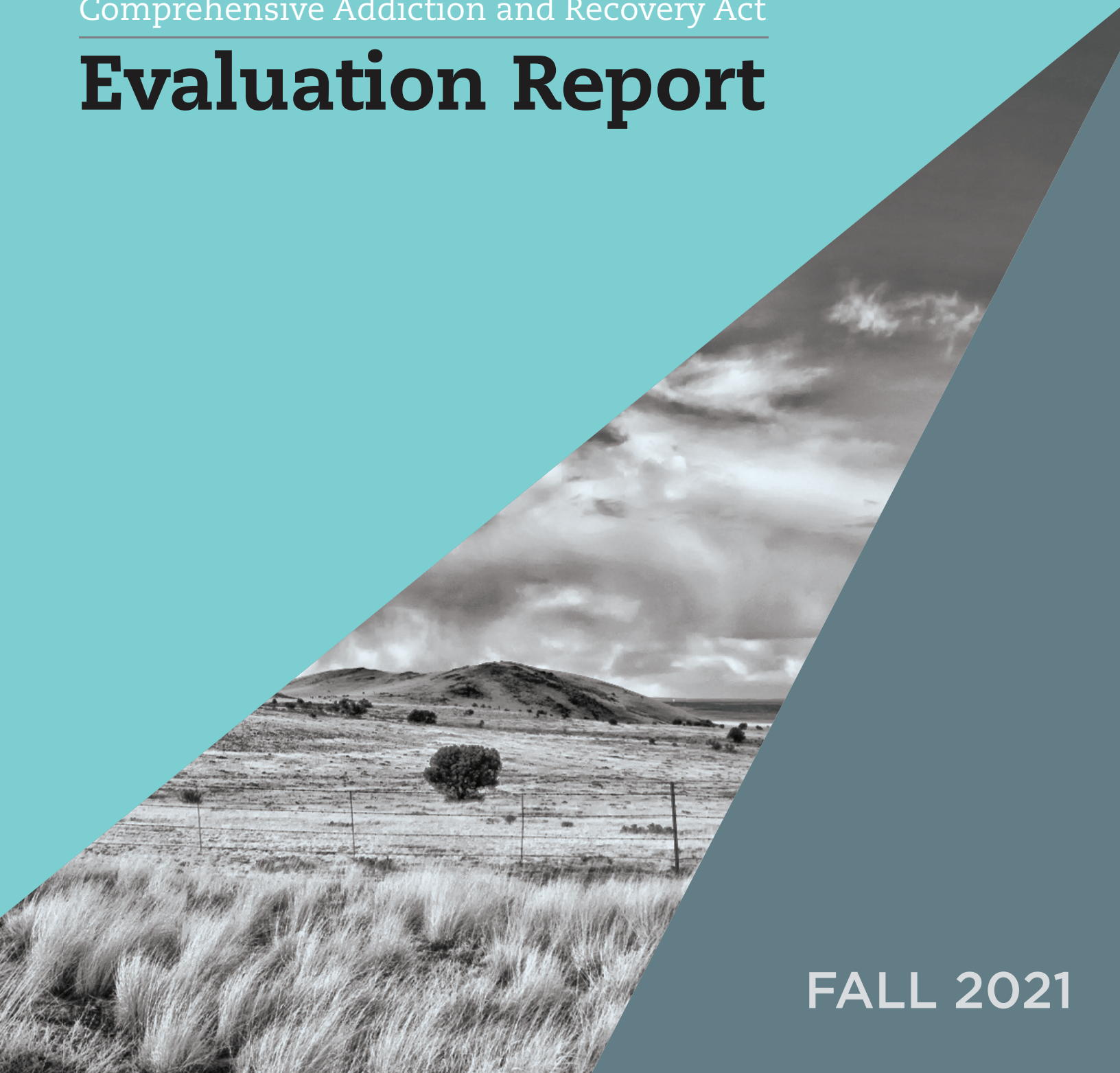
NMDOH
NEW MEXICO DEPARTMENT OF HEALTH

CARA

Comprehensive Addiction and Recovery Act

Evaluation Report



FALL 2021

Introduction

Background

Since 2003, CAPTA (Child Abuse Prevention and Treatment Act) has required that state Governors provide assurance that the state has "policies and procedures to address the needs of substance-exposed infants, including requirements to make appropriate referrals to child protective services (CPS) and other appropriate services, and a requirement to develop a plan of safe care for the affected infants." (U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES). In 2016, CARA (Comprehensive Addiction and Recovery Act) federal legislation was passed to address different aspects of the opioid epidemic including expanded requirements for reporting substance exposed newborns and addressing needs of families with a substance exposed newborn. This CARA legislation, and subsequent changes to CAPTA policies, expanded the substances included in the policy to all substance exposures (not just illegal substances) and increased requirements of state's plan of safe care policies to: 1) address the health and SUD (Substance Use Disorder) treatment needs of family and caregivers as well as infants, and 2) develop and implement state monitoring systems around plans of safe care to "determine whether and in what manner local entities are providing, in accordance with State requirements, referrals to and delivery of appropriate services for the infant and affected family or caregiver." (U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES) In order to effectively implement these new CARA requirements, the State of New Mexico passed house bill 230 in 2019. This bill outlined rules, and reporting and referral processes for hospitals, CYFD (Children, Youth and Family Department), NMDOH (New Mexico Department of Health), Medicaid MCOs (Managed Care Organizations) and other insurance providers to implement the CARA policy with processes specific to New Mexico.

Project Description

The essential components of CARA program design (outlined in detail in HB230) in New Mexico are that: 1) Hospitals create and report POCs (Plans of Care) for all substance exposed newborns; 2) Federally required data around prenatal substance exposures are tracked and reported; 3) Care coordination is provided through the family's insurance provider (primarily Medicaid MCOs) in order to facilitate access to needed services; and 4) A non-punitive approach to prenatal substance exposure by not requiring an automatic referral to Statewide Central Intake at CYFD for child abuse/neglect in the event a prenatal substance exposure is established. The first two components related to reporting are processes that fulfill federal CARA/CAPTA legislation requirements. The second two components are New Mexico specific, and aim to improve outcomes for families with a substance exposed newborn.

