



**ARIZONA SUBSTANCE ABUSE TASK FORCE  
Neonatal Abstinence Syndrome Work Group**

**May 12, 2016  
1:00 p.m.**

**Governor's Executive Tower  
Suite – 230  
1700 West Washington Street  
Phoenix, Arizona 85007**

A general meeting of the Neonatal Abstinence Syndrome Work Group was convened on May 12, 2016 at 1700 Washington Street, Suite 230 Phoenix Arizona, 85007, notice having been duly given.

<b>Members Present (10)</b>	
<b>Debbie Moak</b> , Governor's Office of Youth, Faith and Family	
<b>Beckett, Cindy</b> , Flagstaff Medical Center	
<b>Kate Brophy-McGee</b> , Legislator	
<b>Jennifer Carussetta</b> , Health System Alliance of Arizona	
<b>Elaine Ellis</b> , Phoenix Children's Hospital	
<b>Deb Gullett</b> , Arizona Association of Health Plans	
<b>Thelma Ross</b> , Community Member	
<b>Rick Sloan</b> , Compassionate Care Centers	
<b>Glenn Waterkotte</b> , Retired Neonatal Abstinence Syndrome Doctor	
<b>Michael White</b> , Community Medical Services	
<b>Staff/Guests Present (3)</b>	<b>Members Absent (0)</b>
<b>Sharon Flanagan-Hyde</b> , Flanagan-Hyde Associates	
<b>Peter Flanagan-Hyde</b> , Flanagan-Hyde Associates	
<b>Tara Sundem</b> , Member of the Public	

**A. Call to Order**

Co-Chair **Debbie Moak** called the meeting to order at 1:00 p.m.

**B. Welcome and Introductions**

**Sharon Flanagan-Hyde** asked the work group members to introduce themselves. She reminded

the group of their norms which included:

- Members are to speak candidly
- One person should speak at a time
- Be respectful
- Self-monitor to ensure there are no tangents
- Work toward consensus

### **C. Volunteer to Report at the Task Force Meeting**

**Sharon Flanagan-Hyde** asked for a volunteer to report on the Neonatal Abstinence Syndrome (NAS) Work Group's updates at the Arizona Substance Abuse Task Force meeting that is scheduled to occur on May 25, 2016. **Deb Gullett** offered to provide the updates.

### **D. Presentation on Neonatal Abstinence Syndrome Data**

Guest Presenter, **Jennifer Dudek** presented on NAS.

### **E. Question and Answer Session**

The following statements reflect the results of questions asked by the Work Group members:

- The data that are collected do not include the impact of methamphetamines on neonatal abstinence syndrome.
- Although there is some literature on stimulants leading to NAS, it is recognized that stimulants do not lead to NAS.
- The difference between NAS and drug exposure is NAS is withdrawal from a drug. Drug exposure is not associated with withdrawal. Exposure to substances leads to a child being at risk for NAS.
- Hospitals are required to report NAS or at-risk children.
- Hospital NAS screening documents have not been updated since 2008.
- Studies show that children exposed to methamphetamines and other narcotics have developmental delays, but there are many other social factors that result in developmental delays and other issues.
- The Arizona Department of Health Services (ADHS) does not track whether mothers receive prenatal care. The agency only tracks hospital discharge data. These data are cross-referenced with vital statistics.
- The ADHS will be releasing additional NAS data soon.

### **F. Discussion**

The Work Group members continued discussion from the last NAS meeting that occurred on April 7, 2016.

- The Work Group needs to have further discussion on the Department of Child Safety (DCS) becoming involved with the family unit.
- Hospitals should have a consistent DCS liaison that assesses the safety of the child. Such a liaison could develop a deeper understanding of substance exposure and NAS. Rather than DCS focusing on removing the child, DCS needs to have more of an interventionist role that can help support the family and connect them to services, if eligible.
- Most hospitals treat each mother who tests positive on a case by case basis.
- Mothers who test positive for prescription opioids represent a wide spectrum- some babes never display the effects of exposure, while others show symptoms immediately.

