# State Harm Reduction Strategies to Address Substance Use and Related Outcomes Among Women of Childbearing Age

## *Nevada*

### *Overview*

Nevada's Substance Abuse Prevention and Treatment Agency (SAPTA) is housed under the Nevada Division of Public and Behavioral Health (DPBH) within the Department of Health and Human Services (DHHS). The Maternal, Child, and Adolescent Health (MCAH) program also resides within DPBH. MCH entities and providers have had a long-standing collaborative relationship with SAPTA, which has strengthened over the past two years with shifting substance use trends. Alcohol, tobacco, and opioids remain the most used substances in Nevada. Deaths involving synthetic opioids other than methadone (including fentanyl and fentanyl analogs) continue to rise to a rate of 9.9 per 100,000 individuals in 2018, while prescription opioid-related overdose deaths have declined to a rate of 4.6 (NIDA, 2020). The Neonatal Abstinence Syndrome (NAS) rate in Nevada was 7.7 cases per 1,000 hospital births in 2017 (NIDA, 2020). Additionally, in 2018 Nevada ranked first in the nation in primary and secondary syphilis infections (NCHHSTP, 2018). Nevada does not operate under a formal framework of harm reduction to address these trends. However, they are funding initiatives to spread awareness and resources related to harm reduction under the Southern Nevada Harm Reduction Alliance. Similar harm reduction alliances in the State of Nevada seek to ensure the well-being of residents who may engage in substance-use activities to receive the care they need.

### *Collaboration Between State Maternal and Child Health and Alcohol and Drugs Agencies*

Nevada received the Association of State and Territorial Health Officials (ASTHO) Opioid Use Disorder, Maternal Outcome, Neonatal Abstinence Syndrome Initiative (OMNI) Learning Collaborative grant, which provided an avenue for the SAPTA and MCAH collaborations. Through the Learning Collaborative, leaders were convened from the Medicaid, MCAH, SAPTA, and Division of Child and Family Services (DCFS) sections of DHHS, as well as community stakeholders, including hospital social workers, birthing hospital nurse managers, Managed Care Organizations (MCO), practicing physicians (obstetrician/gynecologist (OB/GYN) and pediatricians), a psychiatrist specializing in medication-assisted treatment, and local child protection agencies. This convening grew into the Nevada Perinatal Health Initiative. Expanding harm reduction practices for pregnant and parenting women who use substances is an explicit guiding principle of this group.

SAPTA, Division of Health Care Financing and Policy (DHFCP), and MCAH also work together to expand access to Long-Acting Reversible Contraception (LARC) for postpartum women who use substances in Labor & Delivery (L&D) settings. The postpartum period is a critical time for women in recovery, as they are most at-risk for relapse. Even in L&D settings where reproductive outcomes are regularly part of the dialogue, LARC uptake is low. Low reimbursement rates for uninsured or under-insured women often contribute to low implementation rates of the service. However, Nevada views contraceptive access expansion as a window of opportunity and an access point for post-partum care – a way to meet women where they present for reproductive health care.

Additionally, the State Title V office and SAPTA has worked to expand Screening, Brief Intervention, and Referral to Treatment (SBIRT) and medication-assisted treatment (MAT) access for pregnant and parenting women who use substances. Their SBIRT initiatives target OB/GYN offices, but have been challenging to scale beyond individual-level practices. The state has used the tenets of implementation science to remove billing barriers to improve systems-level adoption. They facilitate stakeholder buy-in by addressing implementation concerns as they emerge. Additionally, the state has established ongoing systems for stakeholder feedback supported in part by the Substance Abuse and Mental Health Services Administration (SAMHSA), State Opioid Response (SOR) federal funding. Three workgroups and a Core Team, composed of collaborative stakeholders from the ASTHO OMNI Learning Collaborative and Nevada Perinatal Health Initiative, provide the structures for stakeholder feedback. The workgroups focus on: 1) Provider Education and Practice Standards, 2) Comprehensive Addiction Recovery Act (CARA) and plans of safe care, and 3) Medicaid and Financing. The Core Team is responsible for developing a strategic approach that incorporates best-practice outreach, identification, engagement, management and care for Nevada's women of child-bearing age with substance use disorders and pregnant women and their infants with prenatal substance exposure so that physical and behavioral health, safety and recovery outcomes for this vulnerable population improve. The Provider Education and Practice Standards workgroup developed an SBIRT toolkit, the *Reference Guide for Reproductive Health Complicated by Substance Use,* which documents how to address sensitive issues that may arise during the screening process, such as mandated provider reporting for positive infant substance use exposure. To address Medicaid billing, the toolkit also provides tangible steps physicians can take to activate and integrate SBIRT into Evaluation and Management (E&M) Medicaid codes. To further ensure implementation of SBIRT, the initiative provides in-office and online consultations on workflow integration, in partnership with the University of Nevada Reno (UNR). The other workgroups that are part of the Nevada Perinatal Health Initiative serve to advance SBIRT, in addition to other strategies related to supporting people of reproductive age who use substances.

