JOINT STATE GOVERNMENT COMMISSION

General Assembly of the Commonwealth of Pennsylvania

DRAFT

REPORT OF THE OPIOID ABUSE CHILD IMPACT TASK FORCE

Act 2 of 2022

November 2022

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REPORT

Act 2 of 2022 (2022 HB253)
Opioid Abuse Child Impact Task Force

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The Joint State Government Commission was created in 1937 as the primary and central non-partisan, bicameral research and policy development agency for the General Assembly of Pennsylvania.[1]

A fourteen-member Executive Committee comprised of the leadership of both the House of Representatives and the Senate oversees the Commission. The seven Executive Committee members from the House of Representatives are the Speaker, the Majority and Minority Leaders, the Majority and Minority Whips, and the Majority and Minority Caucus Chairs. The seven Executive Committee members from the Senate are the President Pro Tempore, the Majority and Minority Leaders, the Majority and Minority Whips, and the Majority and Minority Caucus Chairs. By statute, the Executive Committee selects a chairman of the Commission from among the members of the General Assembly. Historically, the Executive Committee has also selected a Vice-Chair or Treasurer, or both, for the Commission.

The studies conducted by the Commission are authorized by statute or by a simple or joint resolution. In general, the Commission has the power to conduct investigations, study issues, and gather information as directed by the General Assembly. The Commission provides in-depth research on a variety of topics, crafts recommendations to improve public policy and statutory law, and works closely with legislators and their staff.

A Commission study may involve the appointment of a legislative task force, composed of a specified number of legislators from the House of Representatives or the Senate, or both, as set forth in the enabling statute or resolution. In addition to following the progress of a particular study, the principal role of a task force is to determine whether to authorize the publication of any report resulting from the study and the introduction of any proposed legislation contained in the report. However, task force authorization does not necessarily reflect endorsement of all the findings and recommendations contained in a report.

Some studies involve an appointed advisory committee of professionals or interested parties from across the Commonwealth with expertise in a particular topic; others are managed exclusively by Commission staff with the informal involvement of representatives of those entities that can provide insight and information regarding the particular topic. When a study involves an advisory committee, the Commission seeks consensus among the members.[2] Although an advisory committee member may represent a particular department, agency, association, or group, such representation does not necessarily reflect the endorsement of the department, agency, association, or group of all the findings and recommendations contained in a study report.

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[1] Act of July 1, 1937 (P.L.2460, No.459); 46 P.S. §§ 65–69.

[2] Consensus does not necessarily reflect unanimity among the advisory committee members on each individual policy or legislative recommendation. At a minimum, it reflects the views of a substantial majority of the advisory committee, gained after lengthy review and discussion.

Over the years, nearly one thousand individuals from across the Commonwealth have served as members of the Commission's numerous advisory committees or have assisted the Commission with its studies. Members of advisory committees bring a wide range of knowledge and experience to deliberations involving a particular study. Individuals from countless backgrounds have contributed to the work of the Commission, such as attorneys, judges, professors and other educators, state and local officials, physicians and other health care professionals, business and community leaders, service providers, administrators and other professionals, law enforcement personnel, and concerned citizens. In addition, members of advisory committees donate their time to serve the public good; they are not compensated for their service as members. Consequently, the Commonwealth receives the financial benefit of such volunteerism, along with their shared expertise in developing statutory language and public policy recommendations to improve the law in Pennsylvania.

The Commission periodically reports its findings and recommendations, along with any proposed legislation, to the General Assembly. Certain studies have specific timelines for the publication of a report, as in the case of a discrete or timely topic; other studies, given their complex or considerable nature, are ongoing and involve the publication of periodic reports. Completion of a study, or a particular aspect of an ongoing study, generally results in the publication of a report setting forth background material, policy recommendations, and proposed legislation. However, the release of a report by the Commission does not necessarily reflect the endorsement by the members of the Executive Committee, or the Chair or Vice-Chair of the Commission, of all the findings, recommendations, or conclusions contained in the report. A report containing proposed legislation may also contain official comments, which may be used to construe or apply its provisions.[3]

Since its inception, the Commission has published almost 450 reports on a sweeping range of topics, including administrative law and procedure; agriculture; athletics and sports; banks and banking; commerce and trade; the commercial code; crimes and offenses; decedents, estates, and fiduciaries; detectives and private police; domestic relations; education; elections; eminent domain; environmental resources; escheats; fish; forests, waters, and state parks; game; health and safety; historical sites and museums; insolvency and assignments; insurance; the judiciary and judicial procedure; labor; law and justice; the legislature; liquor; mechanics' liens; mental health; military affairs; mines and mining; municipalities; prisons and parole; procurement; state-licensed professions and occupations; public utilities; public welfare; real and personal property; state government; taxation and fiscal affairs; transportation; vehicles; and workers' compensation.

