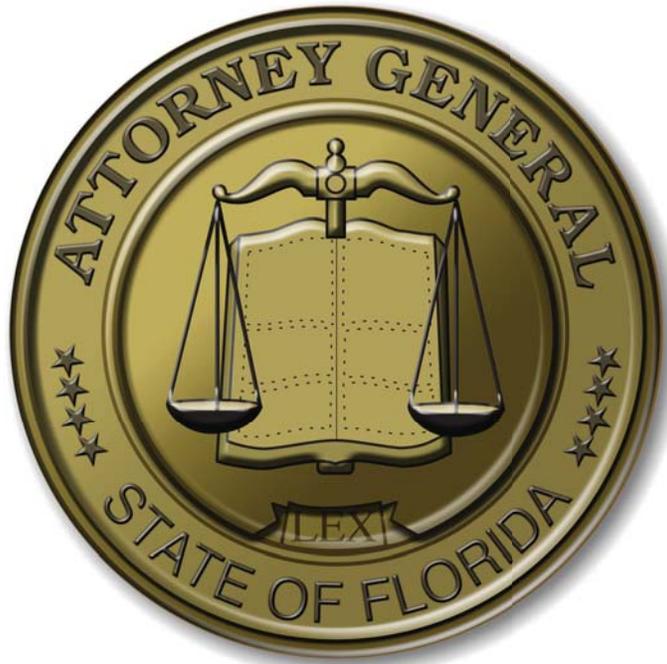


STATEWIDE TASK FORCE
ON
PRESCRIPTION DRUG ABUSE
&
NEWBORNS

February 2013 Final Report



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The Statewide Task Force on Prescription Drug Abuse & Newborns.

Statewide Task Force on Prescription Drug Abuse & Newborns

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EXECUTIVE SUMMARY

The national prescription drug abuse epidemic is now afflicting increasing numbers of pregnant women, fueling an explosion in cases of Neonatal Abstinence Syndrome (NAS) in Florida's newborns. Prescription drug abuse during pregnancy creates adverse health effects in newborns termed NAS. NAS babies suffer terribly from withdrawal symptoms such as tremors, abdominal pain, incessant crying, rapid breathing, and sometimes seizures. Meanwhile, drug prevention and treatment for mothers and the medical care for drug exposed newborns pose significant policy and practice challenges both to the health care community and our social welfare agencies.

The prescription drug driven NAS epidemic also impacts Florida's hospitals. In 2011, there were 1,563 instances of newborns diagnosed with drug exposure in Florida, a three-fold increase since 2007 - and NAS is still widely believed to be an underreported problem. While the numbers of women in Florida giving birth to drug exposed newborns is still thankfully few as a total percentage of pregnancies, NAS afflicted newborns impose disproportionately higher costs on our health care and social service systems compared to healthy deliveries. As the prescription drug epidemic becomes increasingly entrenched in our society, the numbers of NAS babies will only grow absent a strong response from all of us. While society could look the other way and simply focus on the majority of pregnant woman who are not abusing prescription drugs—that is not who we are as Floridians. Floridians want to ensure that the most vulnerable in our society—drug exposed newborns—can grow-up to become healthy, productive citizens.

The 2012 Florida Legislature created the *Statewide Task Force on Prescription Drug Abuse and Newborns* to begin addressing the growing problem of NAS. Attorney General Pam Bondi chairs the Task Force and State Surgeon General John H. Armstrong is Vice-Chair. The 15-member Task Force is composed of medical professionals, law enforcement, prevention experts and state legislators. This Task Force was charged by the Legislature with examining the scope of NAS in Florida, its long-term effects and the costs associated with caring for drug exposed babies, and which drug prevention and intervention strategies work best with pregnant mothers.

The Task Force held five meetings throughout the state, hearing testimony from experts in the fields of addiction, drug prevention, substance abuse treatment and obstetrical care. The dates and locations of task force meetings were as follows:

Tallahassee (The Capitol Building):	April 24, 2012
Tampa (St. Joseph's Women's Hospital):	July 23, 2012
Pembroke Pines (Susan B. Anthony Recovery Center):	October 12, 2012
Tallahassee (Senate Room 401):	December 10, 2012
Conference Call:	January 9, 2013

The Task Force adopted eight specific objectives at the April 24th meeting. The eight objectives, listed below, were then assigned to pertinent task force members for analysis and critique and include:

1. Collect and organize data concerning the nature and extent of neonatal withdrawal syndrome from prescription drugs in Florida. (Jane Murphy)
2. Collect and organize data concerning the costs associated with treating expectant mothers and newborns suffering from withdrawal from prescription drugs. (Keith Nash)
3. Identify available federal, state, and local programs that provide services to mothers who abuse prescription drugs and newborns with neonatal withdrawal syndrome. (Representative Dana Young)
4. Evaluate methods to increase public awareness of the dangers associated with prescription drug abuse, particularly to women, expectant mothers, and newborns. (Dr. Stephanie Haridopolos)

5. Examine barriers to reporting neonatal withdrawal syndrome by medical practitioners while balancing a mother's privacy interests. (Senator Joe Negron)
6. Assess evidence-based methods for caring for a newborn withdrawing from prescription drugs and how nurses can assist the mother in caring for their child. (Willa Fuller)
7. Develop a compendium of best practices for treating both prescription drug addicted mothers and infants withdrawing, both prenatal and postnatal. (Dr. Robert Yelverton)
8. Assess the current state of substance abuse treatment for expectant mothers and determine what best practices should be used to treat drug addicted mothers. (Doug Leonardo)

The Task Force concluded early on that reducing the number of drug exposed newborns must be done collaboratively because today in Florida, no one state agency is solely responsible for addressing the problem of drug addiction. Collaboration is always more difficult in practice than concept given that relevant resources and data are spread across various public and private sector entities. To better utilize scarce resources, State Surgeon General John Armstrong noted that the State of Florida is now attempting to create a drug prevention and treatment system linking services and establishing a system of care to replace a system of fragmented initiatives. Furthermore, while state agencies have important program roles, members of the task force recognized the critical need for Florida to develop a comprehensive strategy regarding drug exposed newborns that seeks to coordinate these program roles into a holistic approach.

Because early prevention programs focus on providing education and awareness of the risks of prescription drug abuse to pregnant women can be particularly life-saving, and cost-effective, the Task Force agrees that prevention should be viewed as a process and not a singular event. The problem of prenatal substance exposure cannot be solved simply by focusing narrowly on just the birth event. Rather, a holistic approach including pre-pregnancy prevention, prenatal and postnatal interventions, and support for affected newborns is needed in Florida. This larger view seeks to address the totality of prevention and treatment of substance use disorders among women of child-bearing age, pregnant women, and the ongoing impact addiction has on families.

Health care providers are in a pivotal position to stem the growing problem of prescription drug abuse and newborns with NAS. For example, health care specialists play a critical role in preventing prescription drug abuse when they find ways to broach the sensitive issue of possible drug use with their patients, voluntarily screen patients for substance abuse and advise patients to the most appropriate care. The Task Force determined that medical professionals in Florida must become more attune to the science of drug addiction. The Task Force therefore recommended immediate improvements not only in training on drug screening protocols, but also for cutting edge pain management education in Florida's medical schools.

Some women fear the involvement of child welfare agencies and fail to seek prenatal care. Indeed, a few states have enacted or proposed legislation directed at maternal substance abuse, including legislation that has led to the incarceration of mothers of drug exposed newborns. This task force is not proposing any criminal penalties, but rather is encouraging safe and effective ways to prevent, identify and treat the problems caused by prescription drug addiction in expecting mothers and NAS newborns. The Task Force has therefore put forward recommendations that should strongly encourage more drug abusing pregnant women to ask for help for themselves and their newborns. The most vulnerable members of our society deserve smart, effective, high-quality care that provides the best opportunity for these women and children to lead healthy productive lives.

The Task Force has fulfilled its mission by outlining the problem of NAS, examining the costs to Florida resulting from NAS, and identifying strategies to reduce the problem of prescription drug addiction among pregnant women. It is important to note that a task force is not the vehicle to solve the problems it was created to examine. A task force is rather a catalyst to bring together multiple stakeholders and guide them to agree on a way forward. The following are the policy recommendations for the Statewide Task Force on Prescription Drug Abuse & Newborns:

I. Prevention

To deter the onset of addiction by providing individuals with the information and skills necessary to stop the problem of prescription drug abuse.

Policy Recommendation	Assignment
1. Develop and implement a coordinated statewide public awareness initiative, through existing community resources, that is intended to educate the public about the dangers of prescription drug abuse during pregnancy.	Attorney General Department of Children & Families Department of Health Florida Association of Healthy Start Coalitions March of Dimes
2. Ensure that all school-based prescription-drug-specific primary prevention efforts are properly developed, evidence-based, rigorously evaluated, and sustainable.	Drug Policy Advisory Council

II. Intervention & Best Practices

This is a broad category that can include: medical training, prenatal health care screenings, methods that detect and respond to substance exposure at the time of delivery, as well as interventions that provide services for the newborn as well as the family immediately after birth.

Policy Recommendation	Assignment
1. Make drug screening pregnant patients a voluntary best practice policy for obstetricians. Screening would occur via the most appropriate methods determined by obstetricians as part of their patient standard of care.	Florida Osteopathic Medical Association Florida Medical Association Department of Health
2. Develop curricula for Florida nursing and medical schools to address addiction as a brain disease, as well as to develop continuing education credits for medical professionals that would enhance the knowledge and skills needed to more effectively manage chronic pain, treat substance use disorders, and better prevent prescription drug diversion.	Department of Health Florida's Medical Schools Board of Governors Florida Medical Association Florida Osteopathic Medical Association Florida Nurses Association
3. Create a toolkit of "best practices" for nurses caring for Neonatal Abstinence Syndrome (NAS) newborns and their families.	Florida Nurses Association The University of South Florida College of Nursing
4. Collaborate with communities (hospital staff, medical personnel, Healthy Start, Early Steps) to implement a system of "case conferencing" for NAS infants so as to better coordinate services before discharge from a hospital.	Department of Health Department of Children & Families Florida Hospital Association Florida Medical Association Florida Association of Healthy Start Coalitions

Policy Recommendation	Assignment
5. Find innovative ways to increase the voluntary use of Florida's Prescription Drug Monitoring Program (PDMP) among medical professionals.	Department of Health Florida Medical Association Florida Osteopathic Medical Association
6. Create an immunity provision in Florida law for pregnant woman seeking prenatal care or substance abuse treatment.	Task Force Members
7. Create a toolkit to help communities establish and maintain <i>Substance Exposed Newborn Workgroups</i> .	Florida Association of Healthy Start Coalitions Florida Perinatal Quality Collaborative Department of Health Department of Children & Families Attorney General
8. Work with federal agencies to fund research projects in Florida aimed at: (1) understanding the full economic costs associated with NAS in Florida; (2) enhancing our understanding of effective treatment methods for NAS infants and mothers with opioid dependence; (3) understanding the long-term consequences of maternal opioid pain reliever abuse on children; and (4) funding expanded access to evidence-based behavioral interventions for at-risk mothers (such as electronic-therapy and nonresidential community-based care).	Department of Health Department of Children & Families Agency for Healthcare Administration Attorney General
9. Ensure appropriate adoption procedures and support is in place for families wishing to adopt a drug exposed newborn.	Governor's Office of Adoption & Child Protection Department of Children & Families
10. The Agency for Health Care Administration will create a workgroup to assess the viability of expanding the Screening Brief Intervention and Referral to Treatment (SBIRT) model beyond health care settings to other settings where at-risk mothers can be reached.	Agency for Health Care Administration Department of Children & Families Department of Health Florida Alcohol & Drug Abuse Association

III. Treatment

This area covers medical and/or psychotherapeutic care for substance dependencies such as alcohol, illegal drugs, or prescription drugs.

Policy Recommendation	Assignment
1. Develop treatment protocols for drug-exposed newborns as well as recommendations for alternatives to narcotics for pain management in pregnant women.	Florida Medical Association Florida Osteopathic Medical Association Florida Perinatal Quality Collaborative
2. Enhance the capacity of the behavioral health system to ensure that pregnant women and mothers have immediate access to the appropriate level of care through a continuum of services that, at a minimum, includes <ul style="list-style-type: none">• Expand residential treatment capacity• Expand intensive outpatient treatment capacity• Fund case management services to assist women leaving treatment	Department of Children & Families Florida Alcohol and Drug Abuse Association
3. Add Neonatal Abstinence Syndrome to the list of Reportable Diseases and Events.	Department of Health

CHAPTER 1

EXTENT OF THE PROBLEM

Key Takeaways:

- Florida has been the epicenter of prescription drug diversion, resulting in more women using or abusing prescription opioid drugs.
- More women abusing prescription drugs translate to an increase in more cases of Neonatal Abstinence Syndrome (NAS).
- NAS refers to medical complications newborns typically experience if their mothers abused illicit or prescription drugs during pregnancy.
- NAS is a treatable disease.
- Determining the exact number of cases of NAS in Florida is difficult because there is significant variability in hospital policies and practices used to determine both the diagnosis and reporting of NAS.
- Nevertheless, in 2011 there were 1,563 newborn drug withdrawal cases reported in Florida. This category includes all classes of drugs.
- A recent national study determined that between 2000 and 2009 average hospital charges for newborns diagnosed with NAS increased from \$39,400 to \$53,400 per baby, about a 35 percent increase.
- The Task Force determined that NAS costs are concentrated in Neonatal Intensive Care Unit expenses, and are typically paid by Medicaid.