The Substance Abuse Block Grant (SABG) and the SOR grant helps encourage key substance use and reproductive health providers to serve the pregnant women, given their prioritization for substance use treatment as a stipulation of the grant. Although the program has demonstrated success in several areas, there remains a need for a strong champion in perinatal behavioral health collaborations (CARA, SBIRT, etc.). The added value of a champion would help drive peer-to-peer uptake of a given practice.

The strong history of collaboration between Nevada's MCAH and SAPTA can be credited to the longevity of the leadership (both over 15 years) that enables stable and trusted relationships between the two agencies. Their co-location within the same division of the Nevada DHHS only strengthens this relationship. Tenured roles provide agency leadership and historical perspective on commitment to projects. Through established partnerships, leaders they can learn from each other to achieve joint objectives. A recent example of this is in their mutual coordination with Medicaid for syphilis testing. Nevada had - and still has - a high congenital syphilis rate associated with maternal intravenous substance use. By utilizing several harm reductions practices the initiative is currently exploring how to expand needle exchange stations in their rural and frontier areas, pilot take-home testing sexually transmitted disease (STD) testing kits, and increase the number of SAPTA clinics enrolled in state-approved laboratories that cover syphilis testing through Medicaid. In addition to strong agency leadership, they have been able to benefit from harm reduction champions. Nevada notes strong advocacy from the State's Mental Health Authority, Stephanie Woodard, and collaborations with this state agency champions the inclusion of harm reduction practices regularly.

Despite these achievements, the state still experiences many barriers to harm reduction implementation. Among these are misconceptions around substance misuse and harm reduction practices in communities and among care providers. SAPTA often encounters substance use treatment clinics with an abstinence-based philosophy (i.e., using substances should not be used as a criteria to discharge patients). Nevada only funds programs that offer MAT as a treatment option for pregnant and parenting women who require substance use treatment. This is rooted in their belief that MAT is harm reduction. SAPTA and the MCAH have also encountered a significant increase in marijuana use during pregnancy. As Nevada has legalized marijuana from strictly medical use to recreational, they have noticed patient perceptions of its risk have decreased. In 2021, the state started to combat misconceptions of marijuana as a wholistic and natural remedy for morning sickness. They plan to continue to address this growing concern.

## *Key Takeaways for Harm Reduction Collaboration*

- Nevada's co-location of MCAH and SAPTA within the DHHS has enhanced collaborative efforts between the substance use agency and MCAH program. While not always possible in states where entities reside in different divisions, streamlining communication and regularly involving both agencies in grants and meetings is an effective practice for harm reduction collaborations.
- Using flexible stakeholder-driven workflow design for new harm reduction services, such as those in Nevada's SBIRT initiative, can help increase uptake of these practices.
- Implementation science can help harm reduction initiatives overcome challenges to systems-level adoption. Nevada used these tenets to create champions and tailor intervention to barriers identified in the implementation environment (i.e., abstinence-based clinic protocols) to increase practice uptake.
- Creating champions, at any professional level, to drive an intervention is an effective way to promote buy-in for harm reduction strategies. Nevada notes the presence of a strong champion in their Congenital Syphilis projects and the need for one in their SBIRT perinatal initiatives.
- Nevada notes that while they promote marijuana use harm reduction practices, many women do not receive accurate information regarding risks of use during pregnancy. Along with harm reduction efforts, accurate information provided by trusted individuals are effective ways to reduce substance misuse and related health outcomes.

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