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ASPE RESEARCH BRIEF
HHS OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF BEHAVIORAL HEALTH, DISABILITY, AND AGING POLICY

THE ROLE OF HEALTH AND HUMAN SERVICE PROVIDERS IN PREVENTING FETAL ALCOHOL SPECTRUM DISORDER

Introduction

In-utero alcohol exposure may lead to disruption in fetal development, contributing to a wide range of neurobehavioral outcomes known as Fetal Alcohol Spectrum Disorder (FASD).[1] FASD is an important public health and social issue[2] and is estimated to affect between 11 and 50 per 1,000 children in the United States.[3] It can include congenital anomalies and may also include a spectrum of physical, mental, behavioral, and/or learning disabilities with lifelong implications.[4,5] ***Exhibit 1*** provides a list of FASD diagnoses.[6]

EXHIBIT 1. FASD Diagnoses

- Fetal Alcohol Syndrome (FAS)
- Partial Fetal Alcohol Syndrome (pFAS)
- Alcohol-Related Neurodevelopmental Disorder (ARND)
- Alcohol-Related Birth Defects (ARBD)
- Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure (NP-PAE)

The total lifetime cost of FASD is estimated to be approximately $2 million per affected individual.[7] Because it is preventable, the costs associated with FASD could be reduced with the implementation of effective prevention policies and programs. This brief is based on findings from an environmental scan of peer-reviewed and grey literature and a meeting of nationally recognized FASD experts that ASPE hosted in September 2019 to discuss policies on prevention, identification, and interventions with individuals affected by FASD.

Importance of Prevention

Prevention is critical to reducing the lifelong disability associated with the identification and treatment of FASD. Alcohol is a known teratogen, a substance that can cause birth defects, and can be most detrimental to the fetus in the earliest weeks of gestation,[8] at a time when women may be unaware of their pregnancy. According to research, nearly half of all pregnancies in the United States are unplanned and the prevalence of alcohol use among non-pregnant women is 53% and the prevalence of binge drinking is 18%.[9] There is no known safe amount or time during pregnancy to consume alcohol.[10,11] As many women of childbearing age could unknowingly be at risk of an alcohol-exposed pregnancy (AEP), targeting prevention efforts at women of childbearing age who

consume alcohol and are trying for pregnancy or may become pregnant is critical to reducing the incidence of FASD.

As shown in ***Exhibit 2***, there are three types of prevention approaches--universal, selective, and indicated. Each of the three approaches can be employed by health and human service providers as they work with women of childbearing age. Engaging in these prevention approaches can help encourage women of childbearing age to take steps to ensure healthy pregnancies and may help reduce the incidence of FASD by stopping or reducing alcohol intake.[12]

EXHIBIT 2. Prevention Approaches
• **Universal Prevention**: Targets the entire population without regard to individual risk factors. • **Selective Prevention**: Targets one or more at-risk sub-populations. • **Indicated Prevention**: Targets individuals who misuse alcohol or have given birth to a child with FASD.

