34%**
Healthcare – Infant/Child	8%	17%	19%	19%	**37%**
Healthcare – All Others Including Hospitals	8%	12%	**31%**	19%	**31%**

Sector	Not at All 1	2	3	4	A lot 5
Emergency/Crisis Response	13%	19%	**38%**	21%	9%
Behavioral Healthcare/Mental Health/Substance Use Treatment	9%	0%	25%	32%	**34%**
Court/Justice System	23%	13%	**23%**	**23%**	19%
Child Welfare	13%	8%	21%	**36%**	23%
Government	17%	**26%**	25%	19%	13%
Other Social Services	6%	6%	**41%**	33%	14%

(N=87)

The stakeholder respondents indicated that the highest levels of collaboration (i.e., 4 or 5) their sector had was with the infant/child healthcare and behavioral healthcare/mental health/substance use treatment sectors. In contrast, they rated collaboration with the child welfare, government, court/justice system, and emergency/crisis response sectors as being least effective (Exhibit 36).

Exhibit 36. Effectiveness of Collaboration

Sector	Not at All Effective 1	2	3	4	Very Effective 5	N/A
Healthcare – Maternal	2%	17%	26%	**32%**	19%	4%
Healthcare – Infant/Child	6%	19%	**25%**	19%	**25%**	6%
Healthcare – All Others Including Hospitals	4%	17%	**30%**	26%	19%	4%
Emergency/Crisis Response	8%	24%	**32%**	20%	14%	2%
Behavioral Healthcare/Mental Health/Substance Use Treatment	4%	15%	**29%**	25%	23%	4%
Court/Justice System	16%	12%	**34%**	14%	12%	12%
Child Welfare	20%	10%	**33%**	22%	14%	2%
Government	19%	17%	**23%**	**23%**	6%	11%
Other Social Services	11%	11%	**30%**	**30%**	17%	2%

Respondents who indicated that some collaboration had not been effective, were asked to describe it and why they thought it was the case. A total of 19 respondents described a few different types of challenges they experienced. Collaboration with DCS and the approach they take (perceived focus on removing the child) was noted by multiple participants. In addition, challenges with staff turnover, time available for the coordination/collaboration, and follow-through by referring agencies were noted.

We would very much like to collaborate more with OB/GYN providers, pediatricians, and child welfare services. Of those entities, the limiting factor appears to be time and attention as they are usually stretched quite thin. Phone calls, emails, and other attempts to outreach to them typically go ignored for long periods of time, if we receive any response at all. ~Key Stakeholder

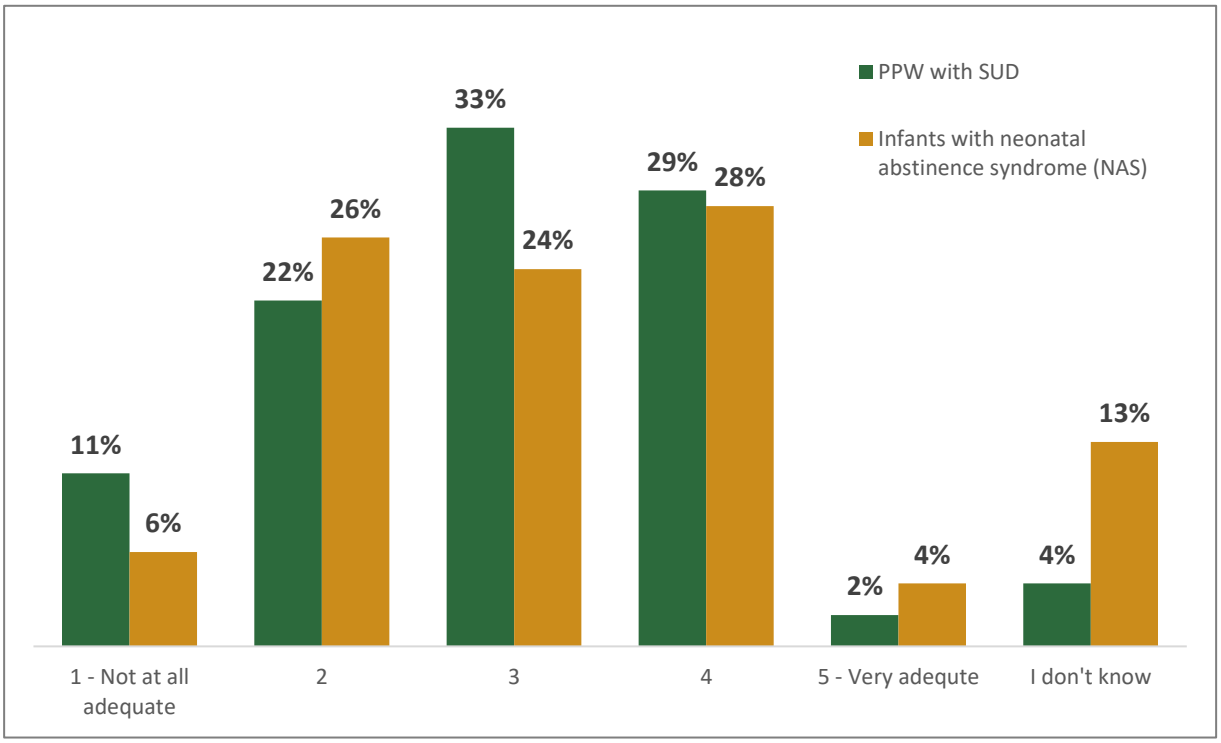
Several individuals noted the need to make the crisis system better equipped to meet the needs of this population.

The crisis system is not designed to meet the needs of women who are pregnant and or have children in my opinion. A mother in need of crisis services will not enter services due to no childcare or respite services in place to provide wrap around support. There needs to be respite for families, allowing women to safely place children while she seeks services, without fear of child welfare removal of children due to crisis admission. ~Key Stakeholder

System Access and Gaps

Only 31% (17) of the stakeholder respondents rated the adequacy of services and supports in their community for PPW with SUD/OUD at either of the two highest levels (4 or 5) (Exhibit 37). Similarly, a third of the stakeholder respondents (32%, n=17) rated the adequacy of services or supports in their community for infants with NAS at either of the two highest levels (4 or 5). More respondents indicated that supports for PPW with SUD/OUD are not at all adequate (11%, n=6) than respondents did for infants with NAS (6%, n=3).

Exhibit 37. Adequacy of Services/Supports for PPW and Infants with NAS in Stakeholder Respondents' Communities



(N=55 PPW; N=54 Infants with NAS)

Higher percentages of respondents in the Central and South region indicated that services for PPW were at the top two levels of adequacy (4 and 5) (Exhibit 38).

Exhibit 38. Adequacy of Services for PPW by Region

	Not at All Adequate 1	2	3	4	Very Adequate 5	I Don't Know
North (n=12)	17%	**50%**	7%	8%	0%	**8%**
Central (n=26)	12%	15%	31%	**53%**	20%	7%
South (n=15)	7%	13%	**53%**	20%	7%	0%
Total (n=55)	11%	22%	**33%**	29%	2%	4%

A higher percent of respondents in the North region, as compared to the Central and South, indicated that they did not know about the adequacy of services for infants with NAS (33%, n=4). A higher percent of respondents in the South region indicated that services were very adequate (13%, n=2) (Exhibit 39).[4]

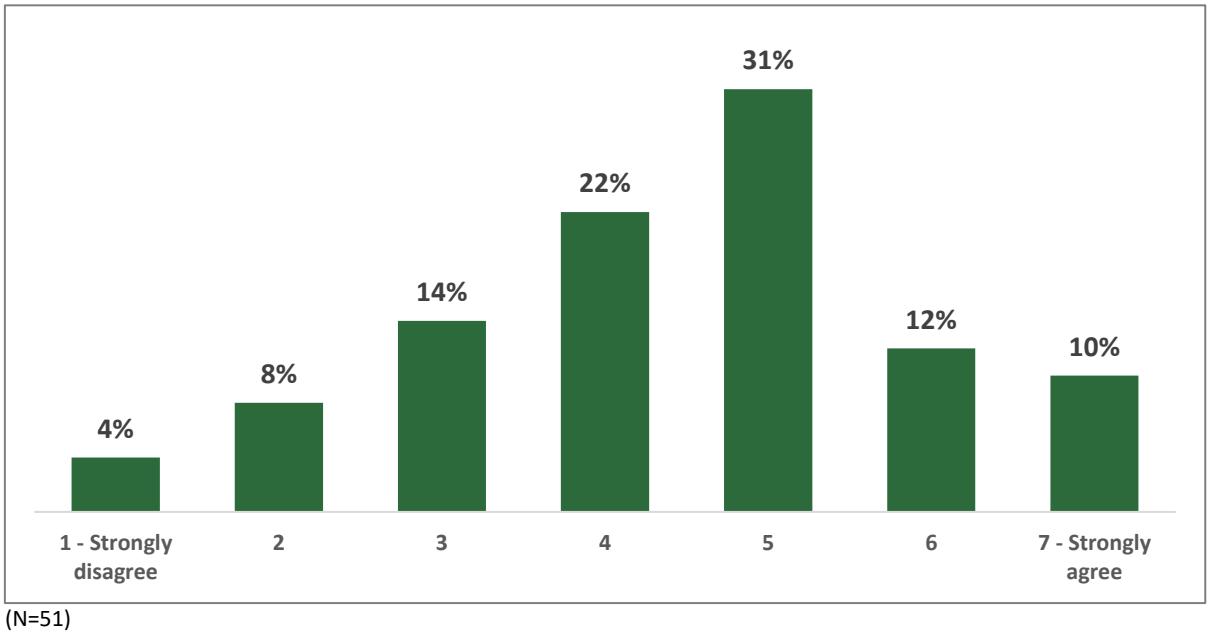
Exhibit 39. Adequacy of Services for Infants with NAS by Region

	Not at All Adequate 1	2	3	4	Very Adequate 5	I Don't Know
North (n=12)	8%	**42%**	0%	17%	0%	**33%**
Central (n=26)	4%	23%	**35%**	31%	0%	8%
South (n=15)	7%	20%	**27%**	**27%**	13%	7%
Total (n=55)	6%	26%	24%	**28%**	4%	13%

Information/Education Needs

Over half (53%, n=27) of the stakeholder respondents agreed at one of the three highest level (5, 6, or 7) that they have the information they need to serve PPW with SUD/OUD (Exhibit 40). However, at least 25% (n=13) selected one of the three lowest rating levels regarding having such information.