Following the completion of a report, subsequent action on the part of the Commission may be required, and, as necessary, the Commission will draft legislation and statutory amendments, update research, track legislation through the legislative process, attend hearings, and answer questions from legislators, legislative staff, interest groups, and constituents.

[3] 1 Pa.C.S. § 1939.

OPIOID ABUSE CHILD IMPACT TASK FORCE

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Members, please review your information and send any changes you may have.

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General Assembly of the Commonwealth of Pennsylvania
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November 2022

To members of the General Assembly:

We are pleased to release Report of the Opioid Abuse Child Impact Task Force, as directed by Act 2 of 2022. The Task Force was composed of the Secretaries of the Departments of Drug and Alcohol Programs, of Health, and of Human Services, along with experts and stakeholders in medicine, substance use disorder, and community services. The group's objectives were, in short, to identify strategies to mitigate the suffering of infants and children caught in the opioid epidemic. After deliberations based on expertise, experience, and evidence, the Task Force developed 11 actionable recommendations for consideration by the General Assembly and Governor.

On behalf of the Joint State Government Commission, we extend our thanks to the Task Force, staff, and care providers for their vital contributions and tireless efforts to help the most helpless emerge from the harms brought by opioid use disorder.

The full report is available at http://jsg.legis.state.pa.us.

Respectfully submitted,

Glenn J. Pasewicz
Executive Director

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INTRODUCTION

The opioid epidemic has had devastating consequences for tens of thousands of people in Pennsylvania through loss of life, broken families, and economic turmoil. It may be no more keenly painful than when it is felt by the infants and children who are swept into tragic circumstances as helpless victims. Since the start of the epidemic, however, dozens of organizations across the spectrum from the highest levels of federal and state governments to regional healthcare consortiums to local community-based organizations have collaborated to pool their resources to make children's needs a priority.

Act 2 of 2022 established the Opioid Abuse Child Impact Task Force to "focus on improving the safety, well-being and permanency of substance-exposed infants and other young children affected by their parents' substance abuse disorders."[4] The Task Force was charged with:

1. Identifying strategies and making short-term and long-term recommendations to prioritize the prevention of substance-exposed infants.

2. Improving outcomes for pregnant and parenting women who are striving to recover from addiction.

3. Promoting the health, safety and permanency of substance-exposed infants and other young children at risk of child abuse and neglect or placement in foster care due to parental alcohol and drug use.

4. Ensuring that the Commonwealth is compliant with the Child Abuse Prevention and Treatment Act (Public Law 93-247, 42 U.S.C. § 5101 et seq.) related to identifying substance-exposed infants and is developing multidisciplinary plans of safe care for these infants.

Task Force members included experts and stakeholders across the range of policy makers, advocates, and providers. The Task Force met seven times to discuss information that had been presented to it and to deliberate over remedies and recommendations to make to the General Assembly and Governor's Office. Presentations were made to the Task Force on several occasions:

- Pennsylvania Perinatal Quality Collaborative - David Kelley, MD, OMAP (DHS Office of Medical Assistance Programs) Chief Medical Officer

[4] Act of Jan. 26, 2022, P.L. 5, No. 2

- Plans of Safe Care and Multidisciplinary Workgroup on Infants with Substance Exposure (MDWISE) - Michele Walsh, PhD, LSW, Executive Assistant OCYF (DHS Office of Children, Youth, and Families)

- Department of Health: Neonatal Abstinence Syndrome - Acting Secretary of Health Denise Johnson, MD, FACOG, FACHE

- Dauphin County: Safe Plan of Care - Marisa McClellan, Administrator

Upon careful consideration of the materials presented to them, along with coalescing around their own experiences and expertise, Task Force members reached consensus on many recommendations. As with any deliberative body, not all ideas were met with enthusiasm, and not all recommendations were agreed to by all Task Force members. Nonetheless, the recommendations constitute a significant commitment by policymakers to expand on those programs that are already working and to find new ways to help the opioid epidemic's most vulnerable victims. The recommendations are stated here briefly; a more detailed discussion of the recommendations comes later in this report.

1. Every effort to connect families to necessary resources should focus on eliminating the stigma commonly associated with substance use disorder.

2. The Department of Health, the Department of Human Services, and the Department of Drug and Alcohol programs should form a Work Group to collaborate among themselves and partner with healthcare providers, community-based organizations, schools, and other entities to work with mothers, infants, and families in the commonwealth's diversity of communities.