CARA policy passed in April of 2019 and implementation began in June of 2019. A CARA team comprised of CYFD and NMDOH staff, with a multidisciplinary CARA workgroup providing oversight and support, began conducting trainings for health systems, healthcare providers, Medicaid MCO care coordination staff, and community groups on CARA rules and processes. Trainings were conducted from June 2019 through March 2020 and are ongoing due to staff turnover. The required date of implementation for Plan of Care reporting was January of 2020.

Intended short term outcomes of the policy include: 1) Hospital staff understand CARA policy and processes to submit Plans of Care; 2) Care coordinators understand CARA policy and processes to provide care coordination and have the capacity to help families; and 3) Health systems will come into and maintain compliance with the CARA policy.

Intended intermediate outcomes of the policy include: 1) Every substance-exposed newborn offered a plan of care if accepted receive a plan of care prior to hospital discharge; 2) Families are connected with services and follow through with services for an adequate duration; 3) Health systems build in supports including tracking referrals and policies for CARA activities; and 4) Reduction in provider bias.

Initially identified intended long-term outcomes of the policy include: 1) Reduction in substantiated cases for substance exposed newborns; 2) Reduced prenatal substance exposure to newborns and less severe health outcomes from exposure; and 3) Improved ability to identify substance exposed newborns.

Evaluation Purpose

The evaluation serves two primary functions: 1) Provide stakeholders including legislators, leadership from NMDOH, CYFD, HSD, and implementation staff an assessment of CARA/CAPTA policy effectiveness through performance and impact reporting, recommendations, and other insights gained; 2) Provide context and feedback to implementing staff on the fidelity with which the policy is implemented in order to improve the program.

Evaluation Methodology

The CARA evaluation team convened in August 2019 to plan for the evaluation of CARA/CAPTA policy. The evaluation team consisted of the lead evaluator (from NMDOH-Maternal Child Health Epidemiology program), NMDOH leadership, CARA implementation staff, and CYFD leadership. Evaluation planning documents were then presented to the larger CARA workgroup to solicit feedback. The evaluation design is mixed methods with quantitative and qualitative methods being used. Quantitative data include a plan of care tracking database, family follow up surveys, provider bias/knowledge surveys, and administrative databases: HSD Medicaid Claims data, vital records birth data, and the Birth Defects registry database. Qualitative data is being collected as part of the family follow up survey, as well as, program reports utilized for implementation evaluation to identify gaps in program delivery.

Limitations

In initial planning sessions, trainings of hospital staff and MCOs were not identified as a factor to be evaluated. As stakeholder conversations continued throughout the evaluation, training evaluations to understand policy knowledge among healthcare providers and MCOs was a critical component.