Exhibit 40. Have the Information Needed to Serve PPW with SUD/OUD



(N=51)

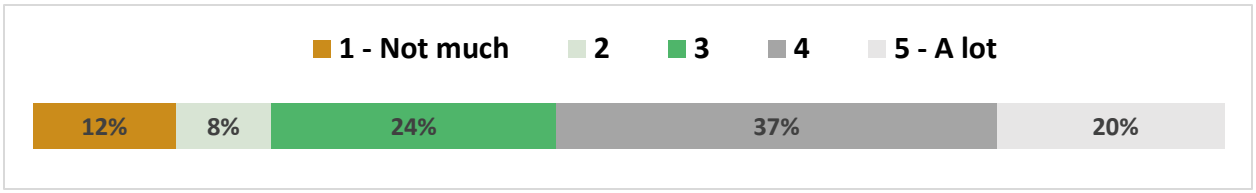
[4] It should be noted that these are small sample sizes and may or may not reflect the entire region.

It really starts with social work, nursing, physicians about decriminalizing it and provide the support that they need to give to moms to help them get over the shame and guilt. The decriminalization is important to change the thinking from moms being a criminal to being someone who deserves treatment. ~OB/Pediatric Provider

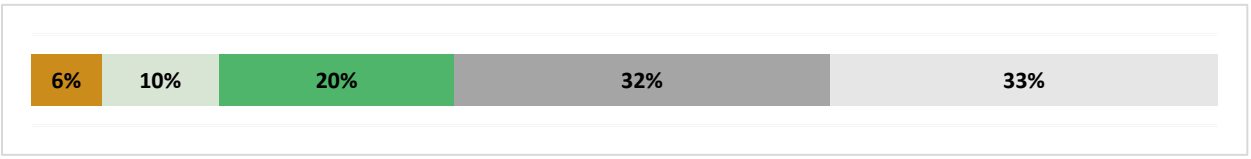
More than half the stakeholder respondents (57%, n=29) reported having a moderate or high level of knowledge (i.e., 4 or 5) of best practice models for treating Substance-Exposed Newborns (SEN)/Neonatal Abstinence Syndrome (NAS). Two-thirds (n=33) of the stakeholder respondents reported having a moderate or high level of knowledge of family-centered care models to support mother-baby dyads. Two-thirds (n=34) of the respondents indicated they have a moderate or high level of knowledge about substance use disorder treatment methods. Two-thirds (n=34) of the respondents indicated they have a moderate or high level of knowledge about the various pathways through which women end up experiencing SUD/OUD. Only 40% (n=20) of the stakeholder respondents were moderately or highly knowledgeable of the *Eat, Sleep, Console* Model of caring for babies with NAS. Almost two-thirds of the stakeholder respondents (65%, n=33) indicated they have a moderate-to-high level of knowledge about how to refer PPWs to resources and supports unrelated to healthcare. Almost three-fourths (73%, n=36) of the stakeholder respondents reported having a moderate or high level of knowledge on how to help PPWs with SUD/OUD enroll in AHCCCS (Exhibit 41).

Exhibit 41. Summary of Stakeholder Knowledge[5]

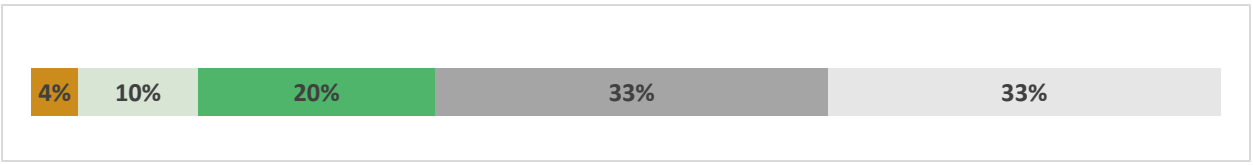
Best Practice Models for Treating SEN/NAS



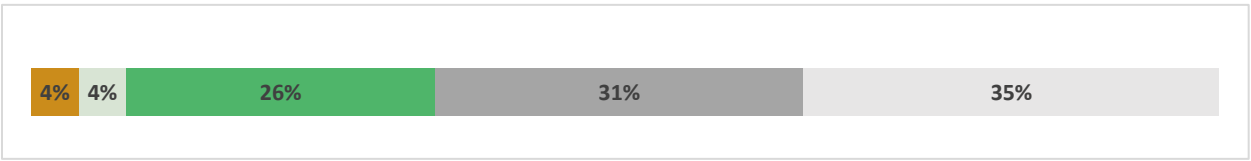
Family-Centered Care Models to Support Mother-Baby Dyads



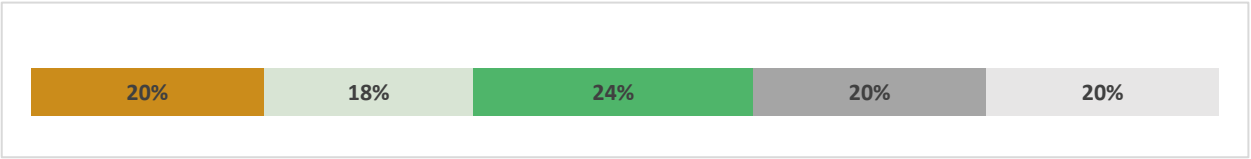
Substance Use Disorder Treatment Methods



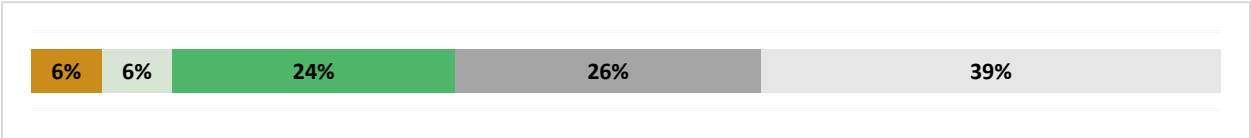
Pathways Through Which Women End Up Experiencing SUD/OUD



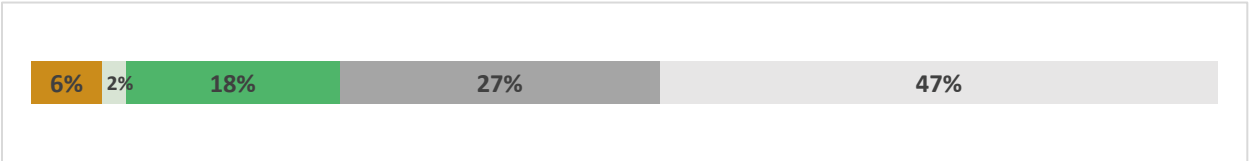
Eat, Sleep, Console Model



How to Refer PPWs with SUD/OUD to Non-Healthcare Related Resources/Supports



How to Help PPWs with SUD/OUD Get on AHCCCS



[5] All items have a total of 51 respondents (n=51) except for the last item on PPW with SUD/OUT receive access has 49 respondents.

When asked, some stakeholders indicated statements related to infants with NAS that were untrue and/or with the potential to be stigmatizing (Exhibit 42). Perceptions regarding this table may vary, but these indicate the wide variety of ways in which people consider this population and potential gaps in information that may exist.

Exhibit 42. Perceptions and Knowledge of NAS/SEN

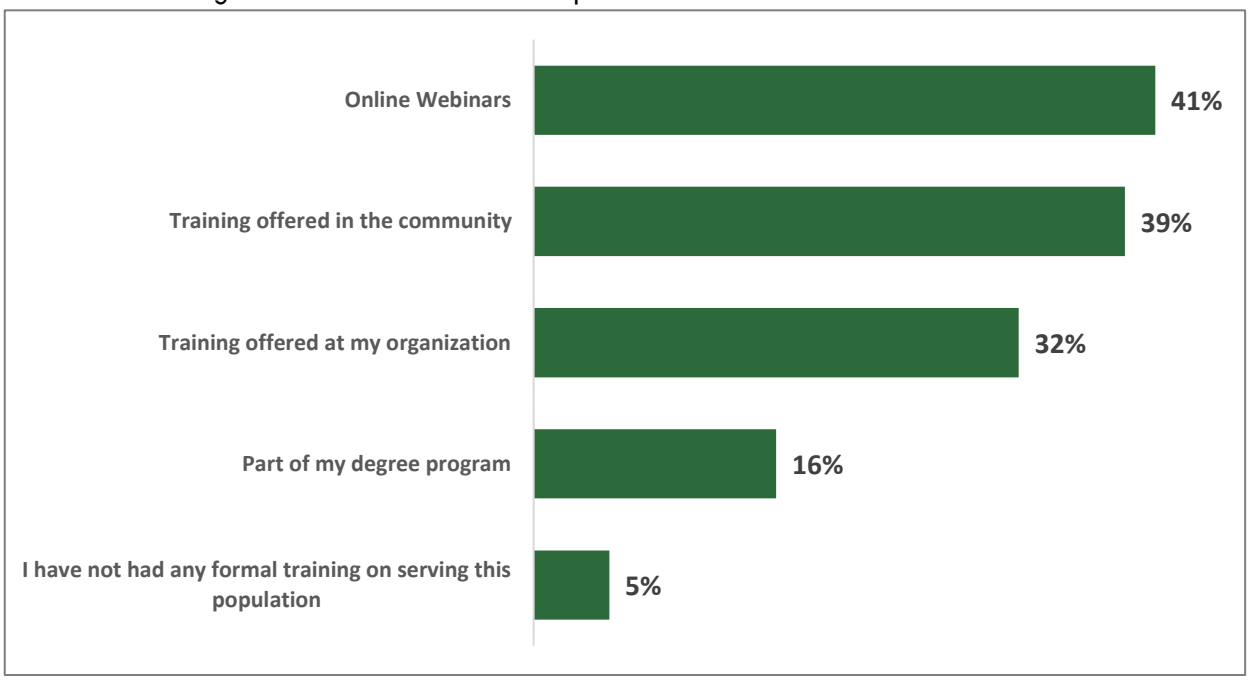
Statement	Statement is untrue and/or stigmatizing	Percentage (number) that reported statement was true
They have a disease inherited from their mothers that can be treated.		17% (15)
They have a withdrawal syndrome because of exposure to certain substances during pregnancy.		53% (46)
They have a disease inherited from their mothers that cannot be treated.	√	1% (1)
They are victims.	√	16% (14)
They always need a chemical intervention/treatment for recovery.	√	2% (2)
They are addicted babies.	√	6% (5)
They have been hurt by the mother's poor choices.	√	10% (9)
The best practice is for them to be monitored/cared for by nurses in the NICU while the mom recovers separately.	√	3% (3)

(N=87)

It [stigma] comes down to misinformation. 80% misinformation with good intention, but some is more the judgment around "addiction is a choice." People in these roles are usually caring passionate people just need the right information…. Empathy for it happening, from an innocent point of view, but I can see how much it affects those receiving it.

Stakeholder respondents indicated they had received training about prenatal substance exposure from a variety of methods include online webinars (41%, n=36), training offered in the community (39%, n=34), or training offered at my organization (32%, n=28) (Exhibit 43).