3. Providers should co-locate services to help ensure that women do not have to travel to multiple locations for more than one service.

4. The Department of Drug and Alcohol Programs' substance use disorder crisis hotline should be expanded to help families impacted by substance use disorder in crisis connect to services and supports without involving ChildLine in situations where abuse is not suspected.

5. The Department of Human Services' Office of Children, Youth, and Families should, in partnership with the Department of Health and the Department of Drug and Alcohol Programs, expand its current KinConnector program.

6. Existing resources should be used at multiple touchpoints, such as healthcare visits, daycares, and schools identify and help infants, children, and teenagers who have experienced substance exposure.

7. The Work Group should investigate opportunities for longitudinal studies that would help determine the effectiveness of Plans of Safe Care.

8. The Department of Drug and Alcohol Programs and the Department of Health should work together to provide naloxone to at-risk families at discharge after a baby is born and make it available at subsequent home visits and medical appointments.

9. The Work Group should, through interagency cooperation at state, county, and municipal levels and through education of healthcare and community providers, reinforce the importance of prescribing and providing medication for opioid use disorder for pregnant women.

10. The Work Group can help provide medication lockboxes to families to prevent accidental or unintentional poisonings.

11. The Work Group should study the increase of incidents of ingestion, both fatal and non-fatal, and develop strategies to address it.

12. The Work Group should identify strategies of how to direct resources and collaborate with Pennsylvania's colleges and universities to expand the state's human services workforce overall.

13. The Work Group should continue work on the subject of universal screenings.

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NEONATAL ABSTINENCE SYNDROME

Neonatal Abstinence Syndrome (NAS) is a medical condition that refers to a group of problems that can occur when a baby suffers withdrawal after being exposed to certain drugs while in their mother's womb and the exposure stops abruptly upon birth. Symptoms appear in the baby's central nervous system, gastrointestinal tract, and their autonomic responses.[5] Substances a mother takes can affect an infant because many substances pass easily through the placenta to reach the fetus.[6] NAS is most often associated with opioids.[7]

Signs and Symptoms

Symptoms and severity vary from infant-to-infant and even within the same infant over time.[8] There is currently no way to accurately predict the severity of NAS expression in any given infant.

CNS symptoms include hyperirritability, high-pitched cry, jitteriness, and tremors. Hyperirritability leads to sleep disturbances and difficulty maintaining a calm state. Involuntary twitching or muscle jerks or seizures, referred to as Myoclonic seizures, are also possible. Heart problems such as tachycardia, tachypnea, and hyper or hypothermia can occur. Additionally, increased muscle tone, mottling, sweating, frequent yawning, nasal stuffiness, excessive sneezing, and nasal flaring are other symptoms. Some of these symptoms may last for months, especially from buprenorphine withdrawal.

GI symptoms include poor feeding, regurgitation, vomiting, and diarrhea. Heroin withdrawal notably has severe GI symptoms. Withdrawal in infants can lead to weight loss and failure to thrive.

It is believed that NAS symptoms arise from neurobehavioral dysregulation.[9] There are four behavioral domains: autonomic control, motor and tone control, state control and attention, and sensory processing, and any number of them might be affected. NAS signs and symptoms then arise when there is an imbalance between the four domains. For example, extra energy put in the

[5] Lauren M. Jansson and Stephen W. Patrick, "Neonatal Abstinence Syndrome," Pediatric Clinics of North America, no. 66 (2019): 353.
[6] "Substance Use While Pregnant and Breastfeeding," NIDA (2022), https://nida.nih.gov/publications/research-reports/substance-use-in-women/substance-use-while-pregnant-breastfeeding.
[7] Saminathan Anbalagan and Magda D. Mendez, "Neonatal Abstinence Syndrome," StatPearls (2022), https://www.ncbi.nlm.nih.gov/books/NBK551498/.
[8]. Jansson and Patrick, "Neonatal," 354.
[9]. Anbalagan and Mendez, "Neonatal."

motor and control domain may lead to increased muscle tone, resulting in less energy for other domains, like state control and attention, which may lead to attention problems.[10]
Factors Affecting NAS Presentation and Severity

Substances

Most NAS cases are caused by opioids, including heroin and fentanyl, and some medications like methadone and buprenorphine.[11] Maternal usage of other drugs in addition to opioids can increase the severity of NAS.[12] Substances like barbiturates, benzodiazepines, nicotine, alcohol, methamphetamine, and inhalants may lead to NAS. Other substances like antidepressants and selective serotonin reuptake inhibitors (SSRI) have led to NAS-like signs in infants, but the evidence is unclear that they truly cause drug withdrawal.[13] Several studies have evaluated the effects of marijuana and NAS and the evidence is unclear; however, there is evidence that marijuana leads to subtle neurobehavioral disturbances in the infant.[14]The timing of the onset of symptoms varies with substances: for heroin, signs begin at 12 to 24 hours of age and for methadone and buprenorphine, signs begin at 48 to 72 hours of age.[15]