Introduction

Prescription drug abuse is both a public health and law enforcement crisis in America, with more than six million Americans abusing prescription drugs.¹ To put this new epidemic into perspective, more Americans currently abuse prescription drugs than the number of those using cocaine, hallucinogens, and heroin combined.² Hospitals are treating ever growing numbers in their emergency rooms - according to the Drug Abuse Warning Network (DAWN) data, emergency room visits involving nonmedical use of narcotic pain relievers increased from 145,000 in 2004 to 360,000 in 2010.^{3,*}

In Florida, pharmaceutical drug diversion and abuse translates to about seven overdose deaths per day, with many additional lives lost-and impacted by-addiction, increased crime, and substantial and increasingly unsustainable medical costs driven by sharp annual increases for drug treatment, emergency medical intervention, and even instances of prescription drug driven Medicaid fraud. To put this carnage statistically, for every 1 overdose death there are 9 treatment admissions, 35 emergency room visits for misuse or abuse, 161 people with abuse and/or dependence issues and a staggering 461 nonmedical users of prescription drugs.⁴

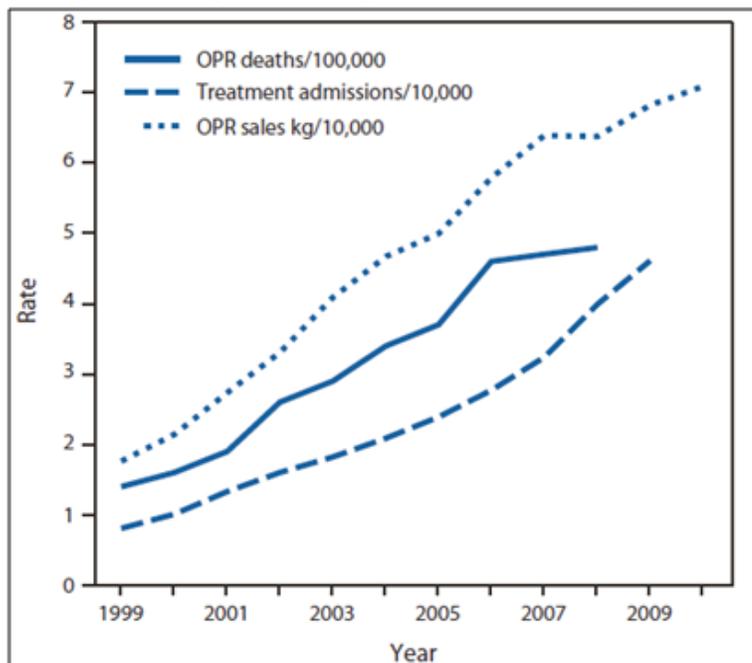
Why Did the Epidemic Spread?

In 2011, Attorney General Bondi's Prescription Drug Diversion & Abuse Roadmap outlined the problem of prescription drug diversion:

What is fueling this health crisis? The National Institute of Drug Abuse (NIDA) reports that the big jump in prescription drug abuse over the past decade was no accident. It came about for a variety of reasons, to include the introduction of a powerful new class of time-released opioids – what some addiction specialists have dubbed “heroin in a pill” – which can be tampered with in such a way as to defeat the time-release mechanism and provide the abuser a fast-acting yet enduring “high;” aggressive marketing strategies by the pharmaceutical industry to promote the widespread use of these new time-released opioids; greater social acceptability for medicating a growing number of conditions; and of course, a flood of diverted pills easy made possible by illicit activity.⁵ Yet other contributing factors include a segment of our population which perceives abusing prescription drugs as inherently less harmful than use of per se illegal drugs like cocaine, meth and heroin.⁶

The below chart shows the rates of opioid pain reliever (OPR) overdose deaths, OPR treatment admissions, and kilograms of OPR sold in the United States from 1999 – 2010.⁷ Clearly, substance abuse treatment admissions and the rate of prescription opioid overdose deaths have increased with the rate of prescription opioid sales.

One particularly disturbing “down-stream” impact of more people abusing prescription drugs has been



Source: Centers for Disease Control and Prevention: MMWR November 2011

more pregnant woman misusing or abusing prescription drugs. More infants are spending longer amounts of time in Neonatal Intensive Care Units (NICU), which exacts significant additional costs for the entire health care system. But the financial burden pales in comparison to the human costs: a new mother not being able to care for her child because it has to withdraw from prescription opioids in a NICU cannot be calculated. Newborns withdrawing from prescription opioids have prolonged high-pitched crying, suffer tremors and seizures and have poor feeding problems. Watching a newborn child withdraw from prescription opioids is a sight no family member should have to endure.

To alleviate the very real suffering in our state, and prevent mounting costs to our health care delivery system, this Final Report of the Statewide Task Force on Prescription Drug Abuse & Newborns seeks to build a

statewide consensus on how to prevent, screen and treat prescription drug abuse in Florida's most vulnerable population.

What Florida Has Done to Solve the Prescription Drug Epidemic

Until recently, Florida was known as the “OxyContin Express,” a major supplier of powerful narcotics (oxycodone and hydrocodone) to addicts and distributors throughout the nation because of a proliferation of unscrupulous pain management clinics called “pill mills”. Florida became the epicenter of prescription drug diversion because of weak regulatory oversight of pain management clinics, limited oversight of physician dispensing habits, as well as being one of the last states in the Union to implement a Prescription Drug Monitoring Program (PDMP).

In 2011, Attorney General Bondi published a statewide *Prescription Drug Diversion and Abuse Roadmap*. The Roadmap either directly led to or reinforced:

- law enforcement and Department of Health regulators working in concert through the Regional Drug Enforcement Strike Forces (2011-present);
- comprehensive anti-pill mill legislation (HB 7095, passed in 2011);
- an operational Prescription Drug Monitoring Program (2011-present);
- new anti-prescription drug diversion prevention messaging starting to take hold.

A critical step forward in organizing Florida’s balanced attack on “pill mills” began in March 2011, when Governor Rick Scott and Attorney General Bondi created Florida’s Regional Drug Enforcement Strike Forces. Using Florida’s seven domestic security regions to organize this statewide effort, each of the seven Strike Forces is co-led by a Sheriff and a Police Chief from within each respective region. Strike Force operations seek to reduce the supply of diverted prescription drugs through intelligence driven, multi-jurisdictional operations against the whole spectrum of the pill mill phenomenon: corrupt wholesalers, unscrupulous “physicians,” rogue pharmacies and “doctor-shopping” “patients” supporting their addictions.

Then in the Spring of 2011, the Florida Legislature enacted HB 7095, a tough new law on prescription drug diversion that:

- Banned dispensing of Schedule II and Schedule III controlled substances by physicians and made a violation of the ban both a third degree felony and grounds for licensure discipline.
- Created a standard of care for all physicians prescribing controlled substances to treat chronic pain.
- Required physicians to either electronically prescribe controlled substances or use counterfeit-proof prescription pads.
- Added new criminal penalties.
- Improved reporting to the state’s PDMP from 15 to 7 days.
- Required wholesale distributors to credential customers and report on distribution of controlled substances.
- Required pharmacies dispensing Schedule IIs and IIIs to be re-permitted with the state.
- Provided \$3 million to fund state Regional Drug Enforcement Strike Forces.

While any one of these legislative enhancements on their own would have helped fight prescription drug diversion and abuse, all of these statutory changes implemented together – and working in tandem with Strike Force operations, stricter regulatory oversight and drug prevention messaging - created dramatic results. To better illustrate the salutary effects of Florida’s crackdown, from March 2011 through December 2012, Regional Drug Enforcement Strike Force efforts alone resulted in 3,742 arrests (including 67 doctors), and the seizure of 848,037 pharmaceutical pills, 121 vehicles, 538 weapons, and \$10,073,807. Additionally, 254 pain clinics have been closed.

Thanks to the Florida Legislature's dispensing - ban coupled with aggressive regulatory efforts to close pill mills - the number of Florida doctors dispensing the most oxycodone within a given year has declined dramatically. In 2010, 98 of the top 100 oxycodone pill dispensing physicians nationally resided in Florida. In 2011, after the passage of HB 7095, only 13 of the top 100 resided in Florida, and, as of the end of 2012, not one Florida doctor appeared on the top 100 list.⁸

The most important result of Florida's turnaround on prescription drug diversion has been the success in lowering the most important negative metric of all: a decline in the number of prescription drug overdose deaths. The significance of this decline in overdose death cannot be overstated: during the previous six years, prescription drug deaths were increasing in Florida on average by 12 percent each year, with oxycodone specific deaths increasing an average of 35 percent each year. Indeed, since 2003, oxycodone deaths were a major factor in Florida's skyrocketing prescription drug overdose death rate. In 2011 however, oxycodone driven overdose deaths in Florida decreased by 17.7 percent (268 fewer deaths). Overall, there were fewer prescription drug related deaths (171 fewer deaths, a 6 percent decline) in 2011 – the last year full statistics are available, including slightly fewer overdose deaths caused by hydrocodone and methadone - when compared to 2010.⁹

Florida is now bringing to bear a broad based strategy for fighting prescription drug trafficking and abuse thanks to the leadership of our Governor, our Legislature and Florida's law enforcement and public health care communities. Ultimately, only a balanced approach using law enforcement, regulatory and public health resources will reduce this extremely large and intertwined public health and law enforcement problem by attacking both the supply side – driven by a flood of diverted pharmaceuticals; and the demand side - driven by pharmaceutical drug abuse and addiction, of the prescription drug epidemic.

Women & the Prescription Drug Epidemic

The use of powerful prescription opioids during a pregnancy can lead to Neonatal Abstinence Syndrome (NAS) in a newborn. While alcohol and tobacco use occurs more frequently during a pregnancy than prescription drug abuse, the increase use of prescribed opioids by pregnant women is fueling an increase in the number of cases of NAS in hospitals all across Florida.

It may be difficult to comprehend why a woman would abuse prescription drugs after finding out she is pregnant. She may not initially disclose to her doctor her use of prescription drugs because she may feel shame or guilt, or, perhaps, she fears she will be reported to a child welfare agency. Other women may believe their use of prescription drugs is safe simply because it was originally prescribed, and therefore may not inform other medical professionals. Finally, some women will not seek medical care until their pregnancy is late term, and they continued to abuse prescription drugs ignorant of the damage they were doing to their unborn child.

Whatever the reason may be for continued use by pregnant women, prescription drug abuse is a real concern. National survey data highlights that pregnant women aged 15 to 44 had a lower rate of illicit drug use when compared to women who were not pregnant in this age group (5.0 percent vs. 10.8 percent). For pregnant women aged 15 to 17, the rate of current illicit drug use was 20.9 percent, so it's clear that drug use decreases as women age (8.2 percent among pregnant women aged 18 to 25, and 2.2 percent among pregnant women aged 26 to 44).¹⁰ This national survey data therefore highlights that a woman's age is a factor to reducing drug use.

While age should not be overemphasized in solving the problem of addiction, it is something the Task

Force has taken into account when proposing statewide policy recommendations. Any statewide or local prevention campaign must find ways to influence younger women. Prevention messaging must be targeted and penetrating enough for young women to change their substance use during the first trimester. An example of effective prevention messaging and programs are highlighted in Chapter 2 of this report.

What is NAS?

NAS refers to a group of medical complications associated with the withdrawal process newborns typically experience after birth if their mothers have used addictive illicit or prescription drugs during pregnancy. NAS is a disorder characterized by infants experiencing Central Nervous System hyper-irritability, gastrointestinal dysfunction and respiratory distress. Infants hindered by these symptoms (Chart II) will experience feeding difficulties, weight loss, sleeping abnormalities and a disruption to the mother-baby relationship.¹¹

Thankfully, NAS is a treatable condition. Even more fortunately, it is critically important to note that neither NAS nor its treatment is known to produce long-term, negative developmental outcomes.¹² It is important therefore to dispel certain myths. For example, a baby should never be referred to as “drug-addicted”. While the mother can be medically defined as addicted to prescription drugs, a fetus or newborn baby cannot be addicted. Consequently, a baby suffering from NAS should always be referred to as a “drug exposed” newborn.

Size and Scope of the Problem in Florida

Determining the exact number of cases of NAS in Florida is difficult because there is significant variability in hospital policies and practice that determine both the diagnosis and reporting of NAS. The International Classification of Diseases, Ninth Revision (ICD-9) hospital discharge database is the most effective tool available for determining the number of NAS cases in Florida. Published by the United States Department of Health and Human Services, ICD-9 is a system for coding signs, symptoms, injuries, diseases, and conditions. The numbers represent billable medical codes that can be used to specify a diagnosis on a reimbursement claim. Unfortunately, because, ICD-9 codes have in the past underestimated the incidence of NAS, Task Force members exercised caution when attempting to make general assumptions about the number of NAS cases caused by prescription drugs.¹³

This Task Force used two ICD-9 codes (779.5 and 760.62) in assessing the total number of drug exposed newborns. The first code, 779.5, captures drug withdrawal syndrome in a newborn of a dependent mother, but this code does not discern prescription drug opioids from illicit opioids. The second code, 760.72, describes narcotics affecting fetus or newborn via placenta or breast milk. The code excludes anesthetic and analgesic drugs administered during labor and delivery (763.5), drug withdrawal (779.5), and cocaine, which is not considered a narcotic (760.75). Both codes exclude fetal alcohol syndrome (760.71).