Another key limitation to evaluating policy outcomes was inconsistent service status data being reported to CARA implementation staff. Initial evaluation design assumed more consistent initial reporting of services referred, received, or declined, with regular updating of service utilization. Currently this is not done, as the central tracking software is still being developed and hospitals and Medicaid MCOs are not fully utilizing this database. As service referral and access by families is the primary activity in the policy to improve outcomes for families of infants with substance exposure, long term outcomes are difficult to fully assess. In addition to limitations caused by data collection software integration, MCOs are only required to report on variables and information outlined in contracts with HSD, which is currently family's engagement status, but not individual services. The evaluation team is currently working with HSD to collect more extensive data related to CARA families.

Implementation Evaluation

Program Design

Instituting state law that requires reporting of all substance-exposed newborns promotes a more thorough understanding of maternal substance use and the subsequent effects on infant health. Mandatory reporting also allows health systems to identify more families in need of services and provide care coordination. Previously, reporting was limited to certain birth defects resulting from prenatal substance exposure. This limited reporting did not facilitate a complete understanding of substance use birthing people, families, and infants, and the ability to provide supportive resources.

The identification of substance-exposed newborns is a function of screening, and currently there is no requirement for universal prenatal substance use screening. Without universal screening, newborns can suffer from delays in maternal substance use treatment (among other services) or may not be identified at all. It also can lead to biased screening, leading to increased diagnosis for certain demographics and under diagnosis for other demographics. Through universal screening, services can be provided to families prenatally to reduce substance related health conditions, provide more accurate data, and reduce biased screening. While standardized screening is described in HB230, rules and processes for universal screening are not, leaving defining screening practices an important goal for CARA implementation staff.

Another attribute of the CARA policy is that the Plan of Care is developed for the substance exposed newborn, and not created until the infant is born. This timing results in families only receiving care coordination relating to the Plan of Care after the prenatal period. This can result in delayed services for some families, including treatment for substance use. The stated long-term outcome of the program design, reduction in severity of NAS (Neonatal Abstinence Syndrome), cannot be completely addressed without a plan of care being created in the prenatal period.

Another important program design feature is the non-punitive nature of the CARA policy. A key assumption is that birthing people who use or had used substances during pregnancy will be more likely to self-report substance use and not avoid prenatal services due to substance use. Previous iterations of legislation identified any prenatal substance exposure as necessitating an automatic referral to CYFD as child abuse and neglect. CARA policy altered that approach to not require an automatic referral to CYFD for prenatal substance exposure, although it still requires any person to report to CYFD any reasonable suspicion of child abuse and neglect, ensuring any newborn at risk of child abuse/neglect receive adequate intervention from CYFD. This caveat is important to ensure reporting of all families that need CYFD involvement, but provider bias can still occur due to reporting being at the discretion of providers.
CARA policy is an unfunded mandate that requires multiple large governmental and health systems to coordinate program implementation, data sharing, and service coordination. With initially one full time staff member responsible for CARA implementation, and currently two full time staff members, staffing barriers exist to fulfill the intended program design. Also, the time frame of implementation likely impeded the initial efficacy of the program. With legislation being enacted in April of 2019, training beginning in July of 2019, and the POC reporting requirement starting January of 2020, the ability to organize all agencies had limitations. This resulted in CARA implementation staff providing care coordination services to families who were not connected with a care coordinator. This differed from the original program design of families receiving care explicitly from MCO care coordinators.

The COVID-19 pandemic also severely impacted hospitals, families, and every other system in New Mexico. The escalation of COVID morbidity, mortality, socioeconomic burden, and strain on healthcare and welfare systems responsible for CARA implementation occurred in the first months of implementation. The pandemic affected system's ability to serve families with a substance exposed newborn.

Training-Birthing Facilities

Successes

Birthing facility trainings in Plan of Care reporting and processes started in early 2019 and continued throughout the year with other facilities. All initial birthing facility trainings were completed by March 2020. Outreach and training were also provided to all Medicaid MCOs, CMS, CYFD field offices, along with other Community Organizations (such as

Home Visiting, Early Intervention) and at other venues, such as the Wylder Conference (NM Pediatric Society Annual Meeting). Training is ongoing due to hospital staff turnover, and all facilities have been trained at least twice. Annual training is provided to Medicaid MCOs and CMS. CYFD field offices continue to be trained as well so they understand the CARA approach and what the requirements of the law are.