Infant Factors

Male infants have been reported to have more severe NAS expression than that suffered by female infants. Preterm infants are also reported to have less severe NAS expression. However, most NAS measurement tools were intended for full term infants, and thus they may not adequately assess preterm infants.[16]

NAS statistics and surveillance

Screenings and Tests

Most NAS cases are detected by ascertaining the mother's drug use history, which should be obtained in a non-judgmental, non-threatening, and caring manner.[17] However, there are many testing options available when this drug history is not readily available, such as sampling infant or maternal urine, meconium, umbilical cord blood, and maternal plasma.[18] Usage of the infant's

[10]. Jansson and Patrick, "Neonatal," 355.
[11]. Jansson and Patrick, "Neonatal," 353.
[12]. Jansson and Patrick, "Neonatal," 354.
[13]. Mark L. Hudak, Rosemarie C. Tan, COMMITTEE ON FETUS AND NEWBORN, COMMITTEE ON DRUGS, and American Academy of Pediatrics, "Neonatal Drug Withdrawal," Pediatrics (Evanston) 129, no. 2 (2012): e541; Anbalagan and Mendez, "Neonatal."
[14]. Samarth Shukla and Harshit Doshi, "Marijuana and Maternal, Perinatal, and Neonatal Outcomes," StatPearls (2022), https://www.ncbi.nlm.nih.gov/books/NBK570616/; S. C. Jaques, A. Kingsburgy, P. Henshchke, C. Chomchai, S. Clews, J. Falconer, M. E. Abdel-Latif, J. M. Feller, and J. L. Oei, "Cannabis, the Pregnant Woman and Her Child: Weeding Out the Myths," Journal of Perinatology 34, no. 6 (2014): 420.
[15]. Jansson and Patrick, "Neonatal," 357.
[16]. Jansson and Patrick, "Neonatal," 354.
[17]. Anbalagan and Mendez, "Neonatal."
[18]. Jansson and Patrick, "Neonatal," 356.

urine and meconium are the most common methods because of ease of collection and timely results. However, the infant's urine can only identify drug exposure a few days before delivery; furthermore, any delays in the collection of urine can lead to false negatives. Meconium testing can identify drug exposure as far back as 20 weeks of gestation. While most opioids can be identified by these tests, synthetic and semi-synthetic opioids require a specialized test to identify.

Hair and umbilical cord testing are less sensitive, more impractical, and are performed less often. As with any kind of test, false positives and false negatives can occur. Soap or alcohol, for example, as well as urine contamination in meconium can lead false positives for amphetamine exposure. False positives can also occur when the mother uses analgesics during the peripartum period. Improper storage of meconium and marijuana exposure can lead to false negatives. Using both maternal urine and infant meconium testing provides the most robust results.[19]

Diagnosis should be carefully made as many NAS signs and symptoms overlap with other conditions; additionally, infants with NAS are at risk for other conditions.[20] Other diagnoses that should be considered include sepsis, birth trauma, gastrointestinal reflux, hyperthyroidism, hypoglycemia, hypocalcemia, and hypoxic-ischemic encephalopathy.

Tools have been developed to assess the severity and the need to start, adjust, and wean medications used to treat NAS. The most used scoring tool is the Finnegan Neonatal Abstinence Scoring System (FNASS) and its modified versions.[21] The original Finnegan score was developed in the early 1970s by Dr. Loretta Finnegan.[22] Despite the 1998 recommendation by the American Academy of Pediatrics to use the simpler 11-item Lipitz scoring tool, use of the Finnegan scoring tool remains widespread.[23]

The tool consists of 21 clinical signs and symptoms divided into three categories. The tool was designed for opioid-exposed infants and full-term babies. Physicians would assess the infants frequently; they usually start treatment after a cumulative score of at least 8. The tool is not without its limitations: it is heavily subjective, requires disturbing the baby for accurate assessment, and lacks generalizability to preterm infants and infants exposed to other substances besides opioids. Additionally, some studies have associated usage of the FNASS with a longer length of hospital stay and pharmacological treatment.