Chart II

Signs & Symptoms of NAS

Central Nervous System

- High-pitched cry
- Irritability, fussiness
- Tremors
- Seizures
- Skin excoriation on knees and face from hyperactivity
- Sleep problems

Gastrointestinal

- Dehydration
- Poor feeding
- Excessive sucking
- Diarrhea
- Poor weight gain

Metabolic, Vasomotor, Respiratory

- Nasal stuffiness, sneezing
- Frequent yawning
- Fever
- Sweating
- Rapid breathing

Chart III

Year	Code 779.5 ONLY	Code 760.72 ONLY	Codes 779.5 & 760.72	# Newborns 779.5 and/or 760.72	Rate per 1,000
2011	1,190	302	71	1,563	7.52
2010	975	278	83	1,336	6.38
2009	696	248	75	1,019	4.72
2008	501	159	34	694	3.08
2007	360	141	35	536	2.31

Chart IV is a five-year summary of NAS cases, and includes the total number of live births that occurred in the corresponding year.

Chart IV

Number of Newborns Diagnosed with Selected Fetal/ Newborn Drug Exposure in Florida		
Year	# of Newborns Diagnosed	# of Live Births
2011	1,563	207,710
2010	1,336	209,520
2009	1,019	216,057
2008	694	225,198
2007	536	232,306

Determining the full extent of NAS was an arduous task for this task force report because Florida hospital discharge data is received as aggregated data from the Agency for Health Care Administration (AHCA). As previously noted, there is no statewide standardization for the diagnosis and reporting of substance exposed newborns; policies and procedures for diagnosis and reporting therefore vary by hospital. A portion of the number of newborns captured in ICD-9 codes also includes mothers who are on a Medicated Assisted Treatment (MAT) program (program discussed further in Chapter 4). Although newborns born from a mother on a MAT program are tabulated in these codes, the mothers are in an improved condition to care for their child, as well as continue on into substance abuse treatment after labor.

Some of the best NAS data is provided directly from Florida hospitals. For example, St. Joseph's Women's Hospital in Tampa reports that there are, on any given day, as many as fourteen percent (14%) of the infants in their NICU suffering from prescription drug abuse caused NAS.¹⁴ Other Florida hospitals, such as Spring Hill Regional Hospital, have reported that as many as thirty percent (30%) of the babies in their NICUs suffer from opioid withdrawal.¹⁵

Because statewide NAS data is captured by each hospital a little differently the statewide trend data on substance exposed newborns is very likely underreported. That is why the Task Force recommends that NAS become a reportable disease. This recommendation would enable Florida's Surgeon General, the

Department of Health, and AHCA to gather more accurate data on the extent of NAS in Florida. Long-term, improved data collection methods will lead to better health outcomes for Floridians by fostering more research to determine the best way to help expectant mothers break their addiction, while also preserving the health of the baby both in-utero and after birth.

Cost of NAS

Determining the societal costs of drug addiction is a complicated task because drug abuse exacts so many direct and indirect costs to society. The difficulty of collecting and analyzing state level data held true as the task force set out to determine the costs of prescription drug abuse and NAS in Florida. Nevertheless, the Task Force was able to use a national study as well as collect a range of Florida hospital NAS-driven cost data to produce a reliable estimate.

The national study the Task Force used was the May 2012 study published in the Journal of the American Medical Association entitled, *Neonatal Abstinence Syndrome and Associated Health Care Expenditures United States*. The report's researchers analyzed hospital charges and found that infants with NAS had longer, more complicated initial hospitalizations. The study determined that between 2000 and 2009, mean hospital charges for newborns diagnosed with NAS increased from \$39,400 to \$53,400 per baby, about a 35 percent increase. To put that increase into perspective, charges for all other hospital births only increased from \$6,600 to \$9,500 during the same time period.¹⁶

Chart V highlights this study's delineation of the various payers of hospital chargers for NAS. Medicaid was the primary payer for the majority of hospital charges for NAS in infants, increasing from 68.7 percent of aggregate charges in 2000 to 77.6 percent of aggregate charges in 2009.¹⁷

Chart V

Proportions of U.S. Hospital Charges for Neonatal Abstinence Syndrome by Payer				
Weighted % (95% CI)				
<i>*Percentages may not sum to 100 because of rounding</i>				
Year	Medicaid	Private Payer	Self-Pay	Other Pay
2000	68.7	18.2	8.7	4.4
2003	69.9	19.8	6.5	3.8
2006	73.7	19.0	5.5	1.9
2009	77.6	17.6	2.9	2.0

Most newborns diagnosed with NAS are admitted to a hospital's NICU, and their average length of stay is about three weeks. The length of the NICU stay is what drives the higher cost of treating NAS, and the length of stay for NAS diagnosed newborns did not decline during the last decade. The researchers concluded that more effective NAS treatments could shorten hospital stays, saving Medicaid dollars.¹⁸

Reviewing Florida specific data, the Task Force found results that were aligned with the national data. Since 2008, on average, seventy-seven percent (77%) of NAS patients were Medicaid patients.¹⁹ In addition to the national data highlighting Medicaid as the primary payer for NAS hospital charges, the Florida specific data supports the findings that Florida Medicaid is the primary payer of hospitals charges.

Chart VI

Medicaid - Newborns (Children Under 1 year with DOB during the fiscal year) diagnosed with Withdrawal Syndrome (ICD9CM Diagnosis Code 7795)

Hospital Claims only (Bucket = '01','03')

SFY	Patients	Claims	Amount	Overall Expenditures	Pct.
FY 2008-09	471	672	\$12,018,224.07	\$12,458,084.37	96.47%
FY 2009-10	769	1,096	\$20,931,373.59	\$21,738,153.67	96.29%
FY 2010-11	940	1,627	\$34,796,282.78	\$35,357,027.98	98.41%
FY 2011-12	919	1,623	\$31,752,169.04	\$32,650,816.32	97.25%

"Patients" are the counts of distinct individuals

"Claims" are the total claims received and paid by Medicaid for these individuals

"Amount" represents the amount paid for the **hospital** services

"Overall Expenditures" represents all expenditures, including hospitalizations, for the individuals for the entire fiscal year



Attorney General Bondi listens to Task Force member Dr. Stephanie Haridopolos at the December 9th meeting in Tallahassee.

CHART VII

**Newborns (Children Under 1 year during the fiscal year) diagnosed with
Withdrawal Syndrome (ICD9CM Diagnosis Code 7795)
Hospital Inpatient
Discharge Data**

Payer Code	Principal Payer Description	FY2008		FY2009		FY2010		FY2011	
			Charges		Charges		Charges		Charges
B	Medicare	1	\$369,606.00	0	0	0	0	2	\$205,070.00
C	Medicaid	515	\$39,548,876.00	821	\$63,909,888.00	961	\$100,616,291.00	884	\$75,011,043.00
D	Medicaid Managed Care	33	\$2,117,152.00	67	\$5,488,803.00	110	\$13,788,713.00	115	\$11,249,830.00
E	Commercial Health Insurance	8	\$163,497.00	47	\$5,832,839.00	96	\$28,472,461.00	95	\$9,505,466.00
F	Workers Compensation	37	\$4,356,602.00	16	\$869,545.00	0	0	0	0
G	Commercial HMO	32	\$3,326,462.00	18	\$753,384.00	0	0	0	0
I	Tricare or Other Federal Program	3	\$210,874.00	6	\$136,180.00	9	\$1,029,702.00	15	\$735,734.00
J	VA	0	0	1	\$16,307.00	0	0	0	0
K	Other State & Local Gov.	1	\$31,155.00	1	\$4,695.00	3	\$62,974.00	2	\$20,895.00
L	Self Pay	43	\$1,372,583.00	44	\$1,069,113.00	59	\$2,015,490.00	59	\$2,514,775.00
M	Other	0	0	3	\$87,347.00	3	\$948,135.00	5	\$304,662.00
N	Non-Payment	1	\$12,773.00	2	\$123,406.00	1	\$163,119.00	2	\$87,901.00
O	Kidcare	0	0	0	0	1	\$108,465.00	2	\$266,716.00
	Total		\$51,509,580.00		\$78,291,507.00		\$147,205,350.00		\$99,902,092.00

The Chart VI represents the numbers for newborns diagnosed with NAS and is based on data extracted from the Florida Medicaid claims database. Chart VII represents similar information, but uses data from Florida Hospital Inpatient Discharge database. Both charts represent numbers of newborns (children under 1 year) who were diagnosed with NAS (ICD-9 refers to it as Drug Withdrawal Syndrome) (ICD-9 diagnosis 779.5) during a state fiscal year (July 1 through June 30). All amounts in Chart VII represent hospital charges and do not necessarily represent actual payment amounts, whereas information in Chart VI represents actual Medicaid payments to the hospitals. Furthermore, Chart VI includes all Medicaid expenditures (Overall Expenditures), in addition to the hospital expenditures for the identified Medicaid beneficiaries, and shows the percentage of hospital expenditures as a percentage of total cost of care.

The following differences between the two charts should also be noted:

- Chart VI represents information on children identified as Medicaid Fee-For-Service recipients, and is based on Medicaid claim payment information. Chart VII includes information extracted from the Hospital Inpatient Discharge data reporting system and is based on hospital reported inpatient discharge data for all newborns during the same period; payer information is self-reported information.
- Chart VI represents only Fee-for-Service Medicaid recipients and does not include Medicaid

recipients who may be covered under a Managed Care Organization (MCOs, HMOs, etc.). There would be no corresponding comparison value Chart VII.

- Chart VI data are based on an examination of one primary diagnosis code and three secondary diagnoses codes, while Chart VII data are based on evaluating over 30 secondary diagnoses for the specific condition.

The Task Force determined that the costs of NAS are mostly being paid by Medicaid and that the costs are concentrated in NICU expenses. This is due to the fact that a drug exposed newborn will have to spend additional time in a NICU receiving treatment before they can be released.

The Roles of Doctors and Nurses

Medical professionals are the keystone to both prevent and alleviate NAS. This can be achieved first and foremost by having well trained doctors and nurses in the various program fields of drug addiction. The 2011 National Prescription Drug Plan supported the need for doctors and nurses to be capable of understanding the full scale of addiction and how prescription drug use can lead to unintended consequences.²⁰ Oftentimes, healthcare providers receive minimal training in how to recognize substance abuse in their patients. Medical professionals have difficult jobs and must constantly keep up with more onerous rules and regulations. However, new training should be instituted that helps the overall care of patients.

One way this can be achieved is through the implementation of the Task Force recommendation to create and implement educational curricula for health care professional schools (medical, nursing, pharmacy and dental) for treatment of drug and alcohol addiction. In addition, there should be ongoing professional education about what constitutes a safe and appropriate use of opioids for pain treatment that also puts an emphasis on minimizing the risk of addiction and substance abuse.

The Mission of the Florida Nurses Association is to serve and support all registered nurses through professional development, advocacy and the promotion of excellence at every level of professional nursing practice. The Association's appointment to the Task Force was Willa Fuller, and she and her fellow nurses were key assets to the Task Force. The Association's overarching recommendation for this report is to train all members of the healthcare team to cope with the emotions typically associated with treating drug exposed newborns. There must also be competent evaluation of infants who are suffering from NAS.

The Florida Nurses Association will lead this effort by creating a toolkit for nurses. The goal will be to produce a toolkit that would be a resource for nurses/caregivers. The toolkit would be cost neutral by disseminating the information via the association's statewide publication, The Florida Nurse, which reaches over 250,000 nurses licensed in the state. Also, the Florida Nurses Association will have the toolkit as a web-based resource for clinicians and the public, and will be posted on their website: www.floridanurse.org

The Role and Response from Child Welfare Agencies

The mission of child welfare agencies is a delicate balance between protecting children and keeping families safely together. The rise of prescription drug abuse, and the increased number of NAS cases has necessitated the Florida Department of Children & Families (DCF) to take an active role in protecting children from the harms of drug exposure. However, Florida as well as the nation, struggle to find consensus on what should be a consistent and evidence-based response to a mother's drug

use during pregnancy. One person's public health challenge is another person's criminal conduct, and to that end prenatal drug exposure does not fit nicely into a single discipline. That is why it is going to take a series of stakeholders to address the problem of prescription drug abuse among women of child bearing years.

Identification and treatment are essential. Florida's response to NAS must therefore be a hybrid approach, combining a law enforcement response and public health-oriented response. We must acknowledge that while the problem of drug abuse is a public health issue, law enforcement and the courts also have a vital role to play in ensuring that a person seeking treatment successfully follows-through because most successful treatment outcomes involve a certain element of coercion. Unlike other health care problems, law enforcement must also be involved because an individual's addiction often has public safety ramifications.

Oftentimes, without the aid of others, an addict will drop out of substance abuse treatment. A hybrid response is therefore effective precisely because it can leverage the criminal justice system to improve treatment compliance. Florida's drug courts are a prime example of this hybrid approach, in that these courts assess drug offenders, linking them to treatment, and then holding them accountable at every turn through judicial sanctions. Florida currently has twenty-one (21) Family Dependency Drug Courts working to protect infants and children whose welfare may be negatively impacted by drug addicted parents. These Family Dependency Drug Courts, which cover seventy (70) percent of the judicial circuits in Florida, work to support and reinforce the family unit. These courts have been successful over the years in getting children their parents back safe and drug-free.²¹

Between 2008 and 2011, eighty-nine percent (89%) of substance exposed newborn patients were discharged from the hospital to routine home care with the mother.²² As noted in prior discussions, a mother may be using prescription drugs during a pregnancy for a variety of reasons. Child welfare investigators must take into account not just drug use, but a wide range of variables that evaluate the parent's capacity to protect and care for the child. The illustrates how reports are received by DCF and the investigative process into allegations of drug exposed newborns.