The Role of Health and Human Services Providers

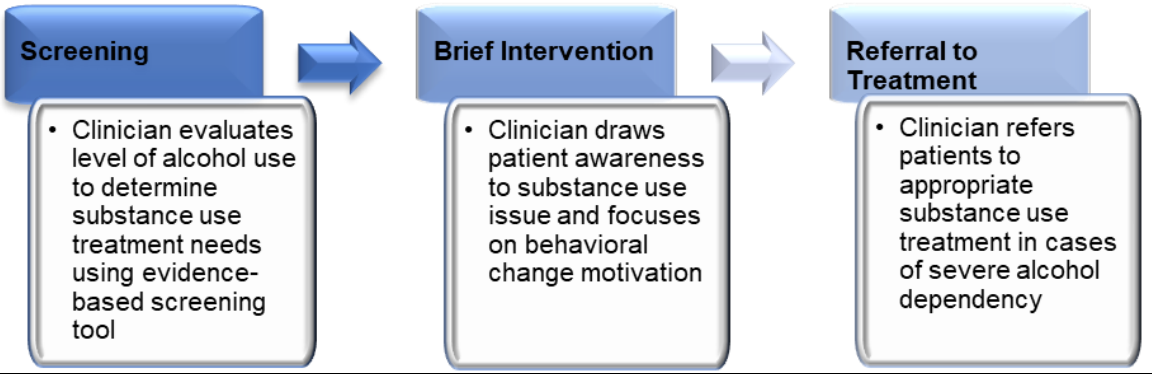
Health and human services providers have an important role to play in offering consistent guidance to all women of childbearing age. A universal approach to prevention may reduce disparities in screening by capturing women who might not be included due to misconceptions regarding risk factors.[13] Additionally, culturally competent care is essential to identify at-risk women to encourage them to reduce/eliminate drinking if they are not using contraception.[14] In addition to providing cautionary messages to women regarding the role of alcohol, providers can also support women in carrying and delivering healthy babies.

Health care providers can also help prevent FASD by implementing evidence-based prevention approaches in their respective settings to reduce risky drinking and increase the use of effective contraception.[15] Providers often experience difficulty identifying alcohol misuse among women because female patients commonly underreport alcohol consumption. In addition, health care providers do not consistently provide information regarding the role that any alcohol during pregnancy may have on FASD and do not reinforce the message that alcohol should be avoided during pregnancy.[16]

Primary Care Providers

A study by Arnold and colleagues found a substantial percentage of primary care providers do not screen women for alcohol use.[17] The study found only 38% of clinical providers screen pregnant women about their alcohol consumption, only 34% screen patients planning to get pregnant, and only 9% screen women of childbearing ages. The lack of screening may be due in part to uncertainty regarding the billing options for the provision of a brief intervention; uncertainty about the actual risks associated with alcohol consumption while pregnant; feelings of unpreparedness to assess and manage alcohol use in patients; or lack of awareness, time, or knowledge about prevention approaches and guidelines.[18,19] In addition, some providers are reluctant to screen women with AEP because specialized treatment for them is not readily available.[20] A first step to prevent AEPs is to train primary care providers in Screening, Brief Intervention, and Referral to Treatment (SBIRT), as shown in ***Exhibit 3***, which has been proven to be an effective approach to identify alcohol misuse in patients.

EXHIBIT 3. SBIRT



Obstetrics and Gynecology (OB/GYN) Providers

OB/GYN providers are well positioned to counsel women of childbearing age regarding the risk of AEP. As pregnancy is a critical time to address risky drinking behaviors, women may be more receptive to cease or reduce alcohol consumption or seek treatment for substance use during pregnancy.[19] Moreover, women who are Medicaid beneficiaries are more likely than those who do not have Medicaid to have coverage for addiction treatment during pregnancy.[21] Training OB/GYN providers to screen patients, quickly evaluating their substance use treatment needs, and referring a patient to treatment is critical to reduce the risk of FASD and prevent an AEP.

While OB/GYN providers play an important role in preventing AEPs, many face challenges identifying alcohol consumption. Many pregnant women may feel afraid or embarrassed to admit to alcohol use or believe that small amounts of alcohol use are not worth reporting. A report by the National Task Force on Fetal Alcohol Syndrome and Fetal Alcohol Effect recommended OB/GYN providers to be trained in screening instruments that are tailored to detect any alcohol use in pregnant women.[15] Furthermore, the National Institute on Alcohol Abuse and Alcoholism Task Force recommends providers ask three targeted questions to detect patterns and frequency of alcohol consumption. Two questions measure averages or extreme patterns in frequency of heavy drinking and typical number of drinks per day when alcohol is used. The final question addresses frequency of alcohol use in the past 12 months, the number of drinks consumed on a typical drinking day in the past 12 months, and the frequency of binge drinking in the past 12 months, to capture the patient's level of consumption and drinking patterns.