There is a modification of the FNASS called MOTHER NAS—it removed overlapping items and included irritability and failure to thrive, tallying to 19 items. Other tools like the Neonatal Withdrawal Inventory (NWI), Neonatal Narcotic Withdrawal Index, and Finnegan Neonatal Abstinence Syndrome Tool – Short Form, have been studied; notably scores between different raters are more consistent and correlate almost 100 percent with FNASS. They have not been as widely adopted for reasons that remain unclear.

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19. Anbalagan and Mendez, "Neonatal."
20. Jansson and Patrick, "Neonatal," 357.
21. Anbalagan and Mendez, "Neonatal."
22. Patrick et al., "Neonatal."
23. Anbalagan and Mendez, "Neonatal."

Scoring tools that utilize objective parameters such as muscle tone and tremors, pupillary size, and skin conductance exist. However, preventing their widespread adoption is their practical difficulties and limited data that validate these parameters' significance.[24]

While scoring tools present challenges, when there is uniformity in scoring processes across hospitals and training of raters to improve the consistency of scores, clinical outcomes are improved, including decreased length of hospital stay.[25]

The use of protocols for scoring is not as widespread as it should be: "In a recent survey of accredited US neonatology fellowship programs, only 55 percent had implemented a written NAS protocol, and only 69 percent used a published abstinence scoring system."[26]

Nationally

Nationally, NAS diagnoses grew 7-fold from 2000 to 2014. By 2014, 30,000 infants were diagnosed with NAS and hospitalization costs ballooned to $500 million.[27] According to Healthcare Cost and Utilization Project (HCUP) data, the cost of a hospital stay for a newborn with NAS was $8,200 in 2017, compared with $1,000 for other newborn hospital stays.[28] Additionally in 2017, the average length of stay to treat NAS was 11 days, much longer than the 2-day average for other newborn hospital stays.

From 2000 to 2016, the incidence of NAS diagnoses due to opioid exposure, referred to as Neonatal Opioid Withdrawal Syndrome (NOWS), increased from 1.2 to 8.8 per 1,000 hospital births.[29] NOWS diagnoses are more prevalent in rural and tribal areas and among infants enrolled in the Medicaid program. Furthermore, there is significant state-to-state variation; West Virginia is the hardest hit with a rate of 33.4 per 1,000 hospital births compared with Hawaii at 0.7 per 1,000 hospital births. Demographically, American Indian and Alaskan native and white infants have the highest incidence rates of NOWS (15.9 and 10.5 per 1,000 hospital births respectively) compared to other races (3.4 per 1,000 and 2.5 per 1,000 hospital births for Black and Hispanic infants respectively).

In October 2015, there was a transition from the ICD-9-CM to the ICD-10-CM, which expanded opioid-related codes.[30] Consequently, caution must be taken when assessing NAS trends before and after the transition.

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[24]. Anbalagan and Mendez, "Neonatal."
[25]. Patrick et al., "Neonatal."
[26]. Hudak et al., "Neonatal," e548.
[27] Jansson and Patrick, "Neonatal," 353–354.
[28] "Data and Statistics About Opioid Use During Pregnancy," CDC (2021), https://www.cdc.gov/pregnancy/opioids/data.html.
[29] Stephen W. Patrick, Wanda D. Barfield, Brenda B. Poindexter, and COMMITTEE ON FETUS AND NEWBORN, COMMITTEE ON SUBSTANCE USE AND PREVENTION, "Neonatal Opioid Withdrawal Syndrome," Pediatrics (Evanston) 146, no. 5 (2020): e2020029074.
[30] Ashley H. Hirai, Jean Y. Ko, Pamela L. Owens, Carol Stocks, and Stephen W. Patrick, "Neonatal Abstinence Syndrome and Maternal Opioid-Related Diagnoses in the US, 2010-2017," JAMA 325, no. 2 (2021): 147.

Pennsylvania

The Pennsylvania Department of Health (DOH) published a report on NAS in Pennsylvania in 2019. NAS surveillance in the commonwealth usually involves the retrospective review of hospital discharge data. Interstate comparison of data is limited due to varied reporting methods and case definitions.

According to Pennsylvania's Department of Human Services (DHS), the overall number of Medical Assistance (MA) beneficiaries who had been diagnosed with OUD (or opioid poisoning) in 2021was almost 126,000 individuals, a slight decrease from a five-year high of 130,000 in 2019. See Table 1.