Preceding the reauthorization of Child Abuse Prevention and Treatment Act (CAPTA) in 2003, state policies directed the reporting of drug exposed newborns to child welfare services. State policy still determines whether or not an official report is required, even though federal law now requires health care providers to refer all infants identified as drug exposed to child welfare services.²³ The Task Force reviewed DCF reporting procedures, with a priority emphasis placed on ensuring the mother's privacy interests are protected. Since all reported allegations of child abuse are received by the DCF Hotline, investigations are maintained electronically in the Florida Safe Families Network (FSFN) - DCF's child welfare computer system. A recording of every hotline call is also maintained.

It is important to note that only those persons given access through a DCF Security Officer can access FSFN. Various levels of access are available and many do not authorize the ability to see abuse reports. Having access to FSFN only gives an individual authorization to see cases relevant to their job duties. Because an investigator cannot simply troll through reports or other information not relevant to their work, a report regarding a mother who has allegedly abused a child through prescription drug abuse can only be viewed by those personnel who have a statutorily granted need to see that report. Any wrongful disclosure of confidential FSFN information is a second degree misdemeanor.²⁴

Until FY 2011-12, calls made to the DCF child abuse hotline about suspected NAS babies were not recorded in a separate category, they were included in the larger specification of “substance misuse.” DCF did however conduct an analysis where a series of assumptions were made about the data and to the following estimate was made, as detailed below in Chart IX.

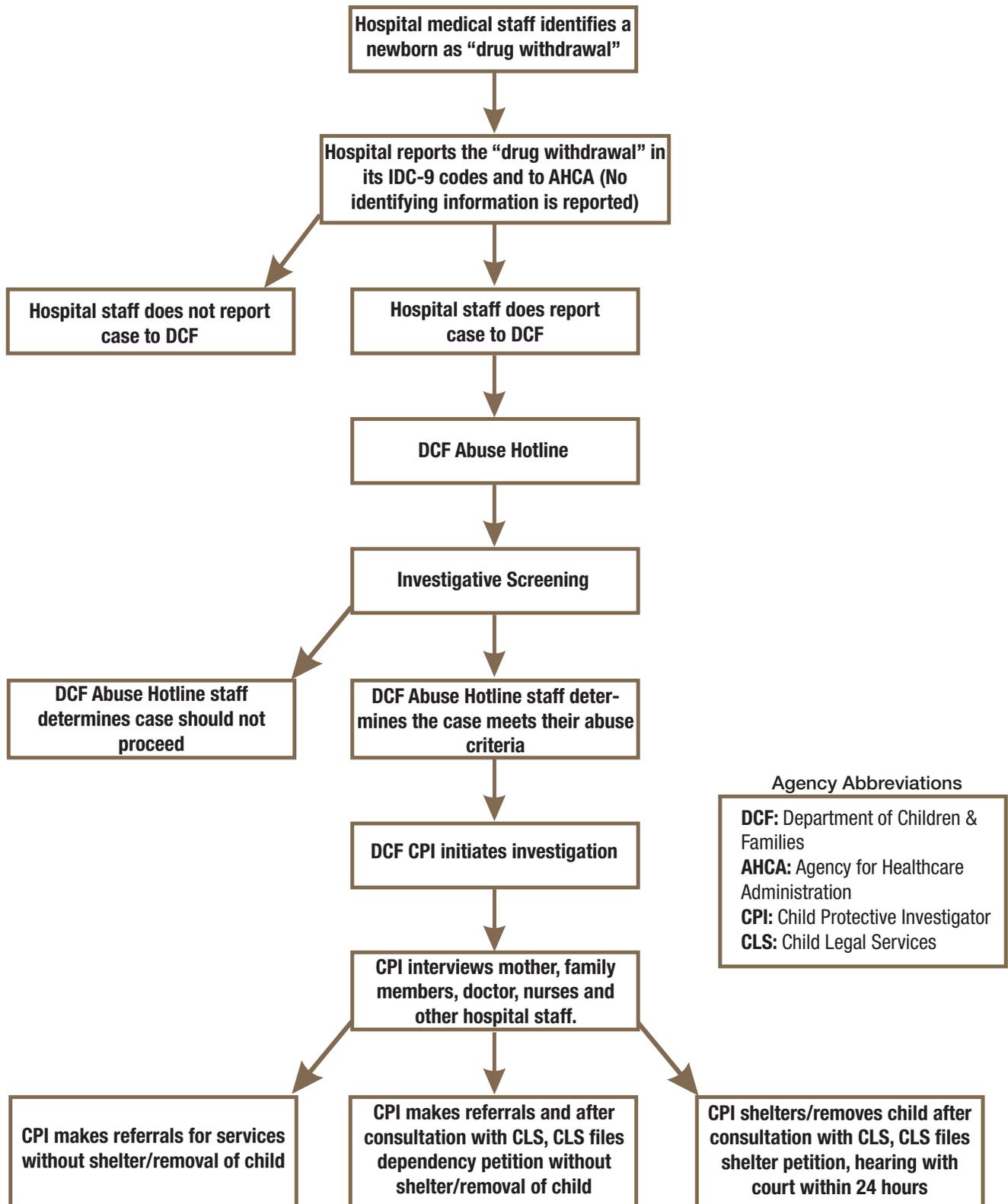
Fiscal Year 2010_11	Mother	Mother	
Reporter Source Descriptions	Allegations 1 day (newborns)	Verified Allegations 1 day (newborns)	% of Substance Misuse for Mothers with Newborns
Hospital Social Worker	1944	729	37.5%
Medical Personnel	59	25	42.4%
Nurse	1046	379	36.2%
Other Health/Mental Health Professional	21	7	33.3%
Physician	2	1	50.0%
Total	3,072	1,141	37.1%

During fiscal year 2010-11, 16,763 children out of 105,998 allegations from the general public were verified as experiencing some form of substance misuse, a verification rate of 15.8 percent. Focusing on medical professionals reporting to the hotline on newborns with Substance Misuse where the mother was among the alleged perpetrators (1,141 / 3,072), the verification rate increases to 37.1 percent, which is more than twice the verification rate for this type of maltreatment.

An explicit goal of the Task Force was to therefore develop policy recommendations which would ensure a woman would be allowed to ask for help, especially from a medical professional, without fear of losing her children. Under current Florida law, a child will not be removed from a parent if there are reasonable efforts by the parent to ensure their child’s safety. For a drug exposed newborn, if the mother voluntarily places the child with the father or another appropriate caretaker until she is well enough to safely care for the child, and does not attempt to secure physical custody of the newborn until she has successfully completed her drug treatment, the mother can retain legal custody while DCF maintains oversight of the child to ensure their safety.

Steps should be taken to remove or reduce the impact of punitive policies regarding prenatal substance use in order to facilitate access to treatment for pregnant women. For example, Hawaii passed legislation in 2004 providing immunity from criminal prosecution for drug offenses for pregnant women seeking prenatal treatment.²⁵ The intent behind the legislation was to encourage substance-using women to seek prenatal care. This Task Force similarly recommends codifying in state law an immunity provision for a mother seeking substance abuse treatment.

DCF Child Abuse Investigative Flow Chart: Drug Exposed Newborn Cases



Conclusion

Prevention and treatment approaches for drug abuse, and more recently for drug exposed newborns, have improved over the past two decades. However, drug addiction still exists. That is not to say that substance abuse prevention programs have not made a difference, quite to the contrary. For example, getting pregnant women to stop drinking alcohol and smoking has been widely successful thanks to sustained and effective prevention messaging; fetal alcohol syndrome cases declined quite dramatically in many areas of the country over the past generation.^{26, 27} Now America is confronted with a prescription drug abuse epidemic, and how we collectively respond will have a profound impact on the generation to come.

Ultimately, Florida can dramatically reduce the incidence of NAS and create better outcomes for both newborns and pregnant women if it embraces a comprehensive approach linking prevention and treatment systems throughout the state. A linked “system of systems” would create many more positive outcomes in our state, by, among other things, advancing awareness of the importance of prenatal screenings, enabling early treatment referrals for addicted pregnant women, and ensuring the widespread availability of specifically tailored aftercare treatment programs for mother and newborn. The following chapters of this report outline how Florida can reduce prescription drug addiction among pregnant women and provide a healthier environment for its newborns.

CHAPTER 2

PREVENTION

Key Takeaways:

- Prevention should be viewed as a process, grounded in science, and not as a one-time event.
- Prevention programs that focus on providing education and awareness of the risks of prescription drug abuse to pregnant women are cost-effective and can be life-saving.
- Doctors and nurses well trained in drug addiction are the keystone to both prevent and alleviate NAS.
- Some prescription drug addicted women-fearing the involvement of child welfare agencies-avoid prenatal care. Florida's prevention messaging needs to ease those concerns, and get women to seek prenatal care and substance abuse treatment.
- The Task Force agreed to not advocate for mandatory prenatal drug screenings, but rather advance substance abuse screening as a component of a complete obstetric standard of care; screening should also be done with the consent of the pregnant woman.
- The Task Force recommended that the SBIRT program be expanded outside the primary care setting in order to reach more women who may need an intervention and referral to treatment. (Screening Brief Intervention and Referral to Treatment-SBIRT-is a public health approach to delivering early intervention to anyone who uses alcohol and/or drugs in unhealthy ways).

Introduction

Conversations about drug exposed newborns tend to focus on the necessary interventions and treatments needed for both the mother and child. But before debating effective treatments, it is critical to first try and prevent drug addiction from occurring. A frequently discussed topic at task force meetings was the general lack of awareness among both the public, and even some in the medical community, as to the dangers of prescription drug abuse. The Task Force agreed that healthcare providers, physicians, pharmacists, and patients must all play important roles in identifying and preventing prescription drug abuse by pregnant women if Florida is to make substantial progress in stopping NAS.

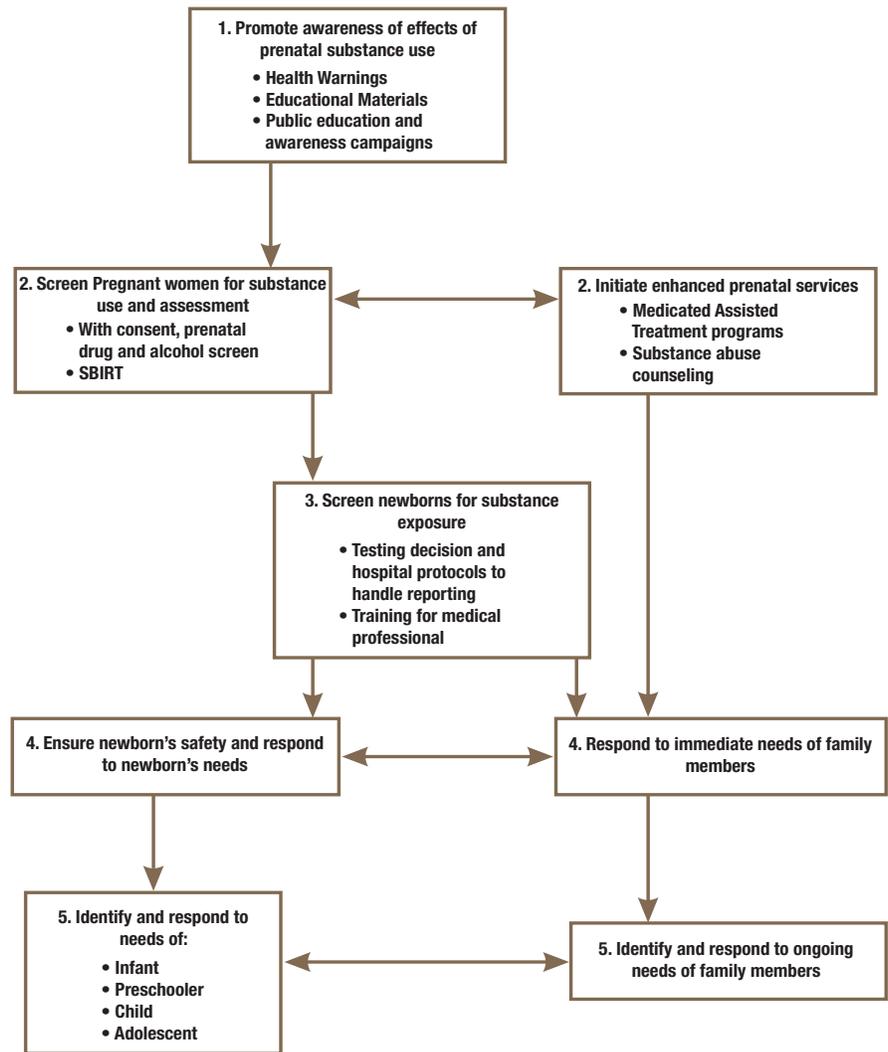
The most cost-effective way to address prescription drug abuse is to make certain it never happens in the first place. Addiction is preventable, and investing funds into prevention services for women can provide significant cost-savings to the child welfare, education and criminal justice systems.²⁸ However, preventing prescription drug abuse poses unique challenges. Prevention strategies must walk the fine line that informs people of the benefits of properly prescribed controlled substances, while at the same time instilling the message that when prescription drugs are misused or abused the consequences can be costly.

