Increase in Neonatal Abstinence Syndrome, Alaska, 2001–2015

Prenatal care information was unknown for 52 (23%) of the Medicaid NAS infants. Among the remaining 179 Medicaid NAS infants, 74 (41%) had no or inadequate care followed by a score combining information on timing and number of prenatal care visits. By comparison, among all Medicaid-eligible births in 2014, 25% had no prenatal care or inadequate care.

Discussion
Both data sources evaluated indicated a consistent increase in the rate of NAS in Alaska. The statewide NAS rate increased more than five-fold from 2001–2012, from less than one to more than five for every 1,000 live births. Similarity, from 2000 to 2012 the rate among all US newborns increased from 1.2 to 5.8 per 1,000 hospital births. The majority of the cost for caring for these infants is billed to Medicaid. Rates were highest in Anchorage and Southeast Alaska, regions that also experience higher rates of other opioid-related outcomes, such as heroin-associated deaths.

Prenatal care visits are an opportunity to screen mothers for opioid use and provide services as appropriate to reduce severity or potentially prevent NAS symptoms for the infant. The high percentage of mothers of infants with NAS identified through Medicaid who had inadequate or no prenatal care indicates that screening mothers for opioid use during prenatal care visits will not identify all infants at risk for NAS. This study was unable to distinguish between appropriately prescribed opioid use, abuse of prescription opioids, and use of illicit drugs. NAS prevention efforts will differ depending on the type of prenatal exposure.

Neither the HDD nor the Medicaid database completely represent Alaska’s total birth population. During 2001–2012, only 67%–83% of in-state births occurred at hospitals reporting to the HDD. During 2004–2015, 52% of all newborns were Medicaid-eligible. Despite this limitation, the burden on the health care system caring for these infants has clearly increased and a broad spectrum of prevention and treatment interventions are needed.

Recommendations
1. Prior to prescribing an opiate, providers should screen all women of reproductive age for their risk of pregnancy and counsel all patients about the potential risk of addiction.
2. Severe withdrawal symptoms among NAS-affected infants can be reduced by screening all pregnant women about their use of opioids and making appropriate referrals. Resources and information about the Screening, Brief Intervention, Referral to Treatment (SBIRT) approach are available (see: https://www.uaa.alaska.edu/shbr/Resources/index.cfm and http://www.uaa.alaska.edu/SHBRT).
3. Participation in the Alaska Prescription Drug Monitoring Program can help prescribers provide better patient care and reduce the risk of addiction, diversion, overdose, and other adverse health effects (for more information, go to: https://www.commerce.alaska.gov/web/cbp/ProfessionalAlllicensing/BoardsofPharmacy/PrescriptionDrugMonitoringProgram).

References