Exhibit 43. Training About Prenatal Substance Exposure



A total of 17% (n=15) indicated that training on serving PPW with SUD/OUD and their children is required at their organization. Another 40% (n=35) indicated that it was not, with the remainder not responding to this item. Most that did have it required, suggested that it was annual or ongoing.

I would make it a requirement that there should be extra training and consultation help for maternal mental health disorders for all program staff that are working with pregnant and postpartum women. ~RBHA/Behavioral Health Provider

Participants were asked to indicate what types of training/information would help them better serve this population. Twenty-three respondents identified that they would like more training/information in areas including MAT, community resources (specific to their communities, including tribal communities), SUD/addiction diagnoses/treatment, best practices in serving PPW with SUD/OUD, effects of substance exposure on child development, trauma-informed care, breastfeeding benefits, infant mental health, family attachment/safety, and current treatments and programs available for this population.

Key Stakeholder Recommendations

Thirty-six respondents provided information on how the system of care in Arizona for PPW with SUD/OUD and infants with NAS/SENS could be improved (Exhibit 44).

Exhibit 44. Recommendations from Stakeholders on Ways to Improve the System of Care

Key Theme	Summary of Recommendations
Resources/ Treatment Options (n=19)	• Service options that keep mom/baby together (including during treatment, post-delivery). • Residential and/or specialty treatment facilities for PPW with SUD. • Consider innovations (e.g., peer run models). • More wrap-around services. • Referring families to existing support programs (e.g., home visitation, support groups. • Establish a full system of care for this population
Collaboration (n=14)	• Earlier and/or universal screening and referral. Streamlined process. • Improve collaboration and coordination between all parts of the health system and DCS (and when does DCS not need as much involvement). • Improved collaboration with OB-GYN and medical providers. • More engagement/collaboration with behavioral health sites. • Bring cross-sector decision-makers to the conversation (DCS, probation, hospital providers and mental health). • More use of care plans and sharing of these plans across providers/DCS. • More case management/care coordination (including engaging with health plan maternal care managers to support PPW). • More collaboration and cooperation, rather than competition.
Education (n=12)	• Educational materials for PPW and classes on infant care. • More provider education (e.g., nurses, pediatricians, OB-GYN, hospital providers) on topics such as perinatal mood disorders, treatment options, prenatal care. • Sharing stories of mothers/babies.
Funding (n=6)	• For specialized care (e.g., offer incentives for providing this care). • Funding to support staffing (and prevent overworked staff). • Consider how SABG is used.
Stigma Reduction/ Culture Change (n=6)	• Normalizing self-care and mental health (and that having a baby can be exhausting and it is ok to need support). • Stigma reduction campaigns focused on healthcare providers.

Perspectives from the Field

This section includes highlights from specific populations that were interviewed and or participated in focus groups. This adds to a more comprehensive picture of the perspectives different stakeholder types may have on this topic. Findings are based on limited samples and may not be representative of the full stakeholder group.

Perspectives from the Field: OB/Pediatric Providers	
Participants: 8 focus group participants and 5 key stakeholder interviews. Includes stakeholders from nonprofits specifically serving PPW and their children, hospital nursing directors, and other service providers working more indirectly with this population (e.g., WIC or home visitation providers).	
What works serving this population:	• Eat, Sleep and Console method (mentioned by most participants) • Breastfeeding when possible is best • Specialized support services for at-risk populations (e.g., girls in foster care) • Making services more treatment focuses rather than criminalizing (and keeping mom with baby if mom compliant with treatment) • Treating mother without judgement and providing information about how the whole timeline from prenatal care, treatment services and what they can do to support their babies • Offer respite and try and encourage mothers to access support to get through treatment and the post-natal period from anyone they can (family, friends etc.) • Wrap-around housing, treatment and support services for mothers and their children (through 1 year old and ideally longer as needed). One place to go and stay minimizes barriers e.g. (transportation, accessing referrals, timing of service availability) • Trauma-informed and integrated care • Services where baby can come too • Provider consistency and trusting relationships
What are the challenges:	• Infants with NAS that are not with the bio-mom • Mothers with infants born with NAS for reasons such as pain medication for a chronic condition—avoiding stereotype, being compassionate and non-judgmental • Mothers not in treatment who have baby—harder for them as in withdrawal etc. • Billing codes for the mothers not just the babies. Appropriate ICD-10 Codes that can be pulled to look at numbers of mothers/babies with PPW/NAS • Systemic challenges that effect this population (e.g., housing) • Limited capacity/funding to serve this population (particularly mentioned related to services outside of hospital setting) • Hospitals not referring out to other providers

Communication and Collaboration Challenges:	• Mother not following through on referrals that are made is challenging. • Not enough behavioral health services available by AHCCCS funded providers (or not available fast enough; e.g., 3 months before can be seen for treatment won't work for this population). Many providers in the state that they suggested could help, but aren't AHCCCS contracted providers • Some collaborative work happening within larger provider systems to serve this population. New collaborations coming about or underway. • Improving communication between providers and DCS and understanding the role of each is needed. • Different providers with very different understanding of this population, MAT, SUD, etc. even within same sites • Competition amongst providers for services/dollars. • Collaboration requires planning, coordination, and roles/responsibilities • Need funding for the case management work that is needed. • Ability to have connected information on what is happening in these women's lives (police reports, different providers, etc.).
What are the gaps:	• Not enough housing services/supports. • Not enough residential services, particularly for families with other children or where both parents in recovery. • SENSE program closes too soon-6 weeks after delivery (need 6 months to a year for them to really be ready). • Not enough mental health services tailored to PPW mental health. • Resources that are available are hard to navigate. • Lack of transportation. • Not enough prenatal intervention (more happens after birth of baby when mandatory report is made to DCS). • Waitlists/limited capacity for the specialized programs for this population. • Need more peer support for this population. • Not enough time (that is funded) to care for this population. • Services offered by providers that align with culture/language preferences.
What resources/ information are needed:	• Education and information available on serving this population, but not everyone has it or has been trained. More dissemination. • MAT directory. • Need resource information for the mom. • More training on trauma-informed care and substance use disorder.

Stigma:	• Educating EVERYONE serving this population how to not be judgmental etc. • More stigma campaigns targeting providers (from an accredited source for those providers). • Decriminalization is key. • Hearing stories from people with these experiences is helpful. Trauma-informed approaches.

Overall Recommendations from OB/Pediatric Providers:

- More awareness campaigns and advocacy around focusing on the mom as best way to help baby
- More widespread dissemination to normalize mental health and services, post-partum challenges for many women, and bring awareness to resources (beyond just providers who may have some of this information).
- Continue working to reduce the stigma/fear that if the mother goes in for services her child will be taken away
- Make sure Medicaid/AHCCCS coverage available for women through 1-year post-partum; Improve ways of coding consistently for these services
- Normalize behavioral health screening and make sure is consistent and wide-spread (e.g., for all women leaving hospital, at all pediatric appointments for mom; or annually for everyone). Ensure providers of all types know what to do if someone screens positive.
- More mental health support for PPW. Normalize regular counseling for this population overall.
- Earlier prenatal services for mom (setup prior to birth of the baby and as early as possible).
- Consider one stop locations for serving this population with all the services mom and baby need in a welcoming and supportive environment
- Provide longer term connections and supports to these mothers as their children grow up.
- Consider that this population requires specialized treatment beyond the standard NICU

OB/Pediatric Voices

Helping mom breastfeed – helps her know she can do this and is equipped for this. Impacts her for the rest of her life. She feels this is same experience that this other mom [without SUD/OUD] had. She is connected to her baby.

I really think the services are there, but unless a woman has a roof over her head and food in her belly she won't seek out services.

How do we follow them if [as providers] we are not connected and cannot see everything they have been through?

Focus very much on children…. Forget that if mom not ok, then baby not ok.

We use the word collaborate, but we still feel like we're competing for services and dollars...I think we're happy to collaborate with anyone who can help provide services, but I think that the idea of the spirit of collaboration can be tough.

I think having the time to care is important. If you don't get reimbursed for the 3 hours [you need to provide services] it is a deterrent to providers who don't have the ability to do things that they can't bill for.

Among new mothers, the biggest worry is someone is going to take our kids. Even telling a healthcare provider that mental health is not ok, feels risky. We need to reduce stigma that the system is not going to take their kids.

Perspectives from the Field: RBHA/Behavioral Health Providers	
Participants: 10 focus group participants and 3 key stakeholder interviews among RBHA and provider representatives. Mixture of direct service and leadership. Primarily from Tucson and Phoenix areas.	
What works serving this population:	• Full wrap-around services with coordination of care across providers serving mother and baby. Includes regular meetings of full care team. One-stop-shop for trauma, SUD and maternal health and mental health. • Support individual needs (e.g., as first-time parents with more parenting skills training). • Resource binders for the mothers with information, services, questions they will have. Helping mothers prepare. • Ensuring agencies have someone highly trained in serving this population. • Hushabye nursery specifically mentioned often.
What are the challenges:	• Multi-system involvement (DCS, courts, providers, etc.). All parts of the system do not know about each other's areas (e.g., DCS knowledge of suboxone and vivitrol). • Childcare challenges for moms coming in for treatment (helped with COVID telehealth). Now challenge has been with telehealth having the mom find a private space to talk without children in the room. • Difficult to classify encounters. Modifier helped but still hard to capture when go back and forth in insurance eligibility as well. • Not enough services in rural areas. • Bias and stigma preventing women from getting the care they need or staying engaged in services. • Housing and residential service availability for pregnant women with SUD. • Knowing the programs out there and available. • Transportation. • Prior authorization process varies by insurance and can take a long time for some insurances and miss the window to get someone into services. Prior authorization hoops (e.g., justifying residential every 7 days for MAT). • More care and support for women before the baby is born, not just after (e.g., funds for cribs). • Mother and baby on different insurance must see different providers.
Communication and Collaboration Challenges	• Challenges with women taking referrals and then following through on services. • Understanding and knowledge across the different providers. • Sharing of information between providers. More information on referrals when sent over. • Cultural shift is needed from a high level-communication. • Needs more seamless communication. • Hospital referral processes for individuals presenting with SUD. • Clarity of instructions between different providers related to medication. Consistent messaging not conflicting. • Pain management understanding and appropriate referrals not happening.

What are the gaps:	• Limited housing options for this population. • Limited residential services availability in general and for this population. • Clinician knowledge of insurance needs. • Specialty workforce trained in an area like this is challenging. • Gaps in providers who can serve women in both substance use disorders and maternal mental health.
What resources/information are needed:	• Breadth of trainings that might be needed seems endless (trauma, substance use treatment, needs of pregnant women etc.). • Online or Relias trainings specifically for those working with this population? Existing ADHS trainings on the topic. See what is out there and help others know about it. • Postpartum Support International provides trainings and webinars. • Need knowledge of resources out there as well. • Lots of different types of staff might need this information (e.g., those answering phones).
Stigma:	• Stigma and perception are major challenges in serving this population. • Needs a full culture shift, including at DCS. • Providers need information and trauma-informed care training so that they are comfortable in serving this population and make a safe space for services. • Help providers understand and get past their own biases. • Women too afraid to talk about their mental health or substance use while pregnant • Has to be ongoing conversation, as there are always new staff and takes time to make this full shift.

