Vermont’s CHARM (Children and Recovering Mothers) Team:

A collaborative approach to supporting pregnant and parenting women with opioid use disorders and their infants

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**July 11 & 12, 2018** • QIC All Sites Meeting
Newport Beach, California
What is CHARM?

- **Children and Recovering Mothers** is an inter-disciplinary and cross-agency team which coordinates care for pregnant and postpartum mothers with a history of opioid use disorder, and their babies.

- **Model collaborative approach**
  
  (US Dept. of Health and Human Services, SAMHSA 2016)
CHARM Goal:

to improve the health and safety outcomes of babies born to women with a history of opioid use disorder by coordinating medical care, substance abuse treatment, child welfare, and social service supports.
CHARM Team - Partner Organizations

UVM Medical Center OBGYN - (COGS) medical, social work, MAT

UVM Children's Hospital - Neonatal medical and social work

Child Welfare - VT DCF Family Services

VT Dept. of Healthcare Access - Moms Program (Medicaid)

VT Dept. of Corrections healthcare services

VT Health Dept. ADAP: Hub and Spokes

VT Health Dept. - Maternal Child Health (WIC)

MAT (Methadone & Buprenorphine) - Howard Center Chittenden Clinic

CHARM Team facilitator - KidSafe Collaborative

Residential & Outpatient Tx - moms & babies (Lund)

Children's Integrated Services: Home Visiting; Child Devpmnt Svcs
CHARM - Beginnings

- 1998
  - No MAT available in VT for pregnant woman with opioid use disorder. Physician request: individual waiver from Opiate Treatment Authority

- 2002
  - Substance Abuse physician, OB and Neonatologist meet, coordinate care for pregnant women needing treatment ★ First methadone clinic opens

- 2003
  - Additional community-based health and social services join coordination: start of multi-disciplinary approach - these efforts lead to the CHARM Team

- 2004-2006
  - KidSafe joins to facilitate. Empanelment as VT Multi-disciplinary Child Protection Team;
  - Development of MOU, Release of Information; operating procedures
Issues and Conflicts:

- Who attends monthly meeting
- How much information can be shared
- No guiding documents for interagency process
- Role of child welfare agency and team members reporting suspected child abuse/neglect

**Current**

- CHARM has operated continuously; MOU and ROI updated.
- VT “Hub & Spoke” SUD Treatment/MAT system: expanded access to care, treatment support, case management
- SAMHSA recognition: model collaboration
Key Elements of CHARM Collaboration

- **A Shared Philosophy**: Improving *care and supports for mothers* is the most important factor in helping to ensure healthy and safe infants.

- **Shared Information** across agencies improves child safety and healthy outcomes.

- **Memorandum of Understanding**: provides an important framework for sharing information and coordinating services.

- **Vermont Law**: “Empanelled” as a multi-disciplinary “child protection” team under VSA Title 33 § 4917.
How Does CHARM Work?

Framework for Collaboration

- Criteria: low threshold – pregnant; opioid use disorder
- Multiple points of referral
- Memorandum of Understanding
  - Signed by leadership of all key organizations
- Consent to Release Information
  - Signed by patients/clients
- State law and policy
  - Supports information sharing; child welfare role
- Operating agreements: formal and informal
- Regular (monthly) Team Meetings
  - 11 Agencies/Departments; Case Reviews; Systems Issues
- Infrastructure and facilitation
CHARM Team Meetings: How it Works

- **Team members:**
  - Average of 11 agencies/departments represented at each CHARM team meeting

- **Meet Monthly**
  - 12-13 participants per month

- **Systems Issues**
  - First 10-15 minutes of each meeting

- **★★ Case Reviews ★★**
  - Average 15-20 case reviews per meeting
UVM Children’s Hospital:
Infants born (at UVM) to opioid dependent women with substance use disorder on methadone or buprenorphine at delivery (N = 1119)
Opioid-Exposed Newborns

- Vermont has a higher rate of opioid-exposed newborns than the U.S. average
  
  2015: 34/1000 live births
  
  VDH, Vermont Uniform Hospital Discharge dataset; uschildhealthdata.org

- Vermont: highest annual rate of NAS (Neonatal Abstinence Syndrome) Incidence – out of 28 surveyed 2012-13
  