All birthing facilities have been trained in reporting Plans of Care. Gallup Indian Medical Center and Northern Navajo Medical Center (Shiprock) are Indian Health Service facilities, are working on the process and decision making for implementation. These facilities are beginning to submit paper Plans of Care.

Barriers

The initial evaluation design did not include any training evaluation. Healthcare provider and staff knowledge of CARA policy could have been assessed to identify limitations in training. In addition to training efficacy, provider bias was identified as a key area to include in trainings and also assess, as it could be a factor limiting the effectiveness of CARA policy. Currently, CARA implementation staff are working to include evaluative components to the trainings, including specific sections teaching about provider bias.

Reporting-Birthing Facilities

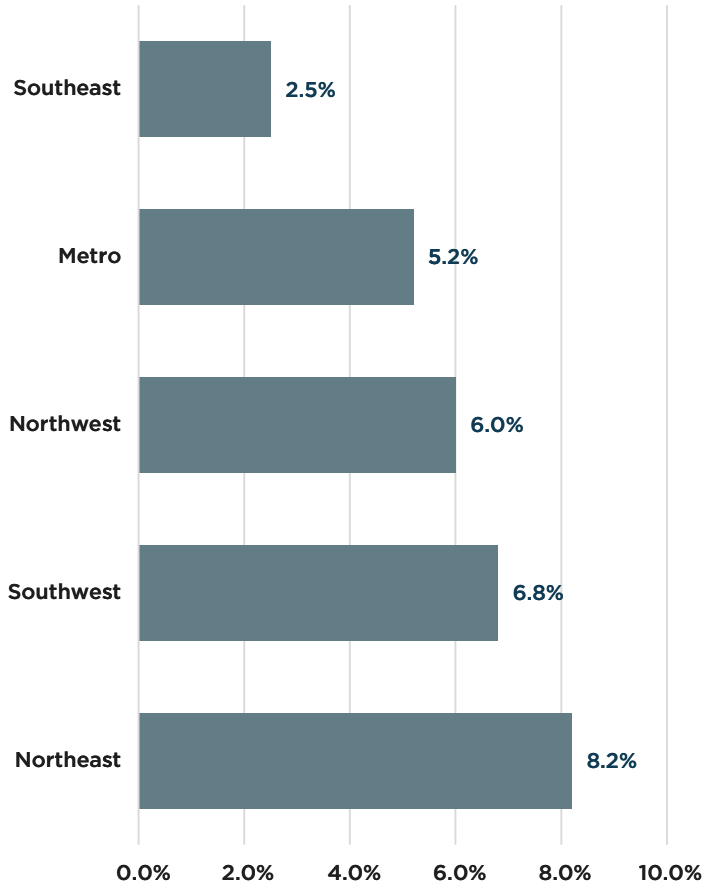
Successes

The majority of birthing facilities are currently reporting. All hospitals except Hobbs (Lea Regional), Rehoboth McKinley, Gallup Indian Medical Center, and Shiprock have implemented the plan of care process and are reporting.

Barriers

Reporting of Plans of Care has been inconsistent at several birthing facilities. During the first six months of 2020, only 63% of NAS (Neonatal Abstinence Syndrome) cases identified in the state's Birth Defect Registry received a Plan of Care and 68% of newborns affected by opioids received a Plan of Care. In addition to inconsistent or deficient Plans of Care reporting, the quality of Plans of Care vary among hospital staff and facilities. Common issues with reporting are missing contact information, missing MCO, and unknown service referral status. Service referral status is sometimes misreported, for instance, a service is reported declined even if a family was interested in the service. Regional disparities also exist in reporting. Facilities in the Southeast region of the state appear to be underreporting Plans of Care, with the proportion of 2020 births with a Plan of Care in the Southeast region over 50% less than the next lowest. Program reports indicate that reduced reporting in the Southeast region may be due to two factors: 1) Birthing people utilizing Texas birthing facilities (especially higher risk births), and out of state facilities not reporting back; and 2) Less screening being conducted in Southeast facilities for that birthing population. Program reports indicate reduced screening may be due to a lack of resources for pregnant people using substances.