Overall Recommendations from RBHA/Behavioral Health Providers:

- Peer professionals who have been through the same services to lessen the stigma. Consider training them to be doulas as well.
- Inter-agency connection and communication.
- One-stop-shop for services (e.g., a campus for women and their children).
- Insurance coverage for long-term services and supports (e.g., 60 days is not enough). Improve claims processing for this population. Use a mobile app to stay connected with and to check-in on this population.
- Respite care for dropping off children on the way to services.
- Transportation coordination
- Required training and consultation for program staff serving this population
- Housing alternatives to residential treatment, but with support services in place.
- Consider AHCCCS classifying maternal mental health as specialized care. Improve access to funds for serving this population. Roll out SABG through direct state contracts.
- Need longer term outcome data on babies with NAS so can know if making a difference.
- Opiate Assistance and Referral line—could place to find and support women in rural areas but not sure if it is being used.
- Consider how SABG funds might be used to support this population.

RBHA/Provider Voices

Attendance [at treatment services] has skyrocketed as things have not required travel and daycare. Challenge is depending on the age of the child, you don't want them in ear shot of what the mother is talking about guilt, shame…

Hard for a woman to come out and verbalize that are using and pregnant. Fear of judgement. Making sure where go they feel like are heard and compassionate.

I would love to see AHCCCS embrace maternal mental health as specialized care. As a provider wanting to bill AHCCCS plans we get denied that they say they have enough providers. But general mental health and maternal mental health need to be addressed differently.

When you have a baby with NAS our natural human instinct is to put blame on someone. So there has to be truly a lot of training to see who is right in front of them with the trauma that the mothers experience.

Sometimes babies and moms aren't on the same insurance plan post birth so they end up having to go to different facilities for care. This makes it challenging for both them and the providers.

In 2015 it was seen as neglect if moms were using MAT, now there has been a shift in DCS which is good, but not everyone seems to know about it. There needs to be a full cultural shift and a change in the system

Perspectives from the Field: TRBHA/Tribal Providers	
Participants: 2 focus groups (6 total participants) and 4 interviews. Representation from 4 tribes across Arizona.*	
What are the challenges:	• Fear of baby being removed and implications for the family across generations when this happens. • No showing to appointments/finding clients. • Finding housing with sober living environment. • Building trust across cultures. • Babies with more intensive support needs. • Covid added more barriers/challenges (e.g., testing requirements, longer wait times to enter treatment, less connection, less opportunities to provide information flyers etc.). • Multi-generational cycles (e.g., babies placed in foster care going on to have challenges as young adults).
Communication and Collaboration Challenges	• Communication between all the systems is challenging. • Collaboration takes time and there is not enough. • Concerns and challenges in working with DCS (e.g., lack of communication, burnout from heavy caseloads and challenging work). • Follow-up and follow through challenging. • Long wait times for some services. • Figuring out appropriate level of treatment and if available. • Long term placement options and funding constrained. • Lack of awareness of all the options available. • Some good collaboration happening between providers, services, law enforcement (e.g., police notifying if a tribal member is detained). • TRBHAs learning from each other is happening and helpful.
What are the gaps:	• Limited telemedicine. • Travel/transportation challenges. • Not enough programs/facilities that support mothers and babies staying together. • Need more safe and supported housing (within our communities). • Limited psychologist and psychiatrist availability. • Need quality and comfortable detox and MAT services for moms. • More focus on prevention. • More education is needed on MAT and how it works. • Funding for culturally appropriate support services is needed (AHCCCS won't always cover).

What resources/information are needed:	• People do not know what resources are available or where to go for help • Protocols from AHCCCS on working with PPW with SUD would be helpful • Training needed for foster parents and kinship placements on working with these babies with complex needs • Information and education for the community on MAT
Cultural considerations	• Whole person health is more the approach of many tribes (as compared to more Western treatment thinking) • Need to incorporate (where we can) culture, religious preferences and local health options (e.g., medicine men, traditional counseling) • Family involvement important • Connecting with people is key • Preferences for tribal-led programs within tribal communities • Recognizing cultural holidays (and being able to close services if appropriate)
Overall Recommendations from TRBHA/Tribal Providers: • More perinatal mental health support (with providers versed in SUD) • Building a comprehensive system of support for women and families • Educating about SUD as a disease to help reduce stigma • Outreach and prevention for all moms, including a list of resources. OB checking in. • Serving kids while mother is receiving services (e.g., placement options, child care available, safely keeping mother/baby together)	

TRBHA/Tribal Provider Voices

One of the challenges is AHCCCS will pay for transportation to AA meetings, however, they won't pay for [someone] to go to a sweat lodge or other culturally appropriate supportive services that a lot of folks in recovery. They love 12 steps meetings we are able to get them to but not some of the cultural and traditional events, and things such as that, that would help build a supportive sober network.

Tribally that is another issue, in Western thinking we're treating the mind, but on the reservation the person is a whole. Therapy is not one on one – family can show up.

I think Native people prefer to be treated in tribal programs and native friendly programs. It can be hard to access services, say, through your average health plan ..if somebody shows up in the front lobby and wants to talk to me I'm going to make every effort to talk to them.

Women are very afraid of being reported to DCS, even though I know DCS can't officially take reports until the child is born. I think we as a team have mixed feelings about that because there are times when a person is not willing to consider residential treatment and continuing to use and you know that the baby is being impacted. Perhaps for life and that's really hard to see that. I have known some women here…who have delivered children at home rather than in a hospital to avoid detection by DCS. It is incredibly painful when DCS comes and removes a baby – a newborn baby. I can't imagine what that's like for some of these ladies even if there's good reasons for it; it doesn't mean that it's not painful for them...

So there's a tremendous fear of detection by DCS and DCS involvement that will prompt people to try to avoid prenatal care, delivering in the hospital.

I've also seen that because people are concerned about the pain associated with labor and delivery there will be a lot of drug use in the days right prior to labor and delivery. So, that often ends up with high meth exposure when the baby is born.

And I've seen early postpartum moms in my office who are on DCS radar, who are trying to do the right thing, but I've watched them, and their attention isn't so much on the baby; it's more on how to access those substances when they are in the active addiction, and I watched it happen and it's kind of heartbreaking because I know if the substance wasn't there but substance overrides the parenting instead – the motherly instinct. If it wasn't there, I think that they would have a far better connection to the baby…

It's very difficult, and once people have children removed, it's never easy for anybody. It's not easy for the foster parent, it's not easy for the kids, it's not easy for the parents, and it can have an impact on families for years and years and years.

~TRBHA/Tribal Provider

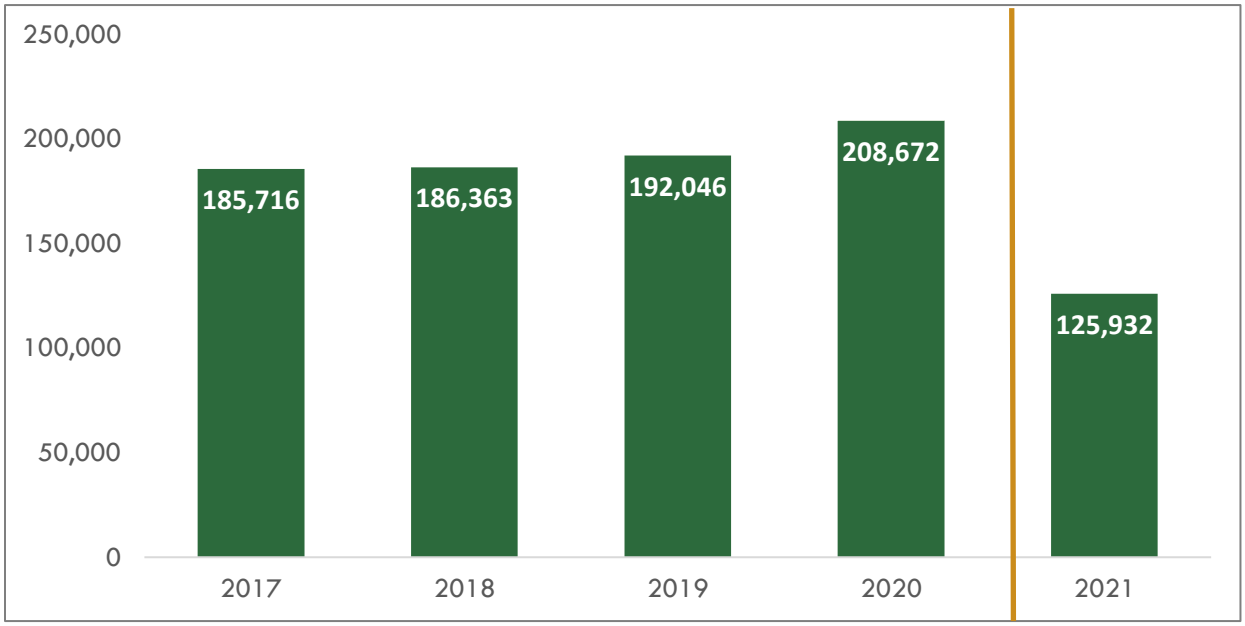
AHCCCS Utilization Data

This section details findings from analysis of AHCCCS encounter data for perinatal women (week 22 of pregnancy to 1 week post birth) with an SUD diagnosis and infants with an NAS diagnosis.

Maternal Data

In the diagnosis file provided by AHCCCS, there are a total of 898,729 records with a 12% increase from state fiscal year 2017 to 2020 (Exhibit 45). As a reminder, data from state fiscal year 2021 is incomplete and should be viewed with this in mind.

Exhibit 45. Maternal Records by State Fiscal Year*



* FY 2021 data may not be complete as encounters are still being received during this timeframe.

Exhibit 46 shows the variability in the number of records across counties over time.