- In addition to increase in opioid use disorder, this may reflect Vermont’s success in improving access to treatment for pregnant women, and reducing barriers to prenatal care. Vermont has a high rate of women on MAT at the time of delivery.
UVM Children’s Hospital
Timing of initiation of Medication-Assisted Treatment (MAT)

% Mothers on MAT prior to conception

Average GA started MAT if not prior to conception
Prenatal Care and MAT in Pregnancy

**UVM Medical Center: 2017** COGS (Comprehensive Obstetric and Gynecological Services) MAT “Hub and Spoke” program

- 52 Pregnant Women
  - Does not include women who received MAT elsewhere, with only prenatal care at COGS
- 23 of the 52: new treatment /induction for buprenorphine at COGS
- Trend: fewer initiations of treatment at COGS, more transfers and/or MAT care at other Spokes
- Hub/Spoke: On-site COGS Social Workers provide referrals to housing, WIC, community based services for COGS MAT patients
Vermont

CHARM Team Data - Calendar Year 2017

Number of Adult Patients “staffed” by CHARM Team 125

Number of babies 103

Total number of individuals served 228

# of Case Reviews 283

Of 113 infants served by NeoMed Clinic, 33 received treatment with medication for symptoms of withdrawal (NAS)
How Does CHARM Work?

Information Sharing at CHARM Meetings and Followup

• At each monthly meeting the CHARM team reviews a list of current cases, and prioritizes cases for discussion:
  ➢ All pregnant patients due in upcoming month
  ➢ Prioritized high risk prenatal patients
  ➢ All new pregnant patients
  ➢ All new babies / post-partum patients within past month
  ➢ Prioritized high risk post-partum patients and their babies

Focus: How are they doing? What do they need? Are there barriers? Who and how can we help address these?
How Does CHARM Work?
Information Sharing at CHARM Meetings and Followup

- **Prenatal Care**
  - **Initial:** Confirm pregnancy, assess for opioid dependence;
  - **Ongoing:** compliance with prenatal visits and monitoring; referrals for specialty or community services
  - **Medication Assisted Treatment:** consistency; urine drug tests; dose adjustment; substance abuse counseling
    - **Followup:** post-partum MAT provider plan
  - **Residential program option for moms and babies**

- **Case Management, Referrals and Support**
  - WIC, breastfeeding, Home Visiting, social support services.
  - Gift cards, transportation passes, baby items
Post-partum and Neonatal Medical Followup

- Prenatal NeoMed visit:
  - Establish trust, address myths, decrease shame, provide information
- NAS Screening:
  - Mother-baby room-in; involve mothers/parents
  - Maximize non-pharmacologic care
  - UVM Children’s Hospital: ~20% opioid-exposed infants require treatment

- Treatment and Follow-Up
  - Treatment with methadone: in hospital, then after stable 72 hours, discharge home with safety supports. Plan of Safe Care.
    - Care-giver education regarding methadone;
    - Neonatal Medical Follow-up 24/7 availability
  - NeoMed Clinic visits within 1 week, then every 2 weeks: methadone wean, monitor growth and development, monitor parent(s) recovery
CHARM and Child Welfare (DCF Family Services)

- **Prenatal/ 30 days prior to due date:**
  Vermont: only state that conducts child welfare assessment prior to the birth of baby. Focus: safe environment for infant. Not Child Abuse Investigation. (Key CHARM Outcome)

- **At birth:**
  ✓ **Plan of Safe Care** (federal requirement): 
    If no other child safety risks: Non-Identified Notification to DCF and Plan of Safe Care (hospital)
  ✓ If child safety risks: **DCF Report**; DCF-FS does Plan of Safe Care
UVM Children’s Hospital

% Discharged with one or both parents: newborns born at UVM to women on MAT

![Graph showing percentage of newborns discharged with one or both parents over years from 2002 to 2016. The percentage decreases from the early 2000s to the mid-2010s, with a notable drop around 2015.](image-url)
UVM CHILDREN’S HOSPITAL
BAYLEY III: MEAN PERCENTILE RANK (N=277) 7-14 MONTHS OF AGE