Proportion of Births with Plan of Care by DOH Region, NM, 2020



Training-Care Coordinators

Successes

All care coordinators were trained at all Medicaid MCOs (Presbyterian, Western Sky, and Blue Shield) and CMS. Trainings were conducted in 2019 prior to policy enactment. Through 2020, care coordination was being conducted by care coordinators at MCOs as well as CARA navigators employed at the New Mexico Department of Health and CYFD. Tribal Social Services have also received training in CARA policy and processes.

Barriers

The initial evaluation design did not include any training evaluation of MCO care coordinators. Care coordinator knowledge of CARA policy could have been assessed to identify limitations in training. Medicaid MCOs and subsequent care coordinator practices differ between each other. The CARA implementation team also began providing care coordination to families, a function not part of the original program design.

Training-Primary Care Providers

Successes

The intended structure of POC reporting is for OB/GYNs, nurses or social workers to complete a POC, provide it to the family, and report it to DOH. PCPs have not been trained unless they attended a hospital training or statewide meeting. The Care Coordinators are currently responsible to assure the PCP receives a copy of the Plan of Care.

Barriers

While provider support of pregnant women who use substances is not a primary focus of the CARA policy currently, it is a component that will affect health outcomes for mothers and children. Feedback from CARA implementation staff identified provider bias towards women as important context that can affect the success of the policy. Anti-bias and implicit bias training were identified as essential components to include in future training to create an environment of support prior to the creation of the POC. In addition, standardized universal screenings conducted at the prenatal level by providers is another area to improve especially for populations that birth out of state.

Evaluation Findings-Outcome Evaluation

Plan of Care Data

Counts and Distribution

There were a total of 1,105 Plans of Care in 2020, the quarterly distribution 233 plans in quarter 1, 243 plans in quarter 2, 339 plans in quarter 3, and 290 plans in quarter 4. The majority of POCs came from Metro hospitals UNMH, Pres Main, and Lovelace Women's accounting for 53.8% (including UNM NICU). Followed by Mountainview at (10.2%), San Juan Regional (7.5%), CSVH (5.1%) and Gila (3.9%). The rest of facilities each had less than 3% of cases each. The distribution of insurance coverage among families who received a Plan of Care in 2020 include Presbyterian (57.8%), Blue Cross Blue Shield (33%), Western Sky (10%), NM Medicaid (5.6%), Private (1.9%), Uninsured (.7%), Out of State (.4%), Self-pay (.3%), Unknown (.2%), and IHS (.1%).

Substance Exposures

Nearly half of infants with prenatal substance exposures involved alcohol and or illicit drugs including opioids, methamphetamines, and cocaine (47%). This classification includes polysubstance exposures involving nicotine, marijuana, and/or other prescription medications (i.e. benzodiazepines, buprenorphine, and methadone). Approximately a third of infants had marijuana only as their substance exposure (35.6%). All other infants were exposed to different combinations marijuana, nicotine, and prescribed substances (17.5%).

Of all plans of care, 20.9% included opioid exposure (not including methadone or buprenorphine). Over half (59%) of opioid exposures included other illicit drug exposures, methamphetamine, cocaine or both. 33.6% of