Exhibit 46. Number of Maternal Records by County and State Fiscal Year

County	2017	2018	2019	2020	2021*
Apache	967	485	885	907	784
Cochise	1,923	1,444	2,758	2,610	1,798
Coconino	1,166	1,431	1,849	2,672	1,279
Gila	1,204	1,209	1,781	1,453	644
Graham	847	586	2,145	1,675	598
Greenlee	69	76	70	3	17
La Paz	695	712	1,120	252	319
Maricopa	110,984	118,617	117,198	135,136	77,725
Mohave	6,567	6,249	4,423	6,631	3,976
Navajo	2,786	3,474	3,481	3,777	3,061
Pima	44,620	38,503	39,369	32,025	21,665
Pinal	7,789	6,314	9,907	10,547	5,683
Santa Cruz	219	205	170	598	491
Yavapai	3,494	3,658	4,309	4,317	3,494
Yuma	2,386	3,380	2,581	6,044	4,201
Unknown		20		25	197
Total	185,719	186,363	192,046	208,672	125,932

*State Fiscal Year 2021 data is incomplete

Length of service

To determine length of service the difference in days between the service begin date and service end date were calculated. In the diagnosis file there are a handful of records (0.06%) with negative days due to errors in the data. The majority (98.27%) of these errors are for pharmacy records and just over three-fourths (77.16%) of the errors are in state fiscal year 2021. Almost all records (99.29%) in the diagnosis file were for single day encounters. Due to this, length of stay does not provide sufficient information to determine potential changes over time.

Demographics

The median age was 28 across all years, with 92% between 20 to 39 years old. Approximately 2 out of 10 records have missing or unknown race, with Caucasian/White accounting for between 60 to 65%, Native American/American Indian approximately 10%, and Black/African American between 4 to 6% with little variation across years. All other races account for less than one percent in each race/ethnic group indicated in the data.

Service Provider Type

There are many types of service providers ranging from pharmacy to behavioral health providers to hospitals. The most frequently used categories are physician and behavioral health outpatient clinic. There was a decrease in behavioral health outpatient clinic records and an increase in integrated clinic records in state fiscal year 2020 and 2021 which may be partially due to changes in behavior from the pandemic or licensure changes. The top service provider types along with hospital for comparison were chosen to compare across years (Exhibit 47).

Exhibit 47. Percentage of Maternal Records with the Top Service Provider Types Plus Hospital by State Fiscal Year

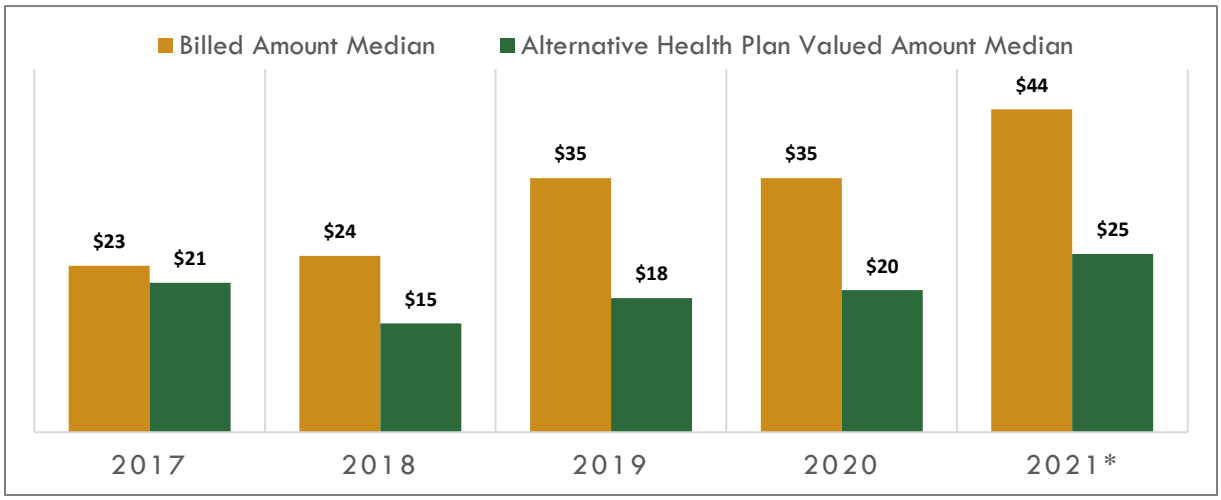
Service Provider Type	2017	2018	2019	2020	2021*
Behavioral Health Residential Facility	5.1%	3.9%	4.1%	4.5%	3.3%
Behavioral Health Outpatient Clinic	30.7%	27.9%	27.2%	23.0%	19.9%
Hospital	0.7%	0.6%	0.8%	0.8%	1.3%
Integrated Clinic	10.0%	9.7%	10.7%	14.1%	14.8%
MD or DO Physician	43.7%	48.7%	47.8%	46.7%	43.5%

*State Fiscal Year 2021 data is incomplete

Costs

Both the billed amount and the alternative health plan valued amount were included in the data. Across all years, the median billed amount in the diagnosis file was $35 with the alternative health plan value amount median at $20 (Exhibit 48). There is a general upward trend in the billed amount rising from $23 in state fiscal year 2017 up to $44 in state fiscal year 2021. There was a drop in the alternative health plan valued amount from state fiscal year 2017 to 2018 with an upward trend for 2019 to 2021.

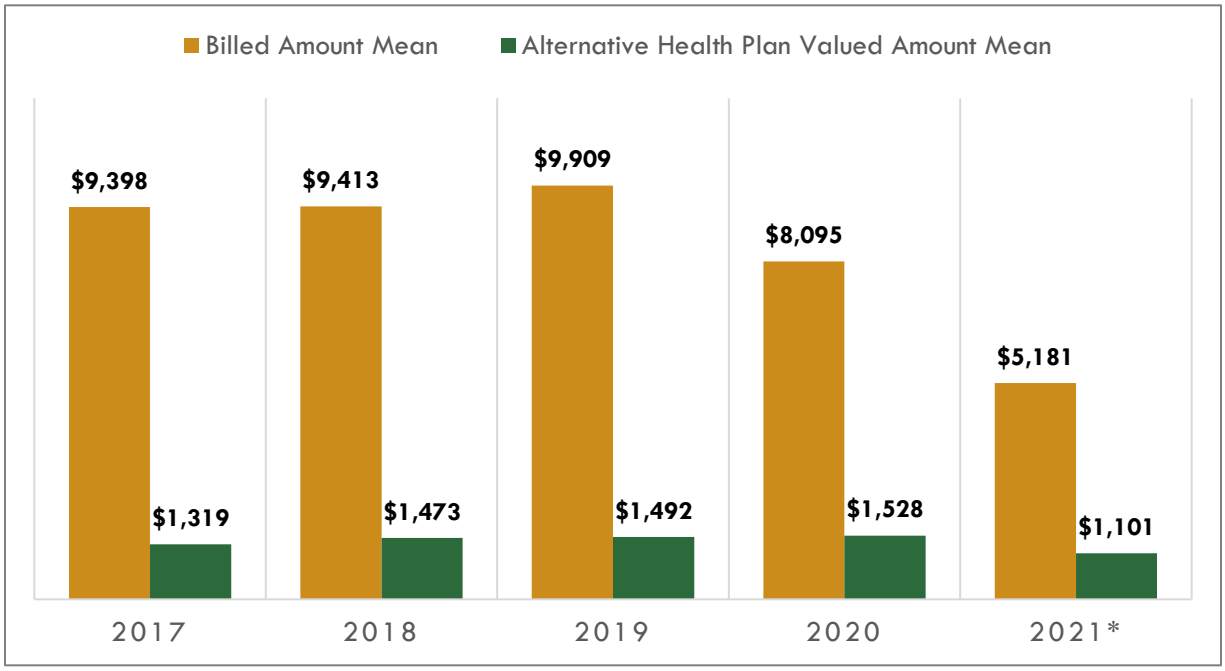
Exhibit 48. Billed Amount and Alternative Health Plan Valued Amount Medians for Maternal Encounters by State Fiscal Year



*State Fiscal Year 2021 data is incomplete

Hospitals account for a small percent of all encounters however, they have the largest amounts billed each year. The median amount billed for hospitals was $479 for both 2020 and 2021. The mean amount billed (per encounter) decreased in state fiscal year 2020 and 2021. Exhibit 49 shows the means rather than the medians for hospital encounters by state fiscal year.

Exhibit 49. Billed Amount and Alternative Health Plan Valued Amount Means Per Encounter for Maternal Hospital Encounters by State Fiscal Year



*State Fiscal Year 2021 data is incomplete

The median amount billed (per encounter) by county and year indicates that there is a large amount of fluctuation in the smaller more rural counties from year to year. Billed amounts are also higher in rural counties (Exhibit 50).

Exhibit 50. Median Maternal Billed Amount Per Encounter by County and Year Rounded to the Nearest Dollar

County	2017	2018	2019	2020	2021*
Apache	$368	$427	$427	$479	$479
Cochise	$95	$95	$328	$496	$53
Coconino	$205	$154	$88	$88	$142
Gila	$59	$68	$150	$35	$120
Graham	$280	$143	$35	$35	$35
Greenlee	$81	$301	$201	$225	$126
La Paz	$391	$45	$427	$455	$131

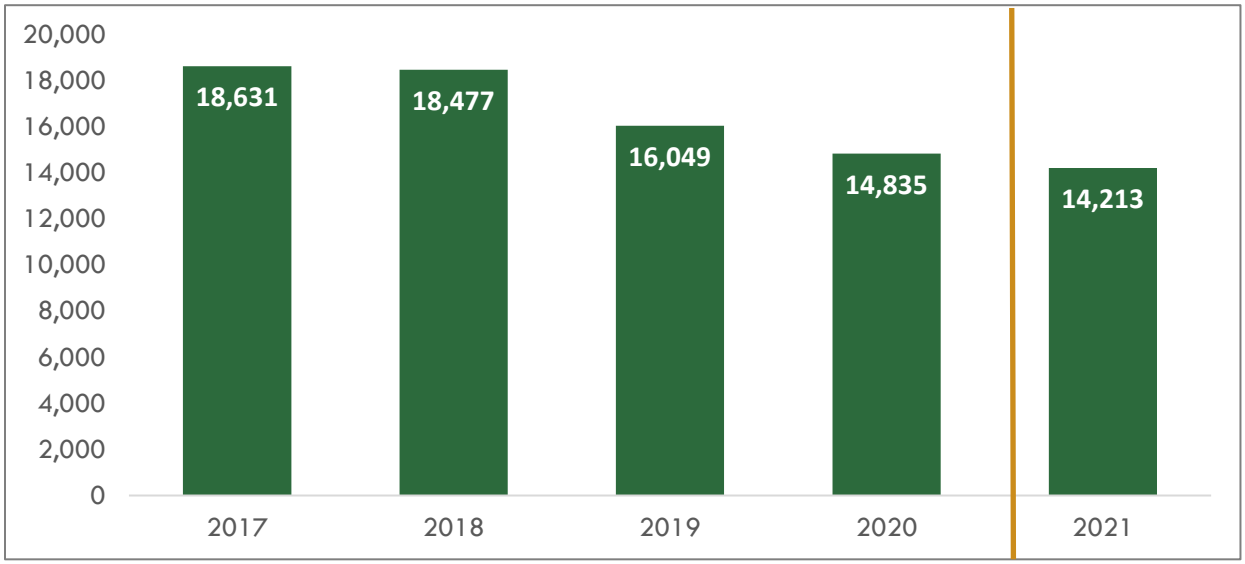
County	2017	2018	2019	2020	2021*
Maricopa	$21	$21	$32	$35	$35
Mohave	$15	$15	$20	$35	$35
Navajo	$391	$427	$455	$455	$479
Pima	$23	$26	$35	$70	$66
Pinal	$69	$34	$75	$83	$104
Santa Cruz	$77	$207	$235	$198	$35
Yavapai	$56	$32	$26	$24	$78
Yuma	$59	$78	$87	$51	$71

*State Fiscal Year 2021 data is incomplete.