Table 1

Medical Assistance Beneficiaries Diagnosed with Opioid Use Disorder
Pennsylvania
2015 - 2021

County	2015	2016	2017	2018	2019	2020	2021	Total
Adams	384	557	502	499	489	463	501	3,395
Allegheny	10,187	12,355	11,888	12,579	13,121	12,476	12,824	85,430
Armstrong	831	1,083	1,017	1,008	991	941	902	6,773
Beaver	1,432	1,805	1,820	1,875	1,896	1,853	1,902	12,583
Bedford	336	451	396	391	443	439	430	2,886
Berks	2,127	2,665	2,638	2,835	2,958	2,805	3,014	19,042
Blair	1,866	2,386	2,270	2,394	2,485	2,336	2,422	16,159
Bradford	267	434	398	447	446	462	480	2,934
Bucks	4,204	5,157	4,767	5,147	5,077	4,428	4,335	33,115
Butler	1,480	1,723	1,726	1,731	1,728	1,671	1,711	11,770
Cambria	1,603	2,150	2,162	2,329	2,313	2,231	2,220	15,008
Cameron	47	81	71	67	71	63	67	467
Carbon	469	570	613	656	710	629	646	4,293
Centre	542	644	600	631	675	648	666	4,406
Chester	1,455	1,924	1,833	1,904	1,944	1,654	1,801	12,515
Clarion	240	299	285	318	350	353	352	2,197
Clearfield	801	1,057	1,079	1,162	1,160	1,082	1,128	7,469
Clinton	289	441	452	621	646	572	624	3,645
Columbia	313	429	402	407	482	495	476	3,004
Crawford	699	830	813	896	912	927	985	6,062
Cumberland	823	1,051	1,010	1,037	1,072	1,066	1,157	7,216
Dauphin	1,376	1,836	1,861	2,124	2,218	2,199	2,380	13,994
Delaware	3,741	4,654	4,314	4,485	4,597	4,158	4,571	30,520
Elk	274	356	352	376	427	439	471	2,695
Erie	2,168	2,637	2,552	2,561	2,665	2,574	2,686	17,843
Fayette	2,307	2,689	3,024	3,146	3,496	3,758	3,678	22,098
Forest	22	31	31	35	35	33	36	223
Franklin	833	1,196	1,071	952	950	906	1,034	6,942
Fulton	85	110	119	91	109	102	115	731

Table 1

Medical Assistance Beneficiaries Diagnosed with Opioid Use Disorder
Pennsylvania
2015 - 2021

County	2015	2016	2017	2018	2019	2020	2021	Total
Greene	549	579	593	660	673	630	691	4,375
Huntingdon	308	400	424	396	398	366	385	2,677
Indiana	662	919	989	990	898	816	843	6,117
Jefferson	309	402	425	445	429	388	406	2,804
Juniata	108	137	131	148	176	167	170	1,037
Lackawanna	2,154	2,714	2,552	3,066	3,388	3,456	3,609	20,939
Lancaster	2,660	3,229	3,260	3,186	3,283	3,110	3,310	22,038
Lawrence	1,407	1,660	1,736	1,640	1,694	1,586	1,637	11,360
Lebanon	678	856	908	915	978	966	984	6,285
Lehigh	1,961	2,416	2,309	2,534	2,764	2,536	2,489	17,009
Luzerne	2,839	3,523	3,748	3,868	4,103	4,227	4,351	26,659
Lycoming	973	1,288	1,316	1,443	1,527	1,503	1,584	9,634
McKean	272	380	403	424	481	487	501	2,948
Mercer	1,198	1,385	1,433	1,423	1,518	1,456	1,502	9,915
Mifflin	525	649	666	651	688	626	670	4,475
Monroe	981	1,282	1,326	1,356	1,423	1,220	1,236	8,824
Montgomery	3,603	4,433	4,090	3,818	3,949	3,469	3,611	26,973
Montour	79	112	97	99	99	88	87	661
Northampton	1,303	1,562	1,618	1,655	1,825	1,721	1,758	11,442
Northumberland	667	820	831	953	1,012	957	1,032	6,272
Perry	215	293	323	288	285	267	306	1,977
Philadelphia	18,214	21,878	22,600	23,866	25,874	22,964	23,536	158,932
Pike	296	360	350	374	375	338	342	2,435
Potter	93	99	93	87	89	80	76	617
Schuylkill	1,121	1,423	1,482	1,573	1,623	1,498	1,543	10,263
Snyder	151	187	169	177	207	191	247	1,329
Somerset	584	757	808	829	836	810	841	5,465
Sullivan	10	19	21	28	31	23	28	160
Susquehanna	172	257	258	303	402	390	395	2,177
Tioga	269	339	317	324	345	339	354	2,287
Union	129	145	134	169	150	150	170	1,047
Venango	618	650	695	729	682	639	660	4,673
Warren	263	335	339	381	401	352	369	2,440
Washington	2,204	2,791	2,974	2,844	2,944	3,018	3,076	19,851
Wayne	309	362	406	420	501	444	430	2,872
Westmoreland	3,602	4,428	4,689	4,286	4,312	4,191	4,139	29,647
Wyoming	183	265	306	256	299	316	321	1,946
York	2,302	3,230	3,461	3,527	3,617	3,412	3,651	23,200
UNKNOWN	912	1,953	193	1,345	1,578	1,216	910	8,107
Total	96,084	120,118	118,539	124,180	130,323	122,176	125,864	837,284

Source: Commonwealth of Pennsylvania, "opendata PA" website, https://data.pa.gov/Opioid-Related/Individuals-Under-Medical-Assistance-Diagnosed-wit/3gj5-t7ah. Updated August 18, 2022.