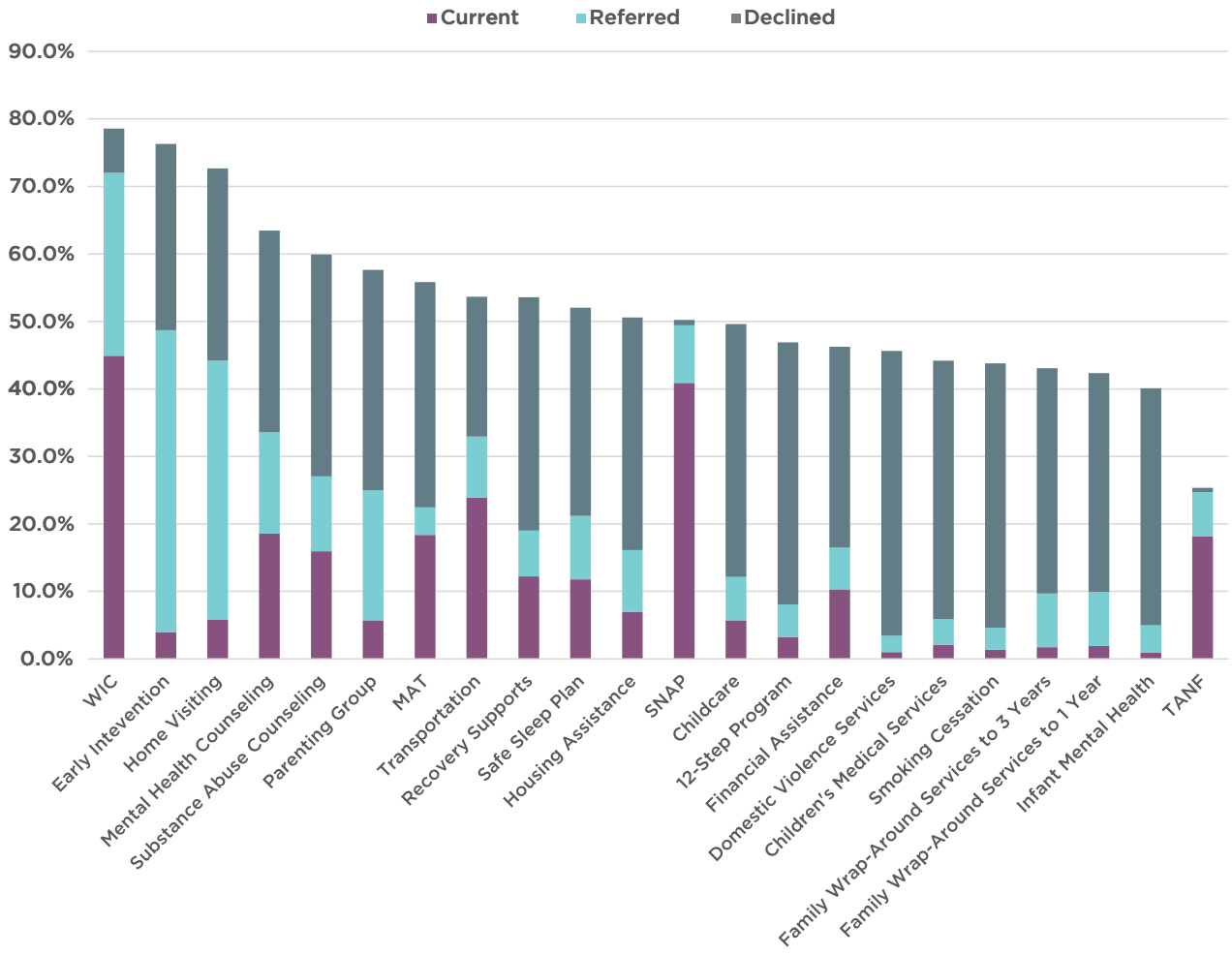
Plans of Care included methamphetamine exposure. 31.3% (n=116) of methamphetamine exposures involved opioids, and 30.2% (n=112) were methamphetamine only.

56% of infants with a plan of care were exposed to one substance, 25.2% were exposed to two substances, 17.2% were exposed to 3 or more substances, and 1.5% were not reported.
In 2020, 41.3% of families reported to not receive care coordination had an alcohol and/or illicit drug exposure compared with 49.7% of families reported to have care coordination. Families who were reported to not have care coordination had a higher proportion of marijuana only exposures as well as other non-illicit and non-alcohol exposures.

Family Engagement

Based on the initial reported services on the Plan of Care, the top 5 services that were current, referred or declined, were Early Intervention, Home Visiting, Mental Health Counseling, Substance Abuse Counseling, and WIC. The top 5 services that families were currently engaged with include, MAT, Mental Health Counseling, WIC, SNAP, and Transportation. The top 5 services that families were referred to include, Early Intervention, Home Visiting, Mental Health Counseling, Parenting Group, and WIC. The top 5 services that families declined were 12-step program, Childcare, Smoking Cessation, Children's Medical Services, and Domestic Violence Services.

Proportion of Plans of Care with Service Referals by Service, NM, 2020, (n=1105)



Plan of Care data show that a high percentage of families are declining services when referred. Based on program feedback, families when followed up with, and explained services, request them after it is reported they declined a service. This indicates a need for continuous follow up with families to identify service needs, as well as hospital staff adequately explaining services. Feedback from implementing staff and results from follow up surveys with families have identified other issues around family engagement including: families unaware that a Plan of Care was created, never receiving a call from a care coordinator, or families refusing care coordination.