Pediatricians

In addition to OB/GYN providers, pediatricians can play an important role in delivering care to not only the child but also the pregnant and postpartum mother through becoming the *de facto* primary care provider for both. In such cases, pediatricians may also be in a position to screen women for prenatal alcohol use. In instances in which a mother reveals alcohol use, the pediatrician may screen the infant for FASD and provide guidance for monitoring the child for developmental markers of FASD. Additionally, the pediatrician may encourage alcohol abstinence for mothers who plan to

have additional children. Through the Maternal and Infant Health Initiative, the Centers for Medicare & Medicaid Services provide technical assistance to states on maternal health screening during pediatric office visits.[22]

Nurses and Community Health Workers

Due to their role in patient care as frontline staff, nurses and community health workers, would benefit from training to detect risky drinking behaviors.[23] Likewise, community providers, such as case workers for the Special Supplemental Nutrition Program for Women, Infants, and Children, are in a unique position to identify risky behaviors as well as identify markers for FASD.[24] These workers are often in the home and have extended periods of contact with women. Health care and community professionals need access to tailored tools to best meet the needs of their clients and should receive training in the implementation of these tools as well as state FASD-focused programs and policies.[25]

Role of Mental Health and Substance Use Disorder (SUD) Providers

Mental health and SUD providers are well-placed to provide preventive services to clients exhibiting risky substance use behaviors. When dealing with pregnant clients, they can promote positive health outcomes by providing consistent messaging encouraging no alcohol use during pregnancy. In addition to consistent messaging, mental health and SUD providers can establish bi-directional referral systems with other health care providers, such as primary care, OB/GYN, and pediatric providers. Through bi-directional referral systems, health care providers can refer patients screened for risky drinking behaviors to SUD treatment programs, and mental health and SUD providers can refer patients to OB/GYN providers to receive contraception to prevent an unplanned pregnancy, or to provide prenatal care to support a pregnancy, depending on the woman's goals. Bi-directional referral systems also facilitate the exchange of important clinical information between providers to improve health outcomes. Furthermore, mental health and SUD providers can often fast-track care for women into a residential or intensive outpatient care facility because of federal regulations associated with the Substance Use Prevention and Treatment Block Grant that require preferential access to treatment for pregnant women.[26,27]

Role of Partners

Alcohol consumption by partners of pregnant women may also impact the likelihood of prenatal alcohol. Multiple studies have found that pregnant women were more likely to consume alcohol in cases where a partner was a risky drinker or dependent on alcohol.[28,29,30] Partners can also use violence and substance use-related tactics to prevent pregnant women from engaging in treatment and recovery.[31] Prevention requires positive messaging about the role of partners to support pregnant women by abstaining or reducing alcohol consumption during the pregnancy as well. Messaging

should emphasize how the partner can influence the woman's decision to drink or not drink during her pregnancy.

Child Welfare

The child welfare systems can play a critical role in the identification of FASD in children who enter the child welfare system and can refer children for evaluation and services. Child welfare workers may also serve a role in screening and referring parents who may misuse alcohol. Child welfare agencies can train their staff to understand the importance of prenatal alcohol exposure in their work, while state and local child welfare policy makers can develop policy and procedures to help staff systematically screen children for FASD.[32] The Child Abuse Prevention and Treatment Act Reauthorization Act of 2010 includes specific directives related to social welfare interventions for those with an FASD diagnosis.[33] In addition, the Family First Prevention Services Act allows states the option to use Title IV-E funding, federal formula entitlement funding to fund certain evidence-based services to families to prevent foster care placement.[34] Through this, child welfare agencies may have access to more funding to provide services for in-home parent skill-based programs as well as mental health services and substance use prevention and treatment services.