One factor that influences whether a woman misuses or abuses prescription drugs during her pregnancy is the extent to which she believes these substances might cause harm to her or her unborn child. For example, studies illustrate that alcohol warning signs increase knowledge and may lessen alcohol

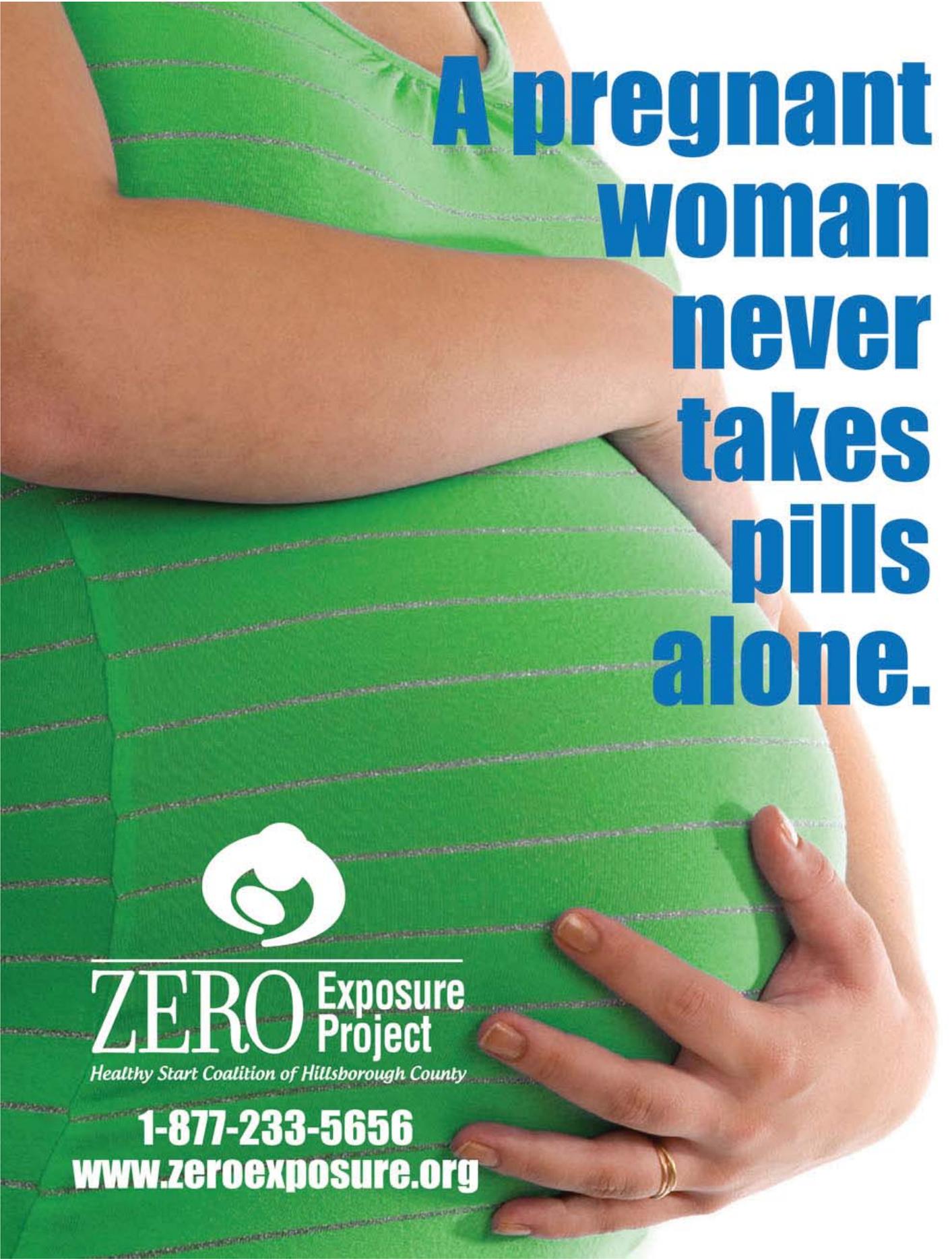
consumption among light to moderate drinkers.²⁹ Warning signs become even more effective when they are woven into a comprehensive strategy that not only provides information but also connects women to substance abuse treatment services. Warning women upfront about the potential dangers of prescription drug abuse during pregnancy does have a positive impact on a segment of women who may abuse prescription drugs. However, some women will ignore clear warnings and continue to use because they are already addicted. For these women, more wide-ranging treatment services will be required.

The U.S. Department of Health and Human Services recently published a report entitled, *Substance-Exposed Infants: State Responses to the Problem*. The report details “The Substance Exposed Infant Framework,” which includes five points of intervention for a drug exposed newborn (Chart below). As the framework shows, the birth event is one of several opportunities to make a difference, and will not be the only one this report focuses on. Public awareness and prenatal screening are the first two points of the framework and will be what the remainder of this chapter will expand upon.

Policy and Practice Framework: Five Points of Intervention



Substance-Exposed Infants: State Responses to the Problem." HHS Pub. No. (SMA) 09-4369. Rockville, MD.



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woman
never
takes
pills
alone.**



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Healthy Start Coalition of Hillsborough County

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Creating Public Awareness: Prevention Campaign

A public education media campaign about NAS in Florida should target two audiences: first, women of child-bearing age and their family, and friends; and second, health and social service providers serving women. Substance abuse prevention has evolved into a science over the previous decade. An effective campaign will not simply raise awareness of the problem, it will instill in women the belief that the substances they put into their bodies can have negative consequences for their health as well the health and well-being of their unborn child.

Task force member Dr. Stephanie Haridopolos evaluated various prevention methods for increasing public awareness of NAS, completing a wide-ranging effort that included public input on creating a statewide NAS prevention slogan. At the October 12th task force meeting, Dr. Haridopolos presented different NAS prevention slogans compiled from public input (Appendix B). The Task Force noted that to be effective, NAS prevention messages must be non-judgmental while encouraging woman to seek help. Task force members agreed that the core of a statewide anti-NAS prevention campaign in Florida must be a compelling visual image coupled with a powerful slogan targeted at young women.

The Zero Exposure Project is a superb example of local leadership collaborating to create an effective prevention campaign. The Zero Exposure Project - an initiative of the Healthy Start Coalition of Hillsborough County - is a community project involving many organizations working together to provide pregnant women with various treatment services to help ensure the delivery of healthy babies. The Zero Exposure Project comprises community collaboration, increased education, targeted outreach, and screening, assessment and treatment for substance using pregnant women. Part of the initiative's success is the creation of a Zero Exposure Committee that plans, coordinates and executes a community wide awareness campaign. The committee's work includes researching what resources are available including public relations and social marketing resources.

The Task Force has put forward a specific policy recommendation to develop and implement a coordinated statewide public awareness initiative, through existing community resources, that is intended to educate the public about the dangers of prescription drug abuse during pregnancy. The Healthy Start Coalition of Hillsborough County is willing to share their work with other organizations who would like to replicate their campaign. Attorney General Bondi, the Department of Children & Families, the Department of Health, March of Dimes, and the Healthy Start Coalition of Hillsborough County will work together to accomplish this prevention recommendation. Replication of the effective Zero Exposure Project statewide will be the ultimate goal.

At the national level, The Medicine Abuse Project - a recently launched prevention campaign to stop teen medicine abuse - can further support Florida's anti-NAS efforts. The Medicine Abuse Project is a multi-year effort bringing together parents, teachers, health care professionals, media and state, local and federal government partners. The Office of National Drug Control Policy, the Drug Enforcement Administration, National Institute on Drug Abuse, Centers for Disease Control and Prevention and the Bureau of Justice Assistance are the campaign's federal partners. The Medicine Abuse Project is leading a national education effort and call to action to: (1) educate about the dangers of abusing prescription and over-the-counter medicines, (2) monitor prescriptions and over-the-counter medicines, (3) safeguard and properly dispose of unused medication and (4) eliminate improper prescribing and dispensing practices.

The model provided by The Medicine Abuse Project is tailored made for Florida's community prevention coalitions. By expanding on their excellent work instilling in our youth the ability to reject drug use,

Florida's fifty-seven (57) Community Anti-Drug Coalitions can also expand NAS prevention messaging. These fifty-seven coalitions will greatly enhance the reach and impact of an anti-NAS campaign in Florida given their already well developed expertise in youth prevention programs and messaging. Ultimately, Florida's Coalitions adopting an aggressive NAS prevention campaign, in concert with law enforcement and medical professionals doing their critical parts, will help to change thousands of lives for the better over time.

Screening for Drug Use

In addition to prevention campaigns, another opportunity to intervene with women at risk of delivering a drug exposed newborn is during the early stages of their pregnancy. Prenatal screening by health care providers can result in early identification, referral for a comprehensive drug and alcohol assessment, and an appropriate link to treatment services. Screening methods can include self-report, interviews, clinical observation or the use of Patient Advisory Reports from Florida's Prescription Drug Monitoring Program (PDMP).

Screening should occur as early in the pregnancy as possible to minimize risk of exposure for the developing infant. Although Medicaid covers the cost of almost forty percent (40%) of hospital births nationally, there is currently no Medicaid requirement for prenatal screening for substance use.³⁰ The Task Force agreed to not advocate for mandatory screenings, but rather advance the notion of screening for substance abuse as a part of a complete obstetric standard of care, and that it should be done with the consent of the pregnant woman.³¹

If the decision is made to screen, there should be no discrimination as to who is, or is not, screened. Having prenatal drug screenings as part of a standard obstetric practice ensures all women, regardless of their socio-economic status, are asked about their drug, alcohol, smoking or prescription drug use. To ensure

that each woman and their unborn child receives the best care possible, and to better put these

Clinical Screening Tools for Prenatal Substance Use and Abuse

4 P's

Parents: Did any of your parents have a problem with alcohol or other drug use?

Partner: Does your partner have a problem with alcohol or drug use?

Past: In the past, have you had difficulties in your life because of alcohol or other drugs, including prescription medications?

Present: In the past month have you drunk any alcohol or used other drugs?

Scoring: Any "yes" should trigger further questions.

CRAFFT: Substance Abuse Screen for Adolescents and Young Adults

C Have you ever ridden in a CAR driven by someone (including yourself) who was high or had been using alcohol or drugs?

R Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?

A Do you ever use alcohol or drugs while you are by yourself or ALONE?

F Do you ever FORGET things you did while using alcohol or drugs?

F Do your FAMILY or friends ever tell you that you should cut down on your drinking or drug use?

T Have you ever gotten in TROUBLE while you were using alcohol or drugs?

Scoring: Two or more positive items indicate the need for further assessment.

Screening, Brief Intervention, and Referral to Treatment

The gap between the number in need of treatment and the number in treatment is a continuing policy concern. It should not take a person to be involved in the criminal justice system to finally receive substance abuse treatment. Earlier interventions are necessary. A majority of Americans visit a health care provider, such as a primary care physician, at least once every 2 years.³³ This interaction puts health care providers in a unique position not only to prescribe the appropriate amount of medications, but also to identify prescription drug abuse when it exists.

Efforts such as Screening, Brief Intervention, and Referral to Treatment (SBIRT) are therefore especially important. SBIRT is a public health approach to delivering early intervention to anyone who uses alcohol and/or drugs in unhealthy ways. SBIRT is succinct, proactive process for identifying substance use in a non-judgmental way, and to then begin to help those with the disease of addiction enter treatment. Research has shown that large numbers of individuals at risk of developing serious alcohol or other drug problems may be identified through primary care screening. Interventions such as SBIRT have been found to reduce healthcare costs, and decrease the frequency and severity of drug and alcohol use.^{34,35}

The Task Force recommended that SBIRT be expanded outside the primary care setting in order to reach more women who may need an intervention and referral to treatment. States are now in the process of determining how SBIRT billing codes should be utilized in their respective Medicaid plans. A few states have activated codes that allow non-physician professionals to conduct SBIRT, but others have limited it to physicians only.³⁶ In order to determine the best approach for Florida, the Agency for Health Care Administration will set-up a workgroup to assess the viability of expanding this initiative. The workgroup will include the Department of Health, the Department of Children & Families and the Florida Alcohol and Drug Abuse Association.

patients at ease, women should be informed upfront that such screening questions are asked of every pregnant woman in Florida, and that their responses will be kept confidential. Routine screening should rely on validated screening tools, such as questionnaires including the 4P's and CRAFFT (see sidebar, page 32).

Florida has thirty-three (33) Healthy Start Coalitions partnering with local public and private medical professionals, hospitals and schools, charities, and social services agencies. Healthy Start promotes optimal prenatal health and developmental outcomes for all pregnant women and babies. The fundamental goals of the Healthy Start program are to reduce infant mortality, reduce the number of low birth weight babies and improve health and developmental outcomes in newborns. Since 2009, the Florida Association of Healthy Start Coalitions has worked with the Florida Department of Health, the Florida Department of Children & Families, the March of Dimes, obstetricians, neonatologist, hospitals and other key stakeholders to address the critical problem of prescription drug abuse and drug exposed newborns.