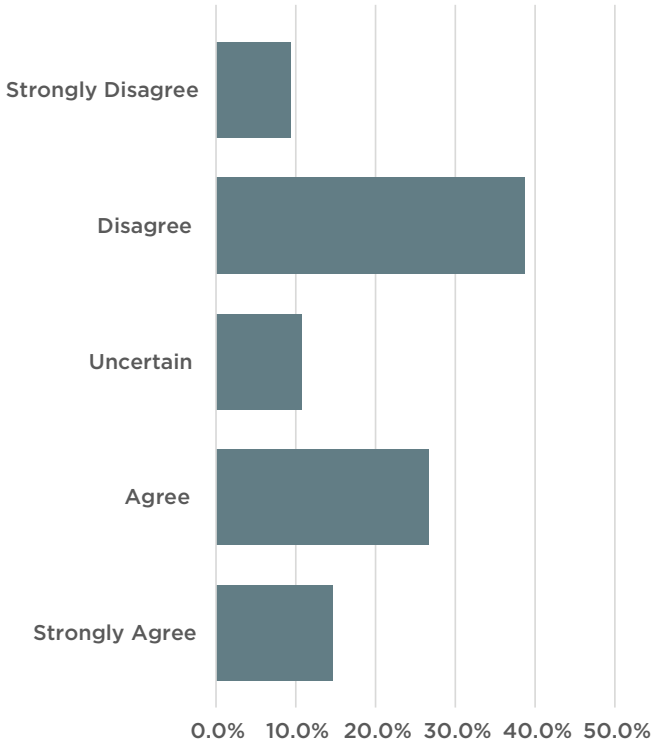
A survey was conducted with families who received a Plan of Care between April and September of 2020. 15.6% (n=91) of families completed the survey at an average of 11 months follow up. Results showed that 41.8% of families did not know what a Plan of Care was or had no one talk to them about it in the hospital. In addition, 57.1% of families completing the survey either were not contacted by a care coordinator or refused services. In comparison, Medicaid MCO reporting showed that 32.3% of families had either not been able to be contacted or refused care coordination in the same time period. The reported proportions differ, but they still indicate a possible need for greater rates of care coordination utilization. 75% of families that refused care coordination and provided a reason said they had supports in place, or just didn't need help.

Although barriers exist to family engagement, survey results show that families that accepted care coordination indicated satisfaction with care coordination. In response to the statement "Your care coordinator has been helpful in connecting you with services", only 3.6% (n=1) of respondents strongly disagreed, with the remainder answering strongly agree, agree, or uncertain.

Barriers also exist in healthcare providers treatment towards families with pregnant people who use substances. In response to the statement, "My healthcare team made me feel judged for having used tobacco, alcohol, or drugs during pregnancy", 41.4% of families answered Strongly Agree, or Agree.

Hospital staff connecting with family and explaining the Plan of Care is an essential step that facilitates a care coordinator having successful engagement. Care coordinators successfully contacting families is essential, and while refusal of care coordination services is not ideal, many families, especially those with exposures to prescribed or more innocuous substances may have resources in place making care coordination unnecessary. Further work with hospital staff and MCOs can help identify ways to help families in most need.

My healthcare team made me feel judged for having used tobacco, alcohol, or drugs during pregnancy



Note: Sample excluded non-responses

CYFD History

The majority of infants with a Plan of Care were discharged to their parental home (82.1%). Other classifications of infant discharge status included designated caregiver (6.6%), foster home (3.5%), precariously housed (3.5%), unknown (2.2%), grandparent's home (2.2%), and facility/shelter (.9%). 57.6% of 2020 Plan of Care families had no CYFD history, and 29.2% of families had a CYFD history that included a substantiated case. The

proportion of families with a CYFD history was similar for families that received Care Coordination (43%) as those who did not receive care coordination (41.3%).

42.6% of families with a Plan of Care in 2020 had at least one subsequent investigation (between January 1, 2020 and June 30, 2021). Almost half (48.8 %) of those subsequent investigations were substantiated, compared to the substantiation rate of 28.6% for the same age group without a Plan of Care in that time-period. Children with a Plan of Care who experienced a substantiated incident of abuse/neglect under 18 months of age (n=286), had a removal rate of 28.5% (n=101), compared to the 28.5% removal rate for that age group overall (statewide, for confirmed victims).