Infant Data

The infant data contained a total of 82,205 records from state fiscal year 2017 through May 2021. There has been a decrease in the number of encounters for infants with substance exposure diagnoses as shown in the exhibit below (Exhibit 51). It is not clear what impact the pandemic, and the absence of full 2021 data, may have on these numbers, however, overall, the trend is decreasing.

Exhibit 51. Infant Records by State Fiscal Year*



*FY 2021 data may not be complete as encounters are still being received during this timeframe.

Exhibit 52 shows the number of records for infants by county, where there is a great deal of variation in numbers served, likely as many infants may need more intensive services available in the urban areas.

Exhibit 52. Number of Records for Infants by County and State Fiscal Year

County	2017	2018	2019	2020	2021*
Apache	124	134	55	64	31
Cochise	141	183	207	230	182
Coconino	225	164	163	202	100
Gila	135	140	150	196	71
Graham	248	138	127	141	115
Greenlee	27	15	1	0	2
La Paz	11	36	20	45	27
Maricopa	11,253	11,602	10,647	9,185	8,957
Mohave	479	644	508	354	360
Navajo	398	185	159	279	281
Pima	4,218	3,741	3,068	2,831	2,714
Pinal	642	697	474	557	558
Santa Cruz	31	12	17	51	60
Yavapai	374	496	218	278	279
Yuma	325	289	235	422	454
Unknown		1			22
Total	18,631	18,477	16,049	14,835	14,213

*State Fiscal Year 2021 data is incomplete.

Length of service

To determine length of service, the difference in days between the service begin date and service end date was calculated. In the infant file, many of the records (91.6%) in the diagnosis file were for single day encounters. The range was from 0 to 202 days for infants with a mean of 1.05, a standard deviation of 5.81, and a median and mode of 0.[6]

Demographics

Infant age on date of service was 0 for 98.4% of records with 1.6% showing age 1. Approximately two-thirds of the records have missing or unknown race. Due to this large amount of missing date infant race was not analyzed.

[6] Some services are not considered a full day of services (resulting in a code of 0 days).

Service Provider Type

As for mothers, there are many types of service providers for infant. The most frequently used categories are physician, hospital, and registered nurse practitioner. There is no real change in provider type across years beyond a possible decrease in registered nurse practitioner in 2021. The top service provider types are shown in Exhibit 53.

Exhibit 53. Percentage of Records with the Top Service Provider Types for Infants by State Fiscal Year

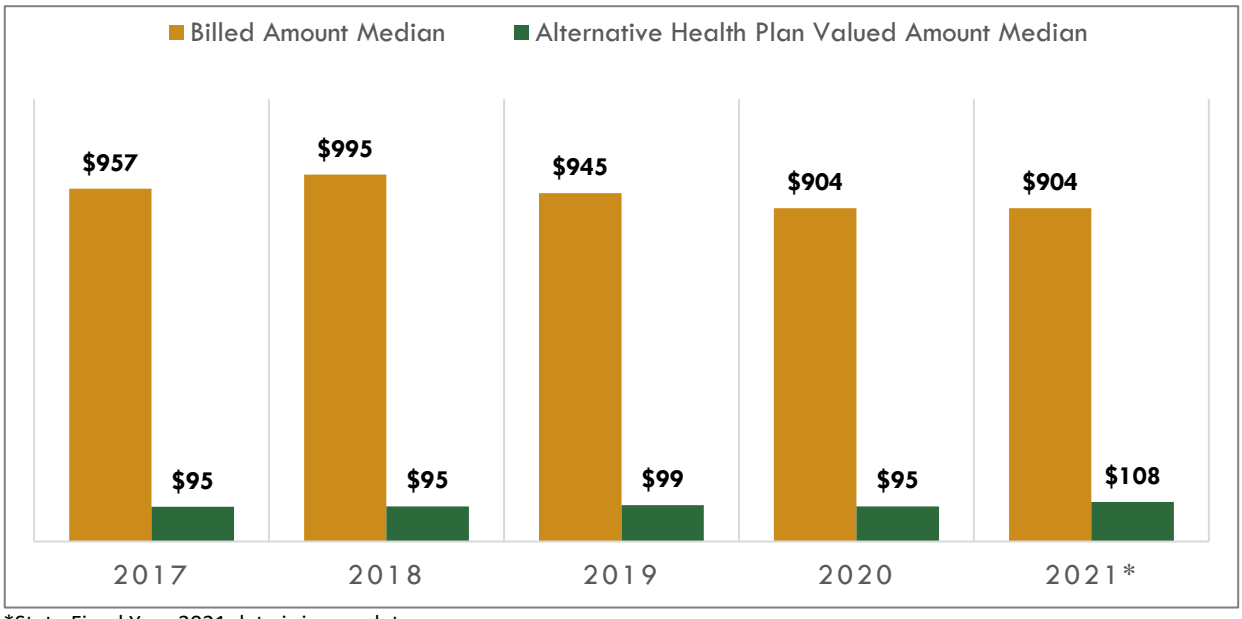
Service Provider Type	2017	2018	2019	2020	2021*
MD or DO Physician	81.9%	80.5%	79.9%	78.6%	81.3%
Hospital	9.9%	9.5%	9.6%	10.7%	9.1%
Registered Nurse Practitioner	4.8%	6.9%	5.9%	5.9%	3.6%

*State Fiscal Year 2021 data is incomplete.

Costs

Both the billed amount and the alternative health plan valued amount per encounter were included in the data. Overall, across all years, the median billed amount in the diagnosis file was $945 with the alternative health plan value amount median at $98, significantly higher than for mothers (Exhibit 54). There is no discernable trend in amounts across years.

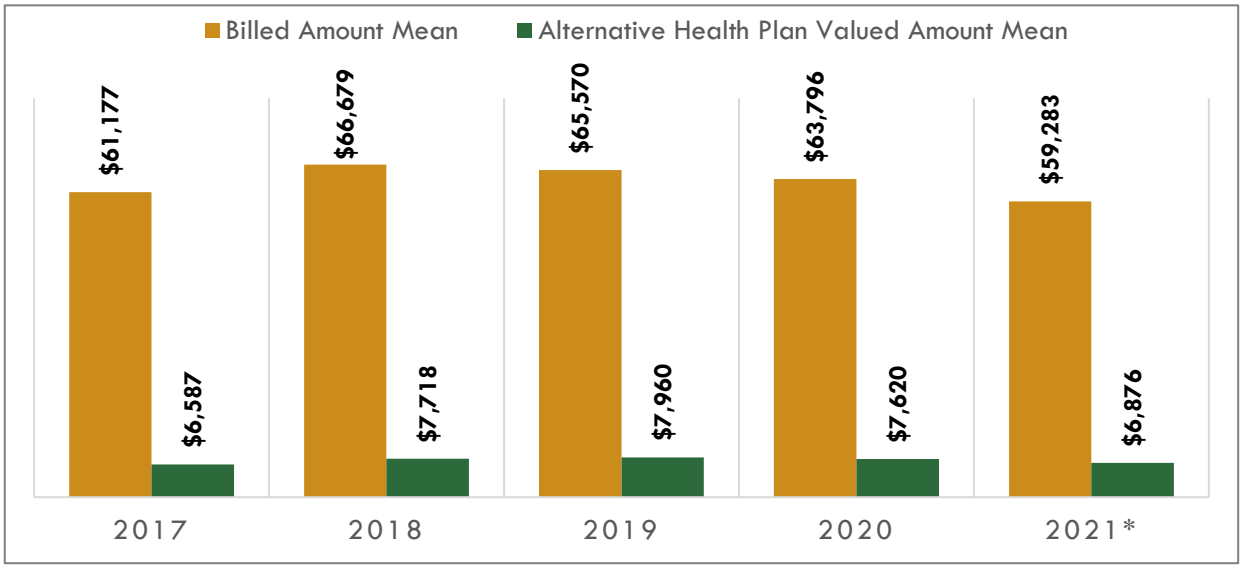
Exhibit 54. Billed Amount and Alternative Health Plan Valued Amount Medians Per Encounter for Infants by State Fiscal Year



*State Fiscal Year 2021 data is incomplete.

As with mothers, infant hospital encounters have the largest amounts billed each year. Infant hospital amounts billed ranged from $14 to $4,413,418. The median amount billed by hospitals was $13,275 with a mean of $63,433 across all years. The means decreased slightly in state fiscal years 2020 and 2021 which may be pandemic related. Exhibit 55 shows the means rather than the medians for infant hospital encounters (per encounter) by state fiscal year.

Exhibit 55. Billed Amount and Alternative Health Plan Valued Amount Means Per Encounter for Infant Hospital Encounters by State Fiscal Year



*State Fiscal Year 2021 data is incomplete.

The median amount billed by county and year indicates that there is a large amount of fluctuation in the smaller more rural counties from year to year for infants similar to mothers. Unlike for mothers, the billed amounts for infants are not consistently higher in rural counties than urban counties (Exhibit 56). This may be due to the increased needs of infants with substance exposure being sent to larger hospitals and other service providers in larger counties. Several counties saw noteworthy drops in billed amounts in state fiscal years 2020 and 2021. This may also be due to pandemic related situations, but they may also indicate other factors as the change is not consistent across all counties. Further research into the factors around these changes should be investigated in Apache, Coconino, Pima, and Pinal counties.

Exhibit 56. Median Billed Amount by County and Year Rounded to the Nearest Dollar

County	2017	2018	2019	2020	2021*
Apache	$780	$995	$854	$507	$314
Cochise	$997	$995	$314	$475	$305
Coconino	$1,020	$1,027	$1,070	$1,059	$683
Gila	$957	$1,027	$1,027	$1,059	$1,130

County	2017	2018	2019	2020	2021*
Graham	$957	$1,027	$1,027	$1,082	$1,081
Greenlee	$1,030	$1,990	$1,658	$1,082	$1,086
La Paz	$391	$1,027	$226	$1,082	$1,128
Maricopa	$957	$995	$945	$921	$904
Mohave	$995	$1,030	$1,059	$470	$1,082
Navajo	$957	$500	$1,027	$1,059	$596
Pima	$874	$881	$921	$610	$450
Pinal	$881	$995	$921	$450	$479
Santa Cruz	$225	$1,070	$263	$200	$305
Yavapai	$995	$1,027	$1,027	$820	$1,082
Yuma	$957	$995	$1,027	$1,082	$1,082

*State Fiscal Year 2021 data is incomplete.

