Eugene S. Farley, Jr. Health Policy Center
UNIVERSITY OF COLORADO **ANSCHUTZ MEDICAL CAMPUS**

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INTEGRATED CARE
FOR WOMEN AND BABIES

Integrated Care for Women and Babies (ICWB): Substances Used and Birth Outcomes Among People Served

This work is supported by Colorado's Behavioral Health Administration

Susan Mathieu MPP, Jennifer Ammerman MHA, Kathy Cebuhar MA, Ryan Jackman MD, Kaylin Klie MD MA, Kyle Knierim MD

Brief #30
January 2024

Key Findings

- More people enrolled in the Interated Care for Women and Babies (ICWB) program are using substances other than opioids than are using opioids; more than half of those enrolled report using cannabis. The percentage of people who received medications for opioid use disorder (MOUD) increased 11.1% from 58.6% in year 1 to 69.7% in year 2.
- The majority of newborns to people enrolled in the initative were born at full term and had normal birthweight, though there were higher rates of premature birth and of low birthweight than both the statewide and national averages for all births. Studies conducted outside of Colorado have found improved outcomes for newborns born to people in treatment when compared to those not in treatment.
- Policy considerations include: continued support for integrating perinatal medical, behavioral health, and substance use disorder (SUD) care for all pregnant people and all substances; expanded support to more practices to increase MOUD prescribing during pregnancy; and, enhanced focus on standardized screening, consistent data collection, and use of a common set of metrics to demonstrate effectiveness of integrated perinatal medical, behavioral health, and SUD care.

Introduction and Overview

Pregnant people who use substances are at higher risk for poor outcomes, including miscarriage, preterm labor, overdose, and delivery-related complications. Infants born to people who have misused substances during pregnancy also face negative outcomes and are more likely to have a low birth weight, be born early, need neonatal intensive care, and be in child protective services than unexposed infants.[1]

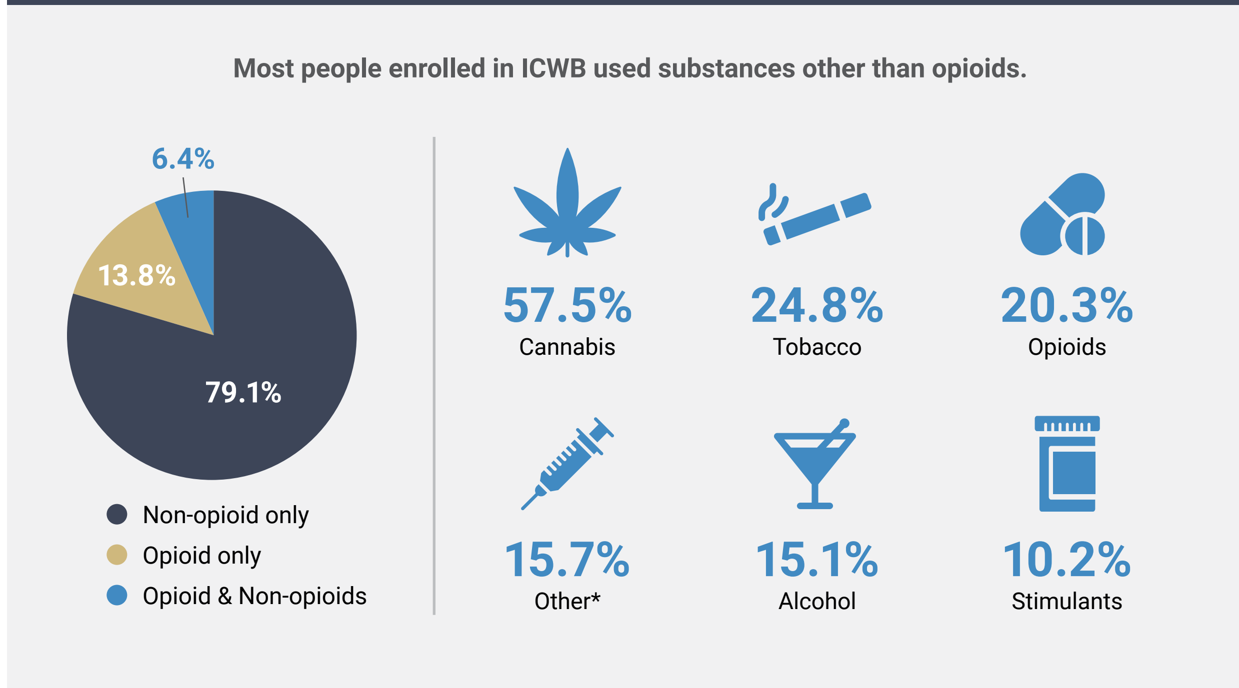
To help improve these outcomes, the ICWB initaitive is supporting the integration of perinatal medical care, behavioral health, and SUD treatment services at clinics across the state. The first cohort, spanning a 30-month period from July 2020 to December 2022, included four medical clinics that offer perinatal medical services and two opioid treatment programs (OTPs). Participating clinics received financial support and technical assistance from a practice facilitator and a clinical health information technology advisor. As a result of ICWB's success, program funding has continued. A second cohort has started and a third cohort will start this year.

Earlier briefs provided an overview of ICWB and the important role peers play in the program's success. This brief summarizes substances used and birth outcomes from ICWB data reported by the three largest clinics in cohort 1: (1) Addiction, Research and Treatment Services (ARTS); (2) Denver Health Women's Care Clinic; and (3) Sunrise Community Health – Monfort Clinic. Together, these clinics have provided care to about 90% of the more than 1,000 women served in the first cohort.