Criminal Justice

Pregnant women in the criminal justice system are nearly three times more likely to have engaged in risky drinking than pregnant women outside of the criminal justice system. Corrections settings may provide opportunities for interventions and treatment engagement. A study found that 15% of pregnant offenders who consumed alcohol participated in alcohol use treatment, as compared to only 1.1% of the comparable general population.[35] However, research has demonstrated that state-level criminal justice-focused prenatal substance use polices targeting alcohol use during pregnancy were not associated with improved birth outcomes. Such policies were often leading women to avoid prenatal care due to risk of child removal and criminal charges.[36]

Role of Health Care and Behavioral Health Payers

Insurance coverage for health care services is critical to prevention; however, many health care and behavioral health payers do not cover all services required for a comprehensive approach to preventing AEPs. One study noted several barriers to care that included issues related to coverage for physical health and mental health care for the same visit, double co-pays for patients (e.g., paying a co-pay for both OB/GYN and SUD treatment received during the same visit), lack of coverage for necessary non-clinical support services, difficulty in securing coverage for care coordination and patient navigators, and limitations in Medicaid coverage for women after 60 days postpartum.[37]

Pregnant mothers on Medicaid can maintain eligibility for coverage beyond 60 days postpartum if they qualify as parents, low-income adults (in the states that have expanded Medicaid) or through another eligibility category in their state.[38] However, since income limits are higher for pregnancy eligibility, many pregnant women in Medicaid are at risk of losing coverage postpartum, particularly in states that did not participate in Medicaid expansion under the Affordable Care Act. The American Rescue Plan (ARP) included for the first time an option for states to expand postpartum coverage for 12 months after birth, which could substantially expand access to substance use screening and treatment. Pennsylvania and Colorado are two states that have expanded access to prenatal and postpartum services for women with SUD prior to the passing of the ARP using health insurance coverage and care delivery reforms (***Exhibit 4***).

EXHIBIT 4. States Using Innovative Strategies

Pennsylvania	Colorado
• Developed statewide health plan to cover coordinating care activities through their Center for Excellence that includes patients with alcohol dependency. • Permits centers to bill a specific G code for $277 a month to provide coordinated care between health care providers and mental health and SUD providers. • Allows for creative ways to support patients, such as one rural provider who purchased a car to transport patients to other services.	• Supports Special Conditions, a SUD treatment program for pregnant and parenting women up to one-year postpartum that can reduce relapse of postpartum women by extending coverage to critical addiction treatment programs. • Developed Regional Accountable Entities (RACs) to provide care coordination of fee for service physical health activities though a per member per month payment. • RACs can also cover costs associated with SBIRT and referring women with alcohol dependency to the appropriate SUD treatment program.

Opportunities

Prevention strategies involving various health and human services providers have been successful in many states. For example, the prevalence of drinking during pregnancy dropped from 15% to 4% and the prevalence of FASD births dropped from 7% to 2% between 1993 and 1998 in Washington state following implementation of prevention initiatives involving health care and child welfare workers.[39] There are still opportunities for expansion of health and human services professionals' efforts to engage in messaging, screening, and research to support prevention efforts. In addition, education and training on FASD identification and treatment can increase health providers' confidence in recognizing FASD and in referring children to specialized services when needed. Efforts to train both health and human services providers can potentially increase the identification and diagnosis of FASD. As outlined in this brief, and its companion brief, State Responses to FASD: Effective Strategies and Ongoing Challenges, existing resources for training and technical assistance can be adapted and shared across health and human services disciplines. Finally, the pending Build Back Better Act makes the postpartum coverage option in ARP permanent and mandatory for

all state Medicaid and CHIP plans. This would allow states to develop robust substance use screening and treatment for the prevention of PAE.

This brief has underscored the potential impact that heath care and human services workers can have on the prevention of FASD. It provides guidance on approaches that health and human services workers can incorporate into everyday messages and interactions with women to promote and support them in making sound choices to protect the health of their unborn children.

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