Summary

Overall, the encounter data indicates that infant care is more costly than maternal care on average and that there are differences in overall expenditures by county.

Discussion and Recommendations

This AHCCCS PPW with SUD/OUD Needs Assessment was conducted with the goal of better understanding, and ultimately improving, the system of care for PPW with an SUD/OUD and their children in Arizona. This assessment utilized CSAT's Comprehensive Treatment Model for Alcohol and Other Drug-Abusing Women and Their Children, which emphasizes the interrelated elements of clinical treatment services, clinical support services, and community support services. This needs assessment also focuses on multiple perspectives and service components, and their inter-connectivity (SAMHSA, 2016a). This needs assessment will ultimately support the AHCCCS State Pilot Grant Program for Treatment for Pregnant and Postpartum Women (PPW-PLT) that increases the integration of treatment and wrap-around services for PPW with SUD/OUD and their children, and their family members. It will as also serve as a baseline for other statewide efforts to improve services for this population in Arizona. Data collection methods included interviews, focus groups, two online surveys (one for PPW and one for key stakeholders), analysis of AHCCCS encounter data, and a brief literature review. The following highlights some of the most pervasive challenges and areas for consideration in serving this population that were illuminated in this needs assessment.

- **PPW often experience numerous challenges and have a history of trauma.** They also have co-occurring needs for housing, transportation, etc. These needs should be addressed together so that women may successfully engage in services. Engagement and retention in services is critical to successful treatment.
- **Systems serving this population are fragmented**, as mother and baby care are considered separately. Provider communication/collaboration across the treatment spectrum could be improved to increase service effectiveness.
- **There are challenges related to the role of DCS in protecting these children, how to achieve the best long-term outcomes for mothers and their children, and how the system can support both**. Helping all stakeholders understand this perspective can help improve communication and collaboration across the system of care.
- **Specialized providers exist and are serving this population, but stakeholders suggest that there are not enough to meet the need.** There also may not be widespread awareness of these specialized providers and when women should be referred to them for support (or potentially a competitive lack of willingness to refer women to other providers because of funding conflicts).

- **There is limited information available for PPW and providers regarding appropriate service delivery for this population, given their complex needs**. Maternal health, pediatric care, and behavioral health providers work with this population as part of their overall client base. There is a need for increased education and training of providers to better meet the specific needs of PPW with SUD/OUD.
- **Participating stakeholders identified the need for more involvement and coordination between DCS, hospitals, OB-GYN/maternal health, and pediatric providers to better serve this population.** It should be noted that most stakeholders who participated in this needs assessment were from the behavioral and public health fields and were OB/GYN and/or pediatric providers. It is unclear if this participating demographic suggests a lower level of engagement of other provider types in this topic or is simply a result of how information on this needs assessment was disseminated through existing AHCCCS networks.
- **Engagement and retention in services could improve if PPW felt more comfortable when accessing services.** Barriers to accessing services include the stigma associated with their situation, providers do not have the necessary space or scheduling that work best to serve families with young children, crowded lobbies, childcare issues, and fear of losing their children to state protective services. Services for this population in local communities and on Tribal Nations appears to be limited.
- **Funding mechanisms support individual treatment codes but may not align with the various health care needs that both mother and baby may experience**. Services for infants are expensive and some stakeholders suggested that these are not funded long enough for women on AHCCCS for their child to reach a stable point.
- **A lot of good work is underway in Arizona, with various providers already doing these types of supportive services to statewide collaborations.**
- **More research (while challenging to collect for this population) is needed to understand the long-term outcomes** for mothers and children that receive various models of care/service.

Based on this data, the recommendations offered by stakeholders, and an initial review of practices in the field, the following recommendations are put forth for consideration.

It is important to note that, while this project was initiated by AHCCCS, the multi-systemic nature of this project requires significant collaboration across state entities, providers, hospitals, etc. It is acknowledged that these recommendations cannot be accomplished by AHCCCS alone, but rather require a coordinated systems approach to best meet the needs of PPW, based on the results of this needs assessment. This project also did not include a comprehensive listing of programs and support services available in Arizona. It is recommended that this type of resource list be developed.

Overall Recommendations

1) Shift the Culture

Existing research and this needs assessment point to concerns that women have in disclosing their substance use while pregnant and seeking treatment (Syvertsen et al., 2020). For example, 56% of the PPW surveyed were afraid that their substance use would be found out. Many did not, even in this anonymous survey, elect to share responses on several of the items related to substance use and prenatal care while pregnant, suggesting discomfort with this topic. The case study presented on pages 28-29 vividly portrays this experience, from the fear and worry to the way the mother is then subsequently treated with stigma by some providers.

While the PPW Survey was not representative of the larger population, the demographics of the PPW who participated show a wide range of education levels and insurance types, which further emphasizes that this population should not be stereotyped (see Exhibits 6 and 7). The fact that some women may find themselves in similar circumstances who are on a prescribed medication (such as an opioid, used as prescribed) adds further intricacy to this population. Overall, all women going through this experience should be treated with compassion and respect.

Some of the stigma likely has to do with a lack of understanding of perinatal health, substance use as a disease, and the overall perceptions of mental health in our culture. **Stigma reduction campaigns** are needed to normalize the conversation about how challenging pregnancy and post-partum timeframes may be for women. Many of the stakeholders suggested that **women need more information on services/resources available** to meet their unique needs.

In addition, **many stakeholders noted that providers themselves are the ones who need more education and information** on topics such as MAT, substance use disorder diagnosis/treatment, and also to hear personal stories from women who have been through this experience to help them better serve and care for this population with compassion and understanding. For example, only 22% of respondents expressed strong agreement that they have the information they need to serve PPW with SUD/OUD and only 17% indicating that training specifically on serving this population was required at their organization. Training on trauma-informed approaches, a commonly recognized best practice (SAMHSA, 2014), were recommended.

2) Expand Screening and Multiple Entry Points to Services

SAMHSA indicates that there are five points of intervention for PPW with substance use disorders (pre-pregnancy, prenatal, birth, neonatal, throughout childhood and adolescence) and that all should be considered (SAMHSA, 2016a). One of the time-points that was regularly referenced in this needs assessment was the pre-pregnancy and prenatal timeframes, where many stakeholders suggested the need **for more screening and assessment of women at their**

maternal health providers or pediatric providers (if they have other children) and treatment providers to also ask about pregnancy. The PPW that we surveyed indicated that the OB-GYN was one of the main providers they had contact with during their pregnancy, and thus, perhaps presents a key point of intervention and support for women and referral to appropriate treatment services.

Key stakeholders indicated that the most common referral source for them was the maternal health provider (30%), followed by self-referral (26%), and general healthcare provider/hospital (21%), further suggesting the importance of these parts of the system in potentially serving as gateways into further treatment and support. The challenge is that only about a third of the PPW (38%, n=6) who responded to the survey elected to share information about their substance use with their doctors, further emphasizing the need to address the stigma item above. Providers also need information on where to send women if they screen positive, as this may serve as a deterrent for some providers to even conduct a screening currently. Despite these challenges, PPW and stakeholders expressed how pregnancy is a key moment for many women in electing to participate in treatment.

Stakeholders regularly mentioned the importance of trying to **reach women earlier in their pregnancies** to ensure they receive treatment services that help improve outcomes for them and the baby. The case study also gave voice to how a woman wished she had gone in for services earlier, as once she was receiving MAT, everything was easier for her, and she regretted not going in sooner. Clients may be better retained by providing more treatment options with lower intensities since clients are at different levels of readiness to engage with services.

3) Enhance the System of Care

This needs assessment echoes earlier research that points to the importance of a **comprehensive care model for this population** (Meinhofer et al., 2020). Current SAMHSA recommendations point to the multi-systemic collaboration required to reach the type of system needed for this population. It is clear AHCCCS is moving in this direction, by bring together stakeholders under the SAMHSA-funded, pilot program that increases the integration of treatment and wrap-around services for PPW with SUD/OUD and their children, and their family members in Pima County, Arizona Using an all-teach and all-learn model, this group will engage cross-sector subject matter experts to deliver intentional content for 20-25 minutes, followed by Q&A, followed by a real-live case study, discussion and recommendations(see Appendix B for details).

Other groups, such as the Arizona Statewide Taskforce have a strategic plan that includes bringing more stakeholders across the system to the table and to make policy recommendations, among other activities (https://azprenatal.wixsite.com/taskforce/strategic-plan).

This needs assessment supports the finding of the collaborative approach that is needed to meet the needs of this population—as emphasized by many stakeholders we spoke with statewide. Specifically, in regard to the system of services that are needed, this needs assessment points to a few areas for further consideration.

- The unique needs of this population may often require **specialized, wrap-around, care beyond what standard providers** can offer. There is a need to continue to **establish one-stop locations** that can house PPW and their families, offer substance use treatment and mental health services, along with the healthcare supports that mom and baby need. Hospitals (and other types of providers) may need to be encouraged to see the value of these providers and to refer out to them as part of their standard practice. **These providers can receive more specialized training and retain high level specialists in serving this population**.
- In areas where these specialized services are not available (or not available for *enough* PPW), then **improved close-looped referral pathways, where care is coordinated across multiple agencies**. Challenges regarding sharing of protected health information and substance use status may be barriers that the state needs to consider how to operate within while maximizing communication.
- The collaboration between **DCS and the healthcare system should be considered at the highest levels of leadership**, and clear joint policies and practices issued to guide workers across these fields in shared approaches to working with this population. These should align with federal guidelines (Child Abuse Prevention and Treatment Act, 2010), and the state has room to determine how best to conduct the dual role of supporting the family while also protecting the child (SAMHSA, 2016a).
- The system of care needs to also ensure **locally-based programming** is available, particularly in rural and tribal communities, to meet the specific needs of those families. These may also need to include other types of wellness or cultural practices that support the spiritual, emotional, and/or physical health of women in these communities, and that take into account local perceptions.
- The system of care should consider the other intervention and support timeframes previously mentioned (SAMHSA, 2016a), and that **PPW with SUD may need ongoing support well-beyond the birth of the baby**, even into the babies' childhood and adolescence. Engaging other community-based supports or programming on an ongoing basis may be important for many of these families.