For the period 2015 through 2021, the number of MA beneficiaries receiving MAT peaked at 79,800 in 2019 and is at its lowest point, 50,000, since 2015's count of 48,700 individuals. See Table 2.

Table 2

Medical Assistance Beneficiaries Receiving Medication Assisted Treatment
Pennsylvania
2015 - 2021

County	2015	2016	2017	2018	2019	2020	2021	Total
Adams	159	245	325	343	404	221	228	1,925
Allegheny	5,763	6,756	7,813	8,357	9,328	5,029	5,274	48,320
Armstrong	498	595	622	634	722	283	228	3,582
Beaver	857	997	1,175	1,263	1,401	703	792	7,188
Bedford	151	203	232	272	322	131	132	1,443
Berks	886	1,088	1,392	1,416	1,618	1,159	1,174	8,733
Blair	1,225	1,405	1,606	1,626	1,740	918	894	9,414
Bradford	91	177	237	268	276	175	180	1,404
Bucks	2,203	2,633	3,115	2,988	3,253	2,092	2,122	18,406
Butler	888	1,017	1,128	1,217	1,289	636	724	6,899
Cambria	941	1,213	1,423	1,473	1,630	756	788	8,224
Cameron	18	26	43	36	27	12	11	173
Carbon	194	240	299	294	326	245	232	1,830
Centre	303	316	354	392	449	317	348	2,479
Chester	624	729	853	833	996	642	761	5,438
Clarion	106	133	161	180	230	105	95	1,010
Clearfield	457	477	539	538	588	381	447	3,427
Clinton	162	231	308	371	454	339	372	2,237
Columbia	157	200	273	266	301	226	216	1,639
Crawford	379	459	524	550	574	318	370	3,174
Cumberland	326	480	613	586	735	452	560	3,752
Dauphin	512	716	972	1,025	1,250	756	942	6,173
Delaware	1,759	2,024	2,276	2,383	2,652	1,738	1,756	14,588
Elk	127	165	197	221	250	155	145	1,260
Erie	1,129	1,380	1,570	1,772	1,885	1,042	1,063	9,841
Fayette	1,497	1,646	1,731	1,895	2,110	1,183	1,254	11,316
Forest	--	--	--	--	--	--	--	24
Franklin	260	365	426	445	501	328	382	2,707
Fulton	31	39	45	53	55	38	46	307
Greene	281	320	341	328	390	262	332	2,254
Huntingdon	132	154	185	207	220	119	115	1,132
Indiana	340	397	460	482	509	209	259	2,656
Jefferson	143	163	188	187	204	107	134	1,126
Juniata	62	67	89	94	107	89	98	606
Lackawanna	1,117	1,385	1,710	1,847	2,138	1,495	1,726	11,418
Lancaster	1,172	1,436	1,627	1,575	1,796	1,110	1,377	10,093
Lawrence	957	1,025	1,145	1,223	1,321	797	876	7,344
Lebanon	276	402	474	460	571	360	472	3,015
Lehigh	717	853	1,107	1,130	1,309	919	991	7,026

Table 2

Medical Assistance Beneficiaries Receiving Medication Assisted Treatment
Pennsylvania
2015 - 2021