- Mothers may be treated for a chronic health condition, so caregivers need to proceed with some form of caution when the baby is exposed.
- Right after the child is born is the best time to approach the mother for treatment. Every situation is different but there is no consistent or standardized policy/best practice for approaching or reaching mom in the moments following childbirth.
- In speaking with many nurses, standardizing a process for connecting mom to treatment may not result in positive outcomes given the small amount of time the mother is in the hospital.
- SBIRT may be a useful tool or model in standardizing a process for connecting the mother to treatment.
- In the past, Banner Hospital had a screening tool that scored the mother in relation to successfully referring to treatment.
- Again, DCS needs to be at the table to discuss their role, with assigned liaisons or some other appropriate role. DCS has experience with this process in Pima County, but has not rolled it out in Maricopa or other counties.
- The number one theme across all work groups is that education needs to increase – law enforcement, corrections, moms, etc. Everyone has a role and is vividly aware that drug abuse and addiction plagues not only Arizona, but the United States.
- In an overprescribing conference, not many providers/prescribers have knowledge or contacts to refer those with addiction issues to the help they need.
- In relation to NAS, it all starts before the mother becomes pregnant or before the child is born. Stopping or minimizing drug use is optimal for the child's health once it is born.
- Again, how many mothers who deliver NAS or substance exposed babies are receiving prenatal care? Where are connections to substance abuse services and education before the child is born?
- Mothers may avoid their prenatal care and follow-up appointments because of shame, fear, guilt, or stigma associated with their substance use. The standard of care needs to be updated or enhanced as to remove the barriers that are perceived in getting prenatal care if the mother is using substances.
- Provider/prescriber perception about addicted mothers varies. Most substance abuse and addiction stem from pain management and other chronic health conditions that are being treated – then all of a sudden a patient becomes pregnant and the baby is now also receiving the same drugs. Obstetricians largely do not have the expertise in treating pregnant women with substance use issues.
- We are seeing the result of medical policies in years past where doctors were forced to treat pain, and if they didn't, they could be sued. Now the pendulum has swung in the opposite direction where doctors can be penalized for over prescribing.
- There needs to be an enhanced effort in increasing partnerships across the medical spectrum.
- DCS should present or speak with the group that specializes in communicating and servicing hospitals that deliver high rates of babies with NAS or drug exposure. This work group could take actions that set standards for DCS and hospitals to make policies more consistent and treatment available that will result in increased positive outcomes.
- Is NAS lower for methadone based on percent of exposure? With 100 moms using methadone, how many deliver NAS babies? The doctor tells the mother the baby will be fine, but there are increased risks for stillbirth if the methadone is weaned off. It may be

exaggerated (98%), but high rates of mothers on methadone deliver NAS babies. The percentage of babies born with NAS due to heroin is not as high as those with methadone. There is a lot of research, but it also indicates 40-60% of mothers on methadone deliver NAS babies.

- Methadone is more beneficial to the mother and baby than heroin.
- The Board of Pharmacy and CSPMP could flag women of childbearing age.
- Unless there is an established rapport with a mom/patient, she will not willingly admit to substance use.
- Stigma continues to be a major theme.
- Best providers, best evidence-based practices and scaling what is working are also a theme.
- There needs to be an increased focus and better understanding of why we are in this situation, not with just NAS, but overprescribing in general.

### **G. Review of Key Information**

**Debbie Moak** announced that the NAS Work Group members will be witnessing the signing of two bills, Senate Bill 1283, a bill that mandates prescribers utilize the Controlled Substances Prescription database prior to prescribing controlled medications; and House Bill 2355, a bill that allows pharmacists to dispense naloxone hydrochloride or any other FDA-approved opioid antagonist to a person who is at risk of opioid overdose, or to family members and others who are in a position to help them.

### **H. Call to the Public**

Member of the public, **Tara Sunder**, reported having seen a dramatic increase in NAS babies, over the past three to four years.

- Discussion about the development of a residential treatment facility where NAS babies can be treated occurred. The hospital is not the ideal setting for NAS newborns. The average stay in a hospital for a NAS baby can be upwards of two months.
- Lily's Place in West Virginia is the first residential treatment facility of its kind, and could be used as a model for Arizona.

### **I. Adjourn**

**Debbie** adjourned the meeting at approximately 2:45 p.m.

Dated May 20, 2016  
Arizona Neonatal Abstinence Syndrome Work Group  
Respectfully Submitted By:  
Christopher Vinyard  
Arizona Health Care Cost Containment System