Every doctor in the state of Florida is required to offer a Healthy Start screening to all pregnant women and their babies. Participation by the patient in the screening however is completely voluntary. By accepting a screening on the Healthy Start Prenatal or Infant Risk Screen (Appendix C), women know within minutes if they or their baby have any individual health risks. After completing a Healthy Start Screen, the doctor's office or delivering facility can then refer back to Healthy Start based on answers provided on the screening form. Healthy Start and the doctor's office continually communicate with each other to

ensure the best possible outcomes for a mother and her newborn child. During 2011-2012 fiscal year a total of 202,237 women and 194,253 infants were voluntarily screened for Healthy Start.³²

Medical professionals can also access Florida's PDMP (called E-FORCSE) to screen their patients to determine what controlled substances they are currently prescribed or have been prescribed in the past. Florida's E-FORCSE is a state-level resource that helps improve patient standard of care by getting prescription drug information to medical professionals in a free and timely manner to help them make determinations regarding the best way to treat their patients. E-FORCSE collects an individual's prescription drug history (those controlled substances Scheduled II-IV) and makes this history available

to registered medical professionals. E-FORCSE is not, however, a “silver bullet” that will reduce all prescription drug diversion and abuse. Rather, the database is simply an important and now integral part of a coordinated plan that Florida has begun using to more effectively curtail and eventually eliminate the prescription drug abuse epidemic.

Conclusion

The fundamental goal of any anti-NAS drug abuse prevention campaign must be to shift women’s perceptions and attitudes regarding the harm that comes from misusing prescription drugs. In addition, medical professional must select the screening method, with patient consent, they are most comfortable with in order to detect potential substance use during pregnancy and then be able to provide follow-up referrals to substance abuse treatment when necessary.

In addition to preventing NAS due to prescription drug abuse, we must remember that women may be abusing alcohol and illegal narcotics as well.³⁷ Polysubstance use - wherein multiple drugs (prescription or otherwise) and alcohol are abused in combinations - is also a contributing factor in many NAS cases. Polysubstance abuse must be addressed during a pregnancy because of adverse effects of multiple drug interactions and the serious maternal and fetal health risks from continued use with no prenatal care.³⁸ While the focus of this Task Force and its report is how to stop prescription drug abuse leading to NAS infants, addressing addiction, in and of itself - regardless of the drug of choice - must be the ultimate goal of Florida’s drug prevention efforts.



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CHAPTER 3

TREATMENT

Key Takeaways:

- Successful outcomes in treating NAS infants are greatly aided when an opioid abusing woman receives medical care early in her pregnancy.
- There are two approaches to treating an opioid drug abusing pregnant woman: a Medicated Assisted Treatment (MAT) program or detoxification.
- A MAT program-using either methadone or buprenorphine-prevents drug withdrawal in a pregnant woman, thereby protecting the fetus from repeated withdrawal episodes.
- Effective pharmacological treatment of prescription drug abusing pregnant women also requires the use of evidence-based behavioral interventions (substance abuse counseling, routine drug testing, and additional recovery support services).
- A substance abuse treatment program for pregnant woman should include:
 - 1) coordinated physical and behavioral health care;
 - 2) collaboration with child welfare and community services (including courts and schools);
 - 3) gender specific evidence-based practices, and
 - 4) a whole family approach (including outreach to fathers and relatives to get them involved in treatment services)

Introduction

The previous chapter highlighted ways medical professionals can help stop the spread of NAS by voluntarily screening their pregnant patients for prescription drug use. The next issue confronting the Task Force was: what should medical professionals do once a pregnant woman has been identified as using prescription drugs? The Task Force found that the most effective response was to have doctors establish a system to review a patient's case and attempt to identify the nature of drug use or possible abuse. After determining the reason for use, the woman's doctor should have a confidential discussion with her, obtaining from her permission to discuss her care with all clinicians involved in her medical treatment.

A doctor must consider the appropriate level of care in their quest to help protect babies-both in-utero and after birth-from the harmful effects of maternal drug abuse. First, a health care professional must distinguish between illicit and legitimate prescription opioid use. Illicit prescription opioid use is taking drugs like methadone, buprenorphine, oxycodone and hydrocodone without a prescription, whereas appropriate use means taking these same prescription drugs under the guidance of a reputable physician. Appropriate use can also include medical professionals using methadone and buprenorphine to treat opioid dependent pregnant women; these opioid agonists help prevent erratic maternal opioid levels, thereby better protecting the opioid dependent woman's fetus from experiencing repeated withdrawal episodes.³⁹

Effective pharmacological treatment of prescription drug abusing pregnant women also requires the

use of evidence-based behavioral interventions. To achieve this superior standard of care, there is a need for more and better education and training on substance abuse addiction for all professionals encountering pregnant women. Unfortunately, many prescription drug abusing women go unrecognized simply by not reporting their drug use during their pregnancy. The Task Force therefore recommends enhanced drug addiction education and training for the medical community, establishing best practice treatment protocols for drug exposed newborns, and enhancing the ability of pregnant women to access substance abuse treatment. These treatment policy recommendations do not advocate for one treatment method over another; that decision is always to be made by the attending physician.

The remainder of this chapter outlines the significance of medicated-assisted treatment for opioid addiction (MAT) programs, current treatment methods for NAS infants, and explains the importance of comprehensive treatment services for women.

Medicated Assisted Treatment Program

The Task Force, led by Dr. Robert Yelverton, set out to develop a compendium of best practices for treating both prescription drug addicted mothers and NAS infants. Hearing testimony from a diverse group of policy experts and medical professionals in Florida, the Task Force received a wide range of perspectives. First and foremost, it was determined that women must seek prenatal care if they believe they may be pregnant. If a woman makes the decision to avoid medical care because she wants to continue to abuse drugs and alcohol, subsequent medical intervention and treatment becomes all the more problematic. The Task Force's proposed immunity provision will hopefully alleviate some women's concerns about seeking early medical care.

After a pregnant woman seeks medical care, and it is determined that she is abusing prescription opioid drugs, there are two approaches to treating her addiction during the pregnancy: a Medicated Assisted Treatment (MAT) program or detoxification. During a pregnancy an opioid drug abusing women is maintained on a MAT (either methadone or buprenorphine) to manage her to the point where there is no drug withdrawal. A person on a MAT program must also agree to routine drug testing to ensure they are not mixing additional substances with their medication. Newborns can develop withdrawal symptoms from a MAT program, but these symptoms can be more easily controlled than either letting a pregnant woman continue illicit opioid drug use, or from an attempt to completely withdraw from the drugs on her own.

A MAT program may appear counterintuitive because a doctor is prescribing a prescription drug addicted pregnant woman an opioid as treatment. Whereas illicit use of opioids (i.e. oxycodone, hydrocodone, etc.) subjects a fetus to repeated episodes of painful drug withdrawal and increases the death rate for both mother and child, a MAT program uses opioid agonists, which are safer for the health and safety of the woman and her unborn child. A successful MAT program removes a prescription opioid dependent woman from a drug-seeking environment, typically leading to improvements in a mother's nutrition and infant birth weight.^{40,41} It is important to note that a pregnant woman in a MAT program must continue with her medicated doses after giving birth, and that she should then receive a follow-up treatment assessment to determine the next appropriate level of drug treatment.

There are differences between prescription methadone and buprenorphine. Methadone is full mu-opioid agonist and is approved by the Food and Drug Administration (FDA) for opioid addiction treatment in pregnant women. Doctors have more than 40 years of experience using methadone to treat opioid drug addiction.⁴² The use of methadone to treat opioid addiction during pregnancy is an accepted standard of care.⁴³ Methadone has a long duration of action (24-36 hours, but shorter in

pregnant women), and is strictly regulated for addiction treatment. During the induction phase a clinician starts with a low dose, increasing dosing levels until withdrawal symptoms stop. Methadone has both advantages and disadvantages. The advantages are that it is safe and addicts' cravings do decrease. But methadone treatment is an arduous program that oftentimes requires long daily commutes to the nearest treatment center.⁴⁴

Buprenorphine is another opioid that can be used in a MAT program. It is a partial mu-opioid agonist and is categorized by the FDA as a Category C pregnancy drug.⁴⁵ Placing the drug in this category means that there have been no well-controlled studies in humans, but that buprenorphine can be prescribed because its potential benefit may warrant use of the drug in pregnant women despite potential risks.⁴⁶ Doctors have a waiver from Drug Enforcement Administration (DEA) to prescribe buprenorphine for addiction. Because it is a partial opioid agonist it is not as strong as methadone. The advantage may be that babies will have fewer withdrawal symptoms, and that could translate into shorter hospital stays. There is a "ceiling" effect that makes it not sufficient in high dose opioid abusers. Pregnant women who cannot tolerate methadone, have failed previously in a methadone program, or women who are steadfast in their desire to avoid methadone may be good candidates for buprenorphine.⁴⁷ To receive buprenorphine a patient does not have to go to a certified methadone clinic every day, lowering the issue of daily transportation costs, and thereby removing a common treatment barrier with methadone.

A 2009 publication by The Cochrane Collaboration evaluated the effectiveness of MAT programs for pregnant women. This report did not find any significant treatment outcome differences between the use of methadone or buprenorphine. This included outcomes for both the mother and for her child. The reason the review was unable to make a definitive statement regarding the superior efficacy of one drug over the other is that clinical reviews and trials are still too few and the sample sizes too small.⁴⁸ However, a 2010 study in the New England Journal of Medicine did find the incidence and severity of NAS greater in infants exposed to methadone compared to those exposed to buprenorphine while in-utero.

The study was a randomized, double-blind trial that compared infants whose mothers were prescribed either methadone or buprenorphine as part of their treatment program. The results found that buprenorphine was an acceptable treatment for opioid dependence in pregnant women. Infants that had prenatal exposure to buprenorphine required less morphine, shorter periods of treatments, and shorter hospital stays for treatment of NAS when compared to methadone. However, it is important to highlight that the positive results of buprenorphine did not translate to fewer cases of NAS infants.⁴⁹ The results of this study will continue to guide clinicians treating opioid abusing pregnant woman, but, at this moment in time, medical professionals will have to determine the course of action that works best for each patient.

Differences between Medicated Assisted Treatments

Methadone

- Less expensive
- Side effects – weight gain, sedation
- Daily travel to treatment facility
- Stigmatized
- Typically effective for all
- More control

Buprenorphine

- More expensive: \$6 to \$8 per pill, 1 to 4 pills per day
- Fewer side effects
- Fewer visits to doctor's office
- Ineffective for some
- Less control

Source: Dr. Mary Sheehan's presentation at the October 12th task force meeting

Ideally, doctors would like to minimize the use of all medications during pregnancy, using non-pharmacologic therapies whenever possible. If medical professionals and their patients decide against a MAT program, the only other option is detoxification. A detoxification program treats a pregnant woman with methadone. The goal of a detox program is to better prevent withdrawal symptoms by lowering the opioid dose over time to the lowest possible level, eventually eliminating the need for methadone altogether. If the medical decision is to go with a detoxification program it should only be conducted at a facility familiar with opioid detoxification for pregnant women. A major reason why most medical professionals, and their patients, select a MAT program over detoxification is due to the fact that detoxification leads to more women eventually returning to illicit opioid use.^{50, 51} A MAT program can also better assist a woman to cope with her addiction while she continues to receive substance abuse counseling, routine drug testing, and additional recovery support services.

Treatment of NAS Infants

Successful outcomes in treating an NAS infant are greatly aided when an opioid abusing woman receives medical care early in her pregnancy. After a safe delivery, the next phase of treating a drug exposed newborn begins. Withdrawal symptoms in an NAS infant may appear within a few minutes or hours to as much as two weeks after birth, but most symptoms will have manifested within the first 72 hours.⁵² An abstinence scoring system (the type of assessment varies by hospital) is used by doctors and nurses to monitor drug exposed newborns in order to assess the onset, progression, and reduction of NAS symptoms.⁵³ A scoring system is usually used every 4-6 hours on all NAS infants. After an infant is safely delivered, and assessed, some doctors will treat NAS with methadone or morphine, will others will use a sedative like Phenobarbital or Clonidine. Treatments on a NAS newborn can last from a few days to several weeks, with the dosage being gradually reduced until the infant is drug-free, eating, and sleeping well.

Clinicians have treated NAS with a variety of drug preparations over the years. Specific drug treatment regimens for NAS infants were summarized in a 1998 American Academy of Pediatrics statement.⁵⁴ Recent reviews show most clinicians using an opioid (morphine or methadone) as the first drug of choice to reduce withdrawal symptoms.⁵⁵ However, doctors are always assessing new methods to improve their patients' care, shorten NICU stays, and improve outcomes for NAS infants.

At the October 12th task force meeting, Dr. William Driscoll, President of Florida Society of Neonatology (FSN), presented information and outcome data on two (2) treatment protocols Jacksonville hospitals have used to treat NAS. Their first protocol treated NAS infants with morphine, with a quarter of the newborns receiving Phenobarbital. The second protocol used the same total daily morphine dose, but the morphine was given more frequently. If an infant did not respond well to morphine treatment then clonidine was used as a second line drug rather than Phenobarbital. Using the second protocol, doctors and nurses were able to reduce NICU treatment time. Jacksonville hospitals have recently begun a third protocol hoping to reduce treatment time even further.

The Florida Society of Neonatology is helping to facilitate statewide collaboration amongst neonatal care providers to find the most efficient treatment strategy. Florida must have collaboration amongst all its perinatal health care stakeholders by using data driven, quality improvement processes to improve maternal and infant health. The Florida Perinatal Quality Collaborative (FPQC) is fulfilling this collaborative need by having a group of perinatal medical professionals meet several times a year to share information on how to improve health care outcomes for mothers and their babies. The FPQC has endorsed and facilitated the FSN in its endeavor to share statewide NAS treatment data. The Task Force fully supports the work of the FPQC, and is looking forward to the results of their ongoing research in the near future.