Dr. Anne Johnston,
Neonatologist,
University of Vermont
Children’s Hospital
Vermont Requirements Related to Substance Exposed Newborns

(revised 10/30/17)

Concern for Maternal Substance Abuse During Pregnancy

- Call DCF Centralized Intake
- Concerns for newborn safety?
  - Yes
  - No
  - No Action Necessary

DCF’s Prenatal report acceptance criteria:

- A medical professional certifies or the mother admits to use of illegal substances, use of non-prescribed prescription medication, or non-medical use or misuse of prescription medication during the last trimester of her pregnancy.
- When there is an allegation that there is likely to be a serious threat to a child’s health or safety due to the mother’s substance abuse during pregnancy, intervention before a child’s birth may assist the family to remediate the issues and avoid the need for DCF custody after the birth.
- DCF Family Services does not intervene in situations in which the sole concern is the mother’s use of marijuana

Assessments may begin approximately one month before the due date or sooner if medical findings indicated that the mother may deliver early.

DCF will assess child safety and engage mother/parents in the development of a Plan of Safe Care
Child Abuse Protection and Treatment Act (CAPTA) Requirements Related to Substance Exposed Newborns

**DCF’s Newborn acceptance criteria:**
- A newborn has a positive toxicology screen for illegal substances or prescription medication not prescribed to the patient or administered by a physician, or
- A newborn is deemed by a medical professional to have neonatal abstinence syndrome as the result of maternal use of illegal substances, non-prescribed prescription medication or misuse of prescribed medication, or a newborn is being treated pharmacologically due to an undetermined exposure; or
- A newborn has been deemed by a medical professional to have Fetal Alcohol Spectrum Disorder
- DCF Family Services does not intervene in situations in which the sole concern is the mother’s use of marijuana.

DCF will assess child safety and engage mother/parents in the development of a Plan of Safe Care

**Hospital Staff are required to make a CAPTA Notification for any of the following:**
- Mother is stable and engaged in treatment
- Mother is being treated with opioids for chronic pain by a physician
- Mother is taking benzodiazepines as prescribed by her physician
- Mother used marijuana during pregnancy

The notification system will request non-identifying information. A Plan of Safe Care will be developed by hospital staff.

**Delivery of Newborn**

- Report to Department for Children and Families DCF Centralized Intake
- Child protection concerns related to maternal substance use
Key Elements of Patient Success
(what indicators do we measure?)

- Start prenatal care early in pregnancy
- Initiate pharmacological treatment for opioid dependence early in pregnancy
- Engage in substance abuse treatment, counseling
- Attend prenatal care appointments
- Attend Neomed Clinic appointments
- Family and social supports, stable housing
- Plan of safe care
Key Elements of Patient Success

- Anything that drives pregnant women with opioid use disorder from seeking treatment results in more prematurity, higher infant mortality, less probability of successful parenting.

- **Health of Baby depends on the mother’s health, the family’s health!**

  Dr. Anne Johnston
CHARM OUTCOMES

- Early prenatal care and MAT = healthier babies
- Reduce shame and stigma
- Stable in substance abuse treatment, access to support services = better able to parent safely
- Allows time for family engagement prior to birth, support services, plan safe environment for infant
- Infants more likely to be discharged in the care of their mother/parent(s)
- Child maltreatment prevention: earlier indication of risk/parent is not able to parent safely

➢ Avoid unnecessary emergency child custody at birth
COLLABORATIVE PROCESS OUTCOMES

- Time-saver = money saver
- Improved understanding of patients/clients, opioid use disorder; minimize misunderstandings
- Improved understanding of each other’s roles and perspectives
- Development of expertise among project partners about health and treatment of opioid-exposed newborns
- Child protection decisions made based on better information from project partners about safety and risks
- Have a “Go-to” contact for questions

Improved collaboration = safer babies
The Children and Recovering Mothers (CHARM) Collaborative in Burlington, VT: A Case Study
National Center on Substance Abuse and Child Welfare

Vermont Health Department - Alcohol and Drug Abuse Programs:
Care Alliance for Opioid Addiction
http://healthvermont.gov/adap/treatment/

University of VT - VCHIP: Improving Care for Opioid-exposed Newborns (ICON)
http://www.uvm.edu/medicine/vchip/?Page=ICON.html
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