4) Support the Mother-Baby Dyad

Emerging research suggests that supporting the mother-baby dyad is important, using models such as *Eat, Sleep, Console*. While more evidence is needed on outcomes, it is clear from the mother's we spoke with, key stakeholders and some literature (e.g., Blount et al., 2019)

that this model is worth consideration for statewide implementation. The experience of women having their children removed while in the NICU and after the birth of the baby is very difficult, has its own long-term outcomes, and may not be necessary in all cases, when an infant plan of safe care and other safety measures are in place to support the well-being of the child. Moving in this direction requires support and engagement from hospitals and DCS. Some of these types of models are currently being implemented, but not yet in hospitals statewide. Over 38% of respondents indicated low levels of knowledge on this model with another third indicating high levels (Exhibit 41).

5) Navigate billing mechanisms for mom-baby dyad

Funding challenges were mentioned by stakeholders throughout this needs assessment. While this needs assessment was not intended as a review of funding approaches or current funding levels, concerns expressed by stakeholders suggest that AHCCCS may want to review the funding in place for these populations and whether, within Medicaid guidelines, there are any potential modifications that could be made to make billing for services for this population easier to navigate (e.g., how to reimburse providers for services to both mom and baby at the same location).

6) Consider Areas for Further Research/Data Collection

This study did not include collection of information related to father involvement and how this engagement and coordination might need to be considered. When the father is present, it is likely that he also needs support handling the complex needs of his family, including young child. Furthermore, father involvement may enhance engagement and retention in services.

A comprehensive review of all programming available in Arizona currently to meet the needs of this population was not feasible within this project timeline. However, it may be helpful for AHCCCS to compile this information or determine how to support other organizations development of an online directly of current resources for serving this population.

As mentioned, additional research is needed on what practices support the best outcomes for mother, baby, and family in the short and long-term who have been through these experiences. This includes additional information from PPW regarding their experiences, service needs, etc. There is also more work needed to hear from specific demographics including African American and Native American women with lived experience.

In summary, there are many aspects of this system of care that are in development, however, this needs assessment highlights several areas for ongoing changes and enhancements to fully meet the complex needs of PPW with SUD/OUD and their infants in Arizona.

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Appendix A. Participating Organizations

Organizations/Task Forces with Participating Members*
4th Trimester Arizona
Apache Behavioral Health Services, Birthified Program
Arizona Complete Health
Arizona Healthcare Cost Containment System, Division of Grants Administration
Arizona Statewide Task Force on Preventing Prenatal Exposure to Alcohol and Other Drugs
Arizona Supplemental Nutrition Program for Women, Infants and Children (WIC)
Banner University Family Care
Banner University Medical Center, Tucson, Family Centered NAS Care Program
Banner University of Arizona College of Medicine, Phoenix
CHEERS
CODAC, Connie Hillman House
Common Spirit Health/Dignity Health – St. Josephs
Community Medical Services
Community Project Management Services Arizona
Cope
Cummings Graduate School
Department of Economic Security, Early Intervention Program
Dignity Health
Easter Seals Blake Foundation
Gila River Healthcare
Haven
Healthy Families
HOPESS Residential Treatment
Hopi Behavioral Health Services
Hushabye Nursery
La Frontera
Lifewell Community Living
Maggie's Place
Maternal, Infant, and Early Childhood Home Visiting (MIECHV)
Maternal Mortality Review Committee
Matrescence 4th Trimester Planning and Support
Navajo Nation, Growing in Beauty Home Visitation Program
Northern Arizona University, Institute for Human Development
Nurse Family Partnership
Parents as Teachers
Pascua Yaqui New Beginnings Clinic
Pascua Yaqui Tribe, Centered Spirit Behavioral Health

Organizations/Task Forces with Participating Members*
Phoenix Children's Hospital
Prevent Child Abuse Arizona
Statewide Maternal Mental Health Taskforce
Summit Healthcare Regional Medical Center
Touchstone Health Services
University of Arizona, Department of Family and Community Medicine
Women's Health Innovations of Arizona
Yavapai Regional Medical Center, Family Resource Center

*Not all survey respondents indicated their organization, thus, this may not represent all organizations who participated, but indicates the variety of groups engaged in this conversation. Some home visitation programs are listed broadly rather than by participating specific sites, as that information was not usually available (e.g., Healthy Families, Parents as Teachers). Taskforces are also included where specific to this population. This data was collected through the data collection efforts and stakeholder advisory group. A specific scan of providers/all programs in Arizona serving this population was not conducted as part of this needs assessment.

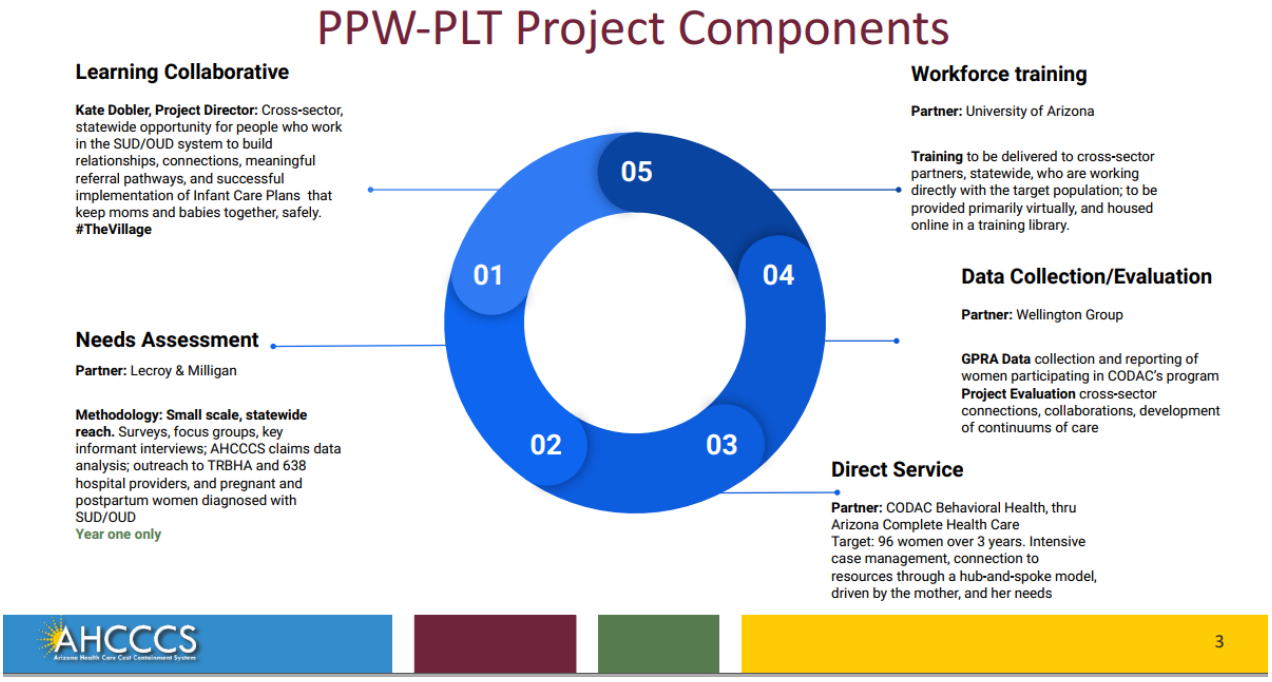
Appendix B. PPW-PLT Grant Overview

AHCCCS was awarded the PPW-PLT from the Substance Abuse and Mental Health Services (SAMHSA). The purpose of the program is to enhance flexibility in the use of funds designed to:

- Support family-based services for pregnant and postpartum women with a primary diagnosis of a substance use disorder (SUD), including opioid use disorders (OUD);
- Help state substance abuse agencies address the continuum of care, including services provided to pregnant and postpartum women in nonresidential-based settings; and
- Promote a coordinated, effective, and efficient state system managed by state substance abuse agencies by encouraging new approaches and models of service delivery.

The project approach includes developing and supporting state, regional, and local level collaborations, including Tribal collaboration, and service enhancements to understand and implement best practices to comprehensively address the full continuum of care related to opioid misuse, abuse, and dependency particularly within the population of pregnant and postpartum women.

The project has a multi-pronged approach: direct service, a learning collaborative made up of cross-sector providers, provision of training to enhance the capacity of the workforce, Government Performance and Results Act(GPRA) data collection and reporting, and a project evaluation. The project includes developing a needs assessment using statewide epidemiological data to identify gaps in the existing system of services and providers impacting pregnant and postpartum women along the continuum of care with a primary diagnosis of a substance use disorder, including opioid use disorders.



Appendix C. Flyers

AHCCCS
Arizona Health Care Cost Containment System

LeCroy & Milligan
ASSOCIATES, INC.

FEEDBACK NEEDED

ARE YOU A WOMAN RECEIVING SERVICES FOR SUBSTANCE USE AND ARE EITHER PREGNANT OR RECENTLY HAD A BABY IN ARIZONA?

IF YOU ANSWERED YES, WE WANT TO TALK TO YOU!

WHY: We are working to better understand and try to improve services for you and other women and children. You may have ideas about what is working well, and what could be working better.

How can I participate?

1. Complete our **online survey** at this survey link

OR

2. Attend a **virtual focus group** and connect and share your experiences with us and other women in your community (bilingual). **Saturday, June 26th from 9-10:30a.m.** Babies welcome! CLICK TO REGISTER

We need your help!

Your information will be kept confidential!

Questions? Please email darcy@lecroymilligan.com

AHCCCS
Arizona Health Care Cost Containment System

LeCroy & Milligan
ASSOCIATES, INC.

NEEDS ASSESSMENT

SERVICES FOR PREGNANT & POST-PARTUM WOMEN WITH A SUBSTANCE USE DISORDER

LeCroy & Milligan Associates was contracted by AHCCCS to conduct a **STATEWIDE** needs assessment to better understand, and ultimately improve, the system of care for pregnant and post-partum women with a substance use disorder, and their children.

WHO: We want to specifically hear from service providers, hospitals, OB/pediatric providers, nonprofits, the criminal justice system, state government entities working with families, tribal entities, and directly from those receiving services.

All stakeholders engaging with this population are invited to participate!

WAYS TO PARTICIPATE

www.

Link to stakeholder survey:
STAKEHOLDER SURVEY

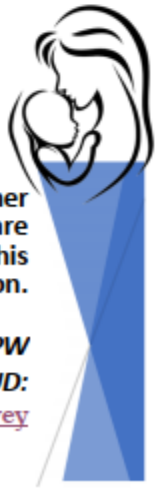
OR

Participate in an upcoming focus group:

OB/Pediatric focus group (anyone working with pediatric population)
6/25/21 from 12-1:30p.m.
REGISTER

RBHA/Behavioral Health Provider focus group 6/28/21 from 3-4:30p.m.
REGISTER

TRBHA/Tribal Provider focus group: TBD
email Valaura at honwungsics@gmail.com



Please send this to other stakeholders and share with women from this population.

Link to survey for *PPW women experiencing SUD:*
PPW Survey

Questions? Please email darcy@lecroymilligan.com