In addition to medical therapy, several environmental and newborn care practices can also ease NAS symptoms in infants. These strategies are typically used shortly after birth of an NAS infant, and continue during their hospital stay. Parents are taught these care-giving methods as well and are instructed to continue them after discharge of the NAS infant. Some of these therapies include reducing environmental noise and light.⁵⁶ Swaddling of the infant, giving small frequent feedings, and if possible maternal breast milk, can ease the withdrawal symptoms of NAS infants and possibly facilitate earlier discharge. Parents who learn these care-giving skills also express greater satisfaction in caring for their child and thus improve the bond between parent and child.⁵⁷

Nurses play an important role in supporting families of NAS infants. However, neonatal nurses can experience fatigue and dissatisfaction when caring for NAS infants and their families. Without suitable training some nurses can simply feel like drug pushers by having to treat an NAS newborn with narcotics. Others resent drug addicted mothers for the harm they have inflicted on their infants. Training can help alleviate some of these problems, but it will not eliminate it. Hospital administrators, perinatal social workers, and doctors need to be aware of the concerns their nurses have in treating NAS infants and their families. Hospital leaders and physicians need to support nurses and help promote stress relieving strategies to improve nursing satisfaction and retainment.

Substance Abuse Treatment: A Continuum of Care

Substance abusing pregnant women need comprehensive treatment services. Simply linking a drug abusing woman to a MAT program will not solve her addiction problem. A complete system of care must be instituted to support and improve her chances of sustaining a drug-free lifestyle, and enable her to care for her child. A woman who births a drug exposed newborn will experience many barriers, including interruption of her relationship with her child, feelings of guilt over the adverse effects her addiction has had on her newborn child, and changes to the family dynamic when a newborn has to stay for an extended period in a NICU. In addition, the woman may experience financial difficulties that can become overwhelming during the process of recovery. That is why a substance abuse treatment program for pregnant woman should include: (1) coordinated physical and behavioral health care; (2) collaboration with child welfare and community services (including courts and schools); (3) gender specific evidence-based practices, and (4) a whole-family approach (including outreach to fathers and relatives to get them involved in treatment services).⁵⁸

Comprehensive treatment services should address all of these issues, and should encourage women to not just enter a treatment program, but stay with the program until they are drug free. Numerous studies have highlighted historically high treatment dropout rates for substance abusing women. To reduce these high drop-out rates, a range of women-centered services should be adopted. Such services may include special groups attuned to the problems of opioid addicted pregnant women, parenting and childcare education and discussion groups, couples counseling, and efficient case management services. Each treatment program is unique and administrators must determine whether all of these services can be located at their treatment facility or can be accessed through links to other community-based agencies.

Conclusion

For over a decade Florida's efforts to resolve the problem of drug abuse have taken a holistic approach, and our collective response to the problem of prescription drug abuse by pregnant women and NAS newborns should be no different. An effectively administered MAT program, along with an array of ancillary supportive services, must be brought to bear in order to effectively aid prescription drug addicted women. Although Florida grants pregnant women priority access to drug treatment, some treatment locations may not be immediately available, especially for women who already have children.⁵⁹ A number of treatment centers may also lack all of the comprehensive treatment services a pregnant woman requires to successfully recover and transition into a safe and healthy mother.

The goal of this Task Force is to support state and local leaders as they address the problem of NAS. Some cities and counties are further along than others in their efforts to provide coordinated responses to families and infants affected by prescription drug abuse. The priority for state leaders must therefore be to ensure routine statewide assessments of NAS are conducted in order to better inform our collective response. By using evidence-based programs to prevent NAS from occurring, but failing that, to quickly identify the abuse and then effectively treat it, we can significantly improve health outcomes for both mother and drug exposed newborn. Closing the treatment gap and providing comprehensive treatment services to more women in need should be a priority when decisions about state funding are made in Tallahassee.

CHAPTER 4

RESOURCES

Key Takeaways:

- Florida must find ways to creatively use federal, state and local resources to reduce prescription drug abuse and NAS cases.
- The Task Force strongly encourages the Federal Government to fund research projects assessing effective treatments for NAS, as well as the long-term impact of in-utero substance abuse on children.
- Florida's Medicaid program is the primary state level resource to treat drug exposed newborns. A majority of hospital treatment costs are paid by Medicaid, and are outlined in Chapter 1.
- The Department of Children & Families currently funds 361 residential substance abuse treatment beds geared towards pregnant women and women with young children, whereby children (up to age 5) can live with their mothers during the mothers' treatment.
- The Florida Department of Health receives funding from state (General Revenue) and federal (Title V Maternal Child Health Block Grant and Medicaid) dollars to support thirty-two (32) Healthy Start coalitions across the state.
 - Healthy Start's goal is to reduce bad maternal and child health outcomes- including infant mortality-while promoting good health and developmental outcomes for Florida's mothers, infants and children.

Introduction

This chapter is a review of federal, state and local funding resources available to prevent, identify and treat prescription drug abuse. While these programs are typically multi-faceted and address many forms of addiction besides prescription drug abuse, Florida must find ways to creatively use these resources on behalf of NAS newborns.⁶⁰

For example, the Federal Government awards competitive grants to help states in their efforts to reduce drug use and its harmful consequences. In fiscal year (FY) 2010 and 2011, Florida received support under the programs shown in Appendix D. A prominent role the Task Force identified for the Federal Government is in funding research projects that assess effective treatments for drug exposed newborns, as well as the long-term impact on children. This is a legitimate role for the Federal Government to employ the numerous research agencies it has at its disposal. Since Florida has been the epicenter of the prescription drug abuse epidemic, the state should be a prime location to draw down funding to research effective, long-term solutions to drug exposed newborns.

The Task Force recommended acquiring additional Federal research funding. The Attorney General's Office has accepted the assignment of working with several state agencies to obtain additional research funding for Florida on NAS. A prime example of this collaborative endeavor was the recent partnership between the Attorney General's Office and the University of Central Florida (UCF) in receiving a National Institute of Justice grant to study Florida's recent anti-"pill mill" legislation, and efforts by health

regulators and law enforcement to reduce diverted pharmaceuticals. The research project will be led by UCF, but will entail cooperation among several state agencies and local law enforcement over the next few years.

The back of this report lists several resources women and families can use to get help. One is a national helpline to aid women seeking substance abuse treatment. Another excellent resource is FloridaHeathFinder.gov. Florida's Agency for Health Care Administration (AHCA) runs this nationally recognized website which allows citizens to access information they need to make well-informed health care decisions. This site contains a listing of Medicaid doctors and specialists, comparison tools for determining the best quality of care, and a "symptom navigator" which opens articles in a health encyclopedia pertinent to that symptom. A full resource listing with contact information is listed on the back of this report.

State Level Resources

The primary state level resource to treat drug exposed newborns is Florida's Medicaid program. The initial chapter of this report outlined the costs of drug exposed newborns and its impact on Florida's Medicaid program. A majority of hospital treatment costs are paid by Medicaid, and were described in Chapter 1. The focus of this chapter will be the resources available via the Department of Children & Families (DCF) and the Department of Health (DOH).

The availability of residential substance abuse treatment beds was discussed at several task force meetings and a full accounting of state funded beds was conducted. During FY 2011-12, there were 1,671 pregnant women served by DCF funded substance abuse treatment providers. The Department directly funds 361 residential beds that are capable of serving pregnant women and women with young children by allowing the children (up to age 5) to live with their mothers during treatment. This accounting only highlights DCF funded beds and does not include unfunded or privately funded substance abuse treatment providers (Appendix E).

Pregnant women and women with dependent children are a priority population for Federal Substance Abuse Prevention and Treatment Block Grant (SAPT) dollars. The Block Grant requires that the state "set aside" a portion of the total award to fund services for these women. The set aside funds a continuum of substance abuse services for addicted women including case management, outpatient, detoxification, residential, in-home-on-site services, intervention, parenting education, medical services, day care, methadone, and after care services. For FY 2011-12, the expenditures for these women totaled approximately \$12,409,112.

The Florida Department of Health receives funding for thirty-two (32) Healthy Start coalitions across the state. Healthy Start is funded with state (General Revenue) and federal (Title V Maternal Child Health Block Grant and Medicaid) dollars. The Department of Health contracts with the coalitions to perform an assessment of the prenatal and infant health care needs within the areas represented by the coalition (catchment area) and develop a Five Year Service Delivery Plan based on the assessment. The goal of Healthy Start is to reduce poor maternal and child health outcomes including infant mortality, and to promote good health and developmental outcomes for all mothers, infants and children in Florida.

Florida Healthy Start Funding

FY2009-10	
Funding Source	AMOUNT
GR	\$38,520,208.00
Medicaid Trust Fund	\$21,982,632.00
MCH BG	\$4,692,254.00
TOTAL	\$65,195,094.00

FY2010-11	
Funding Source	AMOUNT
GR	\$38,775,439.00
Medicaid Trust Fund	\$21,069,120.22
MCH BG	4,692,254.00
TOTAL	\$64,536,813.30

FY2011-12	
Funding Source	AMOUNT
GR	\$33,425,439.00
Medicaid Trust Fund	\$25,110,372.60
MCH BG	4,692,254.00
TOTAL	\$63,228,065.00

FY2012-13	
Funding Source	AMOUNT
GR	\$35,575,439.00
GR (non-recurring)	\$1,000,000.00
Medicaid Trust Fund	25,110,373.00
MCH BG	\$5,692,255.00
TOTAL	\$68,378,067.00

There are two Healthy Start coalitions allocating funds specifically for substance abuse treatment and counseling for pregnant mothers (\$43,927 for Healthy Start Coalition of Flagler-Volusia Counties, Inc. and \$100,000 for Broward Healthy Start Coalition, Inc.). Florida's thirty other Healthy Start coalitions provide broad treatment coordination services for their clients, routinely referring Healthy Start clients to DCF for evaluation and treatment.

DOH also receives funding for the Targeted Outreach for Pregnant Women Act (TOPWA) program. Initially funded by the Florida Legislature in 1998, TOPWA program reaches high-risk HIV-infected pregnant women who are not receiving adequate prenatal care. For the 2012-13 fiscal year TOPWA received \$470,563 from federal funds and \$500,000 from state General Revenue. The purpose of the program is to lower the number of babies born with prenatal drug exposure and HIV infection. TOPWA projects are currently in Miami-Dade, Broward, Palm Beach, Orange, Hillsborough, Pinellas, Duval, St.

Lucie, Glades, Hendry and Lee counties. Projects provide HIV testing and pregnancy testing for women who are not sure of their pregnancy status. Women receive HIV prevention education and are assisted with substance abuse evaluations and treatment as needed. TOPWA however is not a statewide program, serving only the areas referenced above.

Conclusion

The Task Force did not collect specific local level funding data. It is important to note that some county and city commissions may fund additional treatment or may assist with funding prevention programs. However, because there is no central repository collecting and maintaining this information, the Task Force was unable to fully determine the overall scope funding for drug prevention and treatment in Florida. Ultimately, local areas must assess their needs and determine the degree in which they ought to respond. For this state-level task force, a full accounting of federal and state level resources was sufficient for broadly determining what resources are currently available to prevent and treat a mother's prescription drug addiction and NAS newborns.



White House Office of National Drug Control Policy Director Gil Kerlikowske joins Attorney General Bondi and State Representative Dana Young at the first task force meeting in April 2012.

APPENDIX A - 1

COUNTY LEVEL NEWBORN DRUG WITHDRAWAL DATA

	A	B	C	D	E	F
1	FACILITY COUNTY	CY 2007	CY 2008	CY 2009	CY 2010	CY 2011
2	GRAND TOTALS (Based on Livebirths w/779.5 and/or 760.72)	536	694	1,019	1,336	1,563
3						
4	<i>Alachua</i>	21	32	63	87	96
5	<i>Bay</i>	1	6	10	5	17
6	<i>Brevard</i>	27	56	53	78	86
7	<i>Broward</i>	29	35	48	73	55
8	<i>Charlotte</i>	2	5	15	19	23
9	<i>Citrus</i>	1	1	2	8	5
10	<i>Clay</i>	16	8	19	26	35
11	<i>Collier</i>	17	27	25	28	35
12	<i>Columbia</i>		2	5	8	9
13	<i>Dade</i>	14	13	23	18	25
14	<i>DeSoto</i>	1		2	5	3
15	<i>Duval</i>	80	62	118	153	154
16	<i>Escambia</i>	51	52	61	52	61
17	<i>Hernando</i>	34	39	59	79	74
18	<i>Highlands</i>	3	1	5	2	2
19	<i>Hillsborough</i>	24	41	61	90	124
20	<i>Indian River</i>	1	4	7	7	4
21	<i>Jackson</i>	1			2	3
22	<i>Lake</i>	5	1	4	7	18
23	<i>Lee</i>	22	26	56	69	75
24	<i>Leon</i>	4	7	3	10	11
25	<i>Manatee</i>	6	13	16	20	51
26	<i>Marion</i>	12	11	6	13	15
27	<i>Martin</i>	4	4	2	3	5
28	<i>Monroe</i>					1
29	<i>Nassau</i>	1	1	2	3	7
30	<i>Okaloosa</i>	3	5	10	12	14
31	<i>Orange</i>	36	61	66	100	129
32	<i>Osceola</i>	3	5	6	2	4
33	<i>Palm Beach</i>	26	35	45	40	31
34	<i>Pasco</i>	6	7	16	20	33
35	<i>Pinellas</i>	43	67	92	107	155
36	<i>Polk</i>	10	11	13	16	31
37	<i>Putnam</i>		1	2	3	1
38	<i>Santa Rosa</i>		3	1	2	3
39	<i>Sarasota</i>	9	25	43	74	78
40	<i>Seminole</i>		3	5	2	2
41	<i>St. Johns</i>	3	2	7	7	5
42	<i>St. Lucie</i>	3	1	8	8	7
43	<i>Volusia</i>	16	18	34	67	61
44	<i>Walton</i>	1	3	6	11	15

APPENDIX A - 2

FLORIDA DRUG WITHDRAWAL - 799.5

2010 & 2011

		Total number of discharges (2011)	Total number of discharges (2010)
All discharges		1,680	1,374
Payer	Medicaid	1,450 (86.31%)	1,194 (86.90%)
	Private insurance	137 (8.15%)	99 (7.21%)
	Uninsured	67 (3.99%)	68 (4.95%)
	Other	26 (1.55%)	13 (.95%)
Patient Residence	Large central metro	604 (35.95%)	417 (30.35%)
	Large fringe metro (suburbs)	371 (22.08%)	353 (25.69%)
	Medium and small metro	582 (34.64%)	487 (35.44%)
	Micropolitan and noncore (rural)	121 (7.20%)	117 (8.52%)

APPENDIX B

SUGGESTED PREVENTION CAMPAIGN SLOGANS

Slogans:

1. Your baby needs you; get the help you need to be drug-free.
2. If not for you, then do it for the sake of your unborn child. Don't abuse prescription drugs!
3. When you abuse, you both lose.
4. You have a choice...Your Baby Doesn't. Protect your newborn from prescription drug abuse.
5. You are your unborn child's life line; don't misuse prescription drugs.
6. Give birth to opportunity, not addiction. Protect your newborn from prescription drug abuse.
7. Your unborn child has no say – tell your doctor if you are taking prescription drugs.
8. Your baby's future shouldn't begin with detox.

Picture/Image:

9. A pregnant woman with her back to an open medicine cabinet. One hand extended out with her palm facing the cabinet to signify that she rejects the Rx medicines. The other hand over her pregnant belly.
10. A profile of a pregnant woman with the words "drug-free zone" over her belly.

APPENDIX C

FLORIDA HEALTHY START SCREENING TOOL



Help your baby have a healthy start in life!



Please answer the following questions to find out if anything in your life could affect your health or your baby's health. Your answers are confidential. You may qualify for free services from the Healthy Start Program or the Healthy Families Program, no matter what your income level is! (Please complete in ink.)*

Today's Date: _____

	YES	NO
1. Have you graduated from high school or received a GED?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you married now?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are there any children at home younger than 5 years old?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are there any children at home with medical or special needs?	<input type="checkbox"/>	<input type="checkbox"/>
5. Is this a good time for you to be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
6. In the last month, have you felt down, depressed or hopeless?	<input type="checkbox"/>	<input type="checkbox"/>
7. In the last month, have you felt alone when facing problems?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever received mental health services or counseling?	<input type="checkbox"/>	<input type="checkbox"/>
9. In the last year, has someone you know tried to hurt you or threaten you?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have trouble paying your bills?	<input type="checkbox"/>	<input type="checkbox"/>

11. What race are you? Check one or more.
 White Black Other _____

12. In the last month, how many alcoholic drinks did you have per week?
 _____ drinks, did not drink

13. In the last month, how many cigarettes did you smoke a day? (a pack has 20 cigarettes)
 _____ cigarettes, did not smoke

14. Thinking back to just before you got pregnant, did you want to be.....?
 pregnant now pregnant later not pregnant

15. Is this your first pregnancy?
 Yes No If no, give date your last pregnancy ended:
 Date: (month/year) _____

16. Please mark any of the following that have happened.
 Had a baby that was not born alive
 Had a baby born 3 weeks or more before due date
 Had a baby that weighed less than 5 pounds, 8 ounces
 None of the above

PATIENT INFORMATION	Name: First _____ Last _____ M.I. _____ Social Security Number: _____ Date of Birth (mo/day/yr): _____ 17. Age: <input type="checkbox"/> < 18
	Street address (apartment complex name/number): _____ County: _____ City: _____ State: _____ Zip Code: _____
	Prenatal Care covered by: <input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance _____ <input type="checkbox"/> No Insurance <input type="checkbox"/> Other _____
	Best time to contact me: _____ Phone #1 _____ Phone #2 _____

I authorize the exchange of my health information between the Healthy Start Program, Healthy Start Providers, Healthy Start Coalitions, Healthy Families Florida, WIC, Florida Department of Health, and my health care providers for the purposes of providing services, paying for services, improving quality of services or program eligibility. This authorization remains in effect until revoked in writing by me.

Patient Signature: _____ Date: _____

Please initial: _____ Yes _____ No I also authorize specific health information to be exchanged as described above, which includes any of my mental health, TB, alcohol/drug abuse, STD, or HIV/AIDS information.

* If you do not want to participate in the screening process, please complete the patient information section only and sign below:

Signature: _____ Date: _____

PROVIDER ONLY	LMP (mo/day/yr): _____ EDD (mo/day/yr): _____	18. Pre-Pregnancy: Wt: _____ lbs. Height: _____ ft. _____ in. BMI: _____ <input type="checkbox"/> < 19.8 <input type="checkbox"/> > 35.0
	Provider's Name: _____ Provider's ID: _____	19. Pregnancy Interval Less Than 18 Months? <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes
	Provider's Phone Number: _____ Provider's County: _____	20. Trimester at 1st Prenatal Visit? _____ <input type="checkbox"/> 1st <input type="checkbox"/> 2nd
	Healthy Start Screening Score: _____	21. Does patient have an illness that requires ongoing medical care? Specify illness: _____ <input type="checkbox"/> No <input type="checkbox"/> Yes
	Check One: <input type="checkbox"/> Referred to Healthy Start. If score <6, specify: _____ <input type="checkbox"/> Not Referred to Healthy Start.	
	Provider's/Interviewer's Signature and Title _____ Date (mo/day/yr) _____	

DH 3134, 4/08, Stock Number: 5744-100-3134-7

Distribution of copies: WHITE & YELLOW—County Health Department in county where screening occurred
 PINK—Retained in patient's record GREEN—Patient's Copy

APPENDIX D

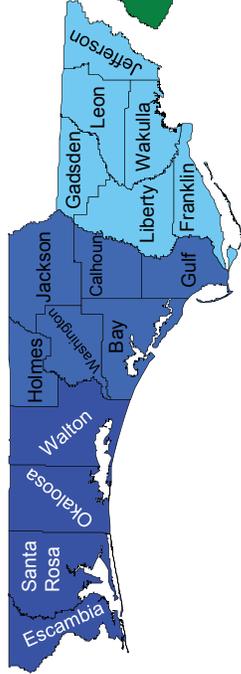
FEDERAL GRANTS AWARDED & AVAILABLE TO REDUCE DRUG AVAILABILITY, USE, AND CONSEQUENCES

Florida		
Federal Agency & Program Name	FY 2010	FY 2011
Department of Education		
<i>Immediate Office of the Secretary</i>		
Safe and Drug-Free Schools and Communities National Programs	\$ 10,586,304	\$ 2,920,151
Executive Office of the President		
<i>Office of National Drug Control Policy</i>		
High Intensity Drug Trafficking Area Program	\$ 27,864,320	\$ 21,552,751
Drug-Free Communities Support Program Grants	\$ 2,945,844	\$ 2,869,616
Department of Health and Human Services		
<i>Administration for Children and Families</i>		
Promoting Safe and Stable Families	\$ 15,465,433	\$ 7,808,847
<i>Health Resources and Services Administration</i>		
Healthy Start Initiative	\$ 5,803,659	\$ 5,664,866
<i>National Institutes of Health</i>		
Drug Abuse and Addiction Research Programs	\$ 17,896,346	\$ 26,577,172
<i>Substance Abuse and Mental Health Services Administration</i>		
Block Grants for Prevention and Treatment of Substance Abuse	\$ 100,688,583	\$ 99,796,302
Projects for Assistance in Transition from Homelessness	\$ 4,081,000	\$ 4,072,000
Projects of Regional and National Significance	\$ 36,487,283	\$ 24,351,081
Access to Recovery Program	\$ 3,349,265	\$ 3,206,520
Housing and Urban Development		
<i>Assistant Secretary for Community Planning and Development</i>		
Shelter Plus Care	\$ 10,057,297	\$ 14,543,504
Department of Justice		
<i>Office of Justice Programs</i>		
Criminal and Juvenile Justice and Mental Health Collaboration Program	\$ 200,000	\$ 249,924
Drug Court Discretionary Grant Program	\$ 1,018,659	\$ 833,349
Edward Byrne Memorial Justice Assistance Grant Program	\$ 43,137,776	\$ 43,573,624
Residential Substance Abuse Treatment for State Prisoners	\$ 1,735,790	\$ 1,416,199
Second Chance Act - Prisoner Reentry Initiative	\$ 3,483,306	\$ 1,598,467
Department of Labor		
<i>Employment and Training Administration</i>		
Reintegration of Ex-Offenders	\$ 500,000	\$ 2,175,523

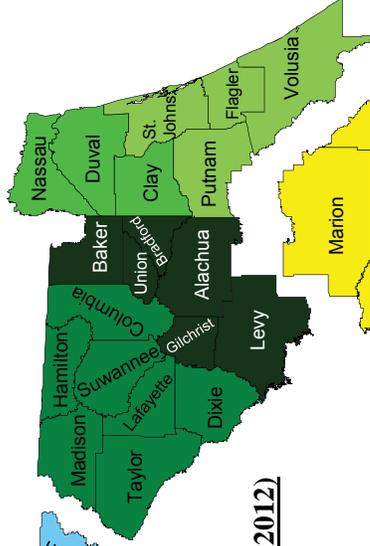
APPENDIX E



Northwest: 15 beds (3 providers)



Northeast: 46 beds (4 providers)



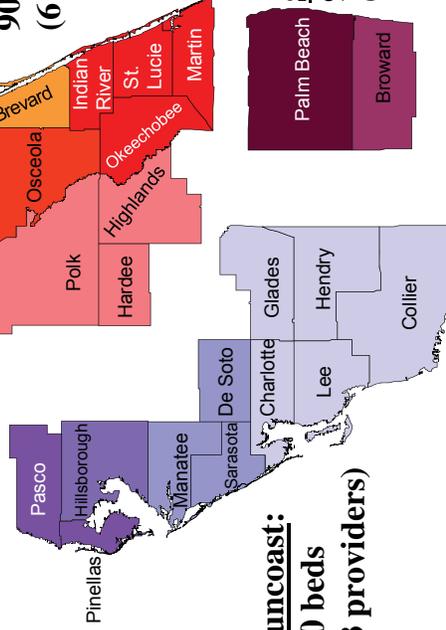
Central: 90 beds (6 providers)

DCF-Funded Beds: Pregnant and/or Post-Partum Women (November 2012)

Region	Circuit	Provider Name	County	Number of DCF-Funded Residential Beds that Serve Pregnant and/or Post-Partum Women (With or Without Infant)
Central	5	Lifestream Behavioral Center, Inc.	Lake	11
	5	The Centers, Inc.	Marion	26
	9	Center for Drug Free Living	Orange	27
	9	Specialized Treatment Education (STEPS)	Orange	8
	18	Center for Drug Free Living	Seminole	9
	19	Counseling and Recovery Center	St. Lucie	9
Northeast	8	Meridian Behavioral Health Care	Alachua	5
	4	Gateway Community Services, Inc.	Duval	5
	7	Haven Recovery Center	Volusia	20
Northwest	7	Stewart Marchman ACT	Volusia	16
	14	Chemical Addictions Recovery Effort	Bay	4
	1	Lakeview Center, Inc.	Escambia	8
	2	DISC Village, Inc.	Leon	3
Southeast	17	Broward Addiction Recovery Center	Broward	15
	17	House of Hope, Inc.	Broward	34
	17	Susan B. Anthony Center, Inc.	Broward	16
	15	Gratitude House, Inc.	Palm Beach	6
	15	The Jerome Golden Center for Behavioral Health	Palm Beach	11
Southern	15	Mayside House	Palm Beach	10
	11	Catholic Charities of the Archdiocese of Miami	Miami-Dade	2
	11	Concept House	Miami-Dade	4
	11	Jessie Trice Community Health Center	Miami-Dade	19
	11	Miami Behavioral Health Center	Miami-Dade	1
	11	Community Action & Human Services Department	Miami-Dade	12
Suncoast	11	Spectrum Program	Miami-Dade	2
	11	The Village South	Miami-Dade	28
	13	Drug Abuse Comprehensive Coordinating Office	Hillsborough	16
Suncoast	6	Operation PAR	Pinellas	25
	12	First Step of Sarasota	Sarasota	9

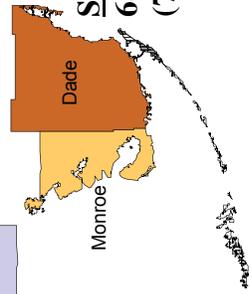
TOTAL: 361

Suncoast: 50 beds (3 providers)



Southeast: 92 beds (6 providers)

Southern: 68 beds (7 providers)



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Statewide Task Force on Prescription Drug Abuse & Newborns Resources

Substance Abuse & Mental Health Service National Helpline
1-800-662-HELP (4357)

Substance Abuse Treatment Facility Locator
www.findtreatment.samhsa.gov

Florida Health Finder
www.FloridaHealthFinder.gov

Medicine Abuse Project
www.medicineabuseproject.org

Florida Attorney General's Office
www.myfloridalegal.com