County	2015	2016	2017	2018	2019	2020	2021	Total
Luzerne	1,645	2,083	2,584	2,689	2,936	1,987	2,212	16,136
Lycoming	500	670	824	837	990	685	739	5,245
McKean	113	126	148	186	226	120	137	1,056
Mercer	807	900	993	979	1,059	593	631	5,962
Mifflin	277	342	385	447	564	440	471	2,926
Monroe	544	649	733	685	720	561	563	4,455
Montgomery	1,630	1,882	2,083	2,132	2,381	1,538	1,636	13,282
Montour	43	66	60	61	75	49	57	411
Northampton	534	625	732	704	816	584	668	4,663
Northumberland	305	384	495	537	621	451	616	3,409
Perry	87	146	197	176	195	121	127	1,049
Philadelphia	9,125	10,455	12,125	12,501	14,828	8,220	7,442	74,696
Pike	132	183	215	211	199	117	150	1,207
Potter	23	26	29	32	28	18	27	183
Schuylkill	397	549	656	701	692	418	410	3,823
Snyder	49	70	98	107	153	107	156	740
Somerset	346	437	520	535	597	288	339	3,062
Sullivan	--	--	--	--	--	--	15	29
Susquehanna	78	109	155	184	165	117	144	952
Tioga	70	84	135	148	198	128	173	936
Union	56	79	85	92	109	75	100	596
Venango	324	316	367	414	461	292	323	2,497
Warren	88	101	124	180	215	127	152	987
Washington	1,163	1,419	1,689	1,747	2,021	1,048	1,199	10,286
Wayne	139	169	222	232	257	163	159	1,341
Westmoreland	2,148	2,475	2,690	2,714	3,016	1,636	1,788	16,467
Wyoming	80	118	150	172	202	154	162	1,038
York	963	1,422	1,774	1,776	2,124	1,256	1,585	10,900
UNKNOWN	118	14	--	3,802	--	7,017	--	10,951
Total	48,684	58,056	67,846	74,211	79,793	54,157	50,097	432,868

Source: Commonwealth of Pennsylvania, "opendata PA," https://data.pa.gov/Opioid-Related/Individuals-with-Medical-Assistance-MA-receiving-M/unzz-dvz6. Updated August 18, 2022.

Data were reported for the years 2016 through 2020 for the annual rates of women (per 1,000) who were receiving Medical Assistance and were diagnosed with OUD during pregnancy. For privacy reasons, counties do not report data in instances where there were fewer than 11 women in the cohort (i.e., deliveries associated with OUD). Therefore, it is difficult to determine trends for the commonwealth overall and for several the counties individually because 29 of the 67 did not have a full reporting for the period. It is possible to see trends for the counties, however, that reported data for each of the years 2016 through 2020. Some counties saw dramatic increases over the period. See Table 3.

Table 3

Annual Rate of Women on Medical Assistance (MA) with Opioid Use Disorder Diagnoses During Pregnancy per 1,000 Deliveries
Pennsylvania
2016 - 2020

County	2016	2017	2018	2019	2020
Dauphin County	17.37	26.58	24.47	24.59	138.61
Lehigh County	15.58	15.86	23.67	24.97	89.62
Berks County	21.15	19.84	26.21	23.71	93.64
Lancaster County	40.39	35.97	37.91	29.84	159.51
Chester County	34.29	35.78	45.28	35.06	105.74
Crawford County	55.37	78.13	67.09	107.59	119.05
Beaver County	61.48	73.39	49.38	97.9	121.55
Centre County	74.22	65.5	50.39	92.74	115.18
Bedford County	60.19	86.29	86.49	92.31	91.4
Lackawanna County	61.1	50.05	55.88	66.31	88.65
Delaware County	42.94	45.76	34.97	50.77	61.39
Northumberland County	59.55	63.78	70.97	57.97	83.94
Luzerne County	45.43	43.62	60.97	54.54	60.61
Franklin County	46.22	43.01	61.84	50.65	56.28
Blair County	65.84	86.4	81.46	89.32	76.38
Clearfield County	90.91	163.2	126.07	99.46	104.65
Venango County	108.33	145.73	137.44	138.61	101.85
Butler County	77.86	88.83	100	102.9	71.21
Indiana County	92.86	79.14	70.37	66.18	84.03
Lebanon County	37.28	29.22	25.36	41.6	33.63
Washington County	90.63	106.06	107.87	98.2	81.52
Columbia County	49.06	53.57	54.85	--	43.39
Cumberland County	46.45	44.3	41.15	51.89	39.43
Mercer County	76.27	89.17	119.47	95.67	62.26
Clarion County	72.29	--	119.72	111.11	52.66
Erie County	38.44	42.06	47.3	36.85	26.79
Bucks County	87.02	96.8	108.82	84.07	55.56
Cambria County	86.71	113.97	118.34	119.22	54.39
Fayette County	146.67	120.22	136.36	121.99	89.66
Lycoming County	55.89	58.44	86.96	90.91	31.98
Allegheny County	58.75	51.04	54.55	53.06	27.98
Lawrence County	89.62	112.87	114.88	104.27	38.53
Greene County	186.34	156.76	140.13	132.91	74.4
Elk County	131.15	207.21	174.31	185.71	46.98
Armstrong County	108.49	90.5	82.95	96.33	30.25
Bradford County	--	51.28	42.86	57.55	27.81
Cameron County	--	