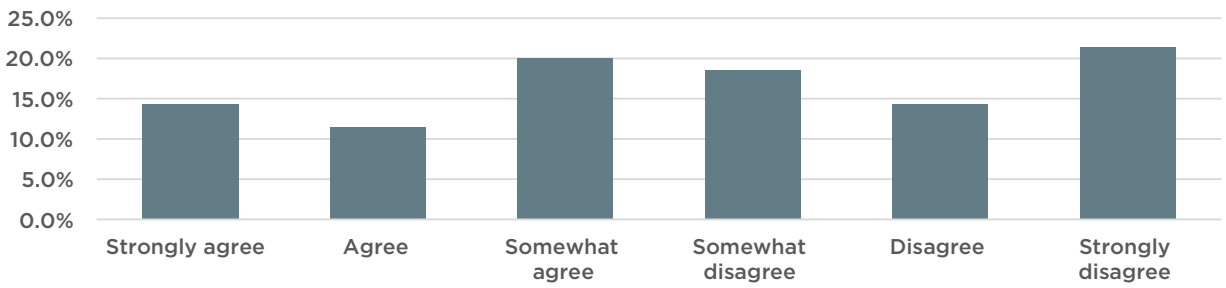
Provider Bias

A provider bias survey was administered to the Perinatal Collaborative stakeholder list of medical professionals throughout New Mexico. The goal of the survey was to take a population level measure of provider beliefs and stigma towards pregnant people who use substances, as well as knowledge of CARA policy. The survey also included questions related to beliefs around CARA policy, and the non-punitive nature of the policy.

70 providers statewide responded to the survey; 32.9% of respondents were nurses, 28.6% were doctors, 20% were certified nurse practitioners, 10% were other profession, 4.3% were social workers, 2.9% were obstetricians, and 1.4% were pediatricians. 38.6% of providers served pregnant women in an outpatient setting, 21.4% served in an inpatient and outpatient setting, 35.7% served in an inpatient setting, and 4.3% did not serve pregnant women. Among provider respondents, 55.7% primarily worked in rural facilities, 40.0% in urban facilities, and 4.3% in rural-frontier facilities. Four questions were asked of providers to assess knowledge of CARA policy. 94.3% of respondents correctly answered that CARA policy requires a plan of care be filed for all birthing people with a positive drug screen/alcohol screen. 95.7% correctly answered that a plan of care is not the same thing as a referral for an investigation. A lower proportion of providers, 88.6% knew that substance use during pregnancy is not considered criminal conduct under NM statute. The lowest proportion, 35.7%, of providers answered that clinical best practice requires that all people be tested for substance use upon admission to a hospital/delivery unit. This question indicates a need for more training and outreach among providers to standardize screening practices.

Providers were also asked to respond to questions about beliefs around criminality of substance use during pregnancy. 94.2 % of providers somewhat disagreed, disagreed, or strongly disagreed that a person using substances should lose custody of their child, and 95.7% of providers somewhat disagreed, disagreed, or strongly disagreed that a person using substances during pregnancy is criminal and should be treated as such. But when responding to the statement, “A person who is using substances while pregnant should automatically be referred to CYFD for an investigation”, responses were varied with nearly equal proportion of providers disagreeing to some extent (54.3%) to providers agreeing to some extent (45.7%). These results show differing views on reporting to CYFD. While the policy is intended to not require a referral to CYFD for newborn substance exposure, a proportion of physicians still think that an automatic referral should be created.

A person who is using substances while pregnant should automatically be referred to CYFD (Children's Youth and Family Department) for an investigation



Service Gaps

In rural areas of New Mexico, there are no MAT (Medication Assisted Treatment) inpatient facilities that accept pregnant women or mothers with their newborns. Currently, the only inpatient treatment programs for pregnant women and mothers with their newborns are located in Carlsbad, Santa Fe Recovery in Santa Fe (expanding to Gallup), and Milagro-Mariposa in Bernalillo County. Program reports indicate a lack of these facilities reduces hospital's willingness to screen for substance use due to the inability to provide resources to a pregnant woman with a positive screen.

Recommendations:

1) Increase prenatal screening for substance exposure. Universal prenatal screening can help reduce bias in screening, increase prenatal services for mothers in need, and increase reporting and understanding of prenatal substance exposures in New Mexico.

2) Increase hospital staff engagement with families to collaboratively create Plan of Care, explain Plan of Care, and explain that care coordinator will contact them. Also, ensure that timing of Plan of Care creation at delivery is feasible for new parents.

3) Increase provider training to address implicit bias and beliefs that prenatal substance use necessitates an automatic referral for prenatal substance use.

4) Explore alternative means of service provision through community health workers.

5) Increase access to housing and financial resources for families with a substance exposed newborn.