More people are using substances other than opioids

Opioid use disorder (OUD) is a focus of many policies and programs. This is unsurprising given the increase in opioid-related overdose deaths, legal settlements, and the declaration of the opioid crisis as a public health emergency starting in October 2017. However, many other substances are used during pregancy that can have serious health consequences. By design, ICWB provides support to people using any substance that can negatively impact pregnant people and their newborns. This design decision aligns with the needs of people enrolled; the vast majority (nearly four out of five) of patients who screened positive for substance use reported using substances other than opioids (Figure 1 below).

Figure 1: Substances Used by People Enrolled in ICWB



Notes: numbers in the pie chart do not add to 100% due to incomplete data for less than 1% of enrollees; people could report more than one substance used; "other" includes all substances not able to be categorized as one of the above.

Of those using a substance other than opioids, more than half used cannabis, one in four were using tobacco, and nearly one in six used alcohol.

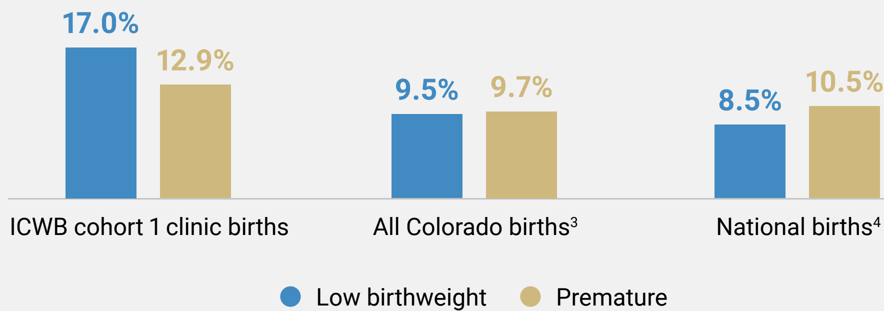
MOUD prescribing increased but there is still room for improvement

Evidence supporting the effectiveness of MOUD continues to grow for all populations. For those who are pregnant, a recent study found that MOUD during the prenatal period was associated with improved outcomes for newborns.[2] ICWB practices made significant progress in implementing this "gold-standard" treatment, prescribing MOUD to 64.8% of those enrolled in ICWB who were using opioids. Notably, the percentage increased 11.1% from 58.6% in year 1 to 69.7% in year 2, suggesting that clinics became more comfortable prescribing MOUD with the learning calls, new workforce investments, and support from ICWB subject matter experts. While a promising trend, more than one in four program enrollees did not receive MOUD treatment, which underlines the need for continued support for a diverse set of treatment services even within high performing practices.

Newborns born to those in the program are more likely to be small and born early

A total of 642 children were born to ICWB enrollees. The majority were born at full term and a normal birthweight, though newborns of ICWB enrollees showed higher rates of premature birth and of low birthweight than both the statewide and national averages for all births (Figure 2 below).

Figure 2: Birth Outcomes



Low birthweight   Premature

This observation is in line with research which found that preterm births and low birthweight newborn rates were higher among people using substances than for those not using substances.

ICWB is not designed in a way to quantify the benefits of prenatal substance use treatment as compared to outcomes for those not in treatment, but there is some informatnion from other states:

- In a Massachusetts study, rates were about twice as high for those not in treatment: preterm births were 19.0% compared to 10.1%, and low birthweight rates were 18.0% compared to 7.8%;[4] and
- In an older study, pregnant women receiving treatment in a residential substance use program gave birth to newborns with higher mean birthweight than those not in treatment (3227 vs 2800 grams). The gestational age was similar across the two groups.[5]

Policy Considerations

1. **Continue support for integrating SUD and perinatal medical and behavioral care for all pregnant people and all substances.** There is evidence that cannabis, tobacco and alcohol (the three most common substances being used) have negative impacts on individuals giving birth, the newborns and other family members. While there are restrictions on how opioid settlement dollars must be used, activities that target the full range of substances used in pregnancy will have broader impact. If opioid settlement dollars focus only on opioids, additional funded efforts should support care for those using other substances.
2. **Expand support to more practices to increase MOUD prescribing during pregnancy.** The majority of ICWB enrollees with OUD were prescribed MOUD, with rates increasing over time. There is, however, opportunity and need to increase prescribing. One of the barriers in place during the time this data was collected has since been removed: providers no longer need a special Drug Enforcement Agency (DEA) waiver to prescribe MOUD (buprenorphine). With this barrier removed, continued support to practices to address any fear, uncertainty related to prescribing to pregnant people, or stigma around SUD care could ensure all people receive this treatment.

3. **Focus on universal, evidence-based standardized screening for substance use and consistent collection of information.** This could improve the understanding of program strengths and needs and help make program adjustments as appropriate.

4. **Promote a common, parsimonious set of metrics able to demonstrate effectiveness of integrated perinatal medical, behavioral health, and SUD care.** There are multiple efforts in Colorado to improve SUD services for pregnant and parenting people. These include but are not limited to, the Prenatal Plus Program (PN+); the Maternal Opioid Misuse (MOM) model; the Improve Perinatal Access, Coordination, and Treatment for Behavioral Health (IMPACT BH) program, the Colorado Hospitals Substance Exposed Newborns (CHoSEN) initiative, as well as other work underway at the Colorado Perinatal Care Quality Collaborative (CPCQC). While these initiatives do have distinct foci and some metrics should differ, a core set of perinatal, early childhood, health system, and community level common metrics would support assessment and evaluations of separate or layered programming. User friendly data collection systems could further support Colorado's multi-sector efforts to improve perinatal health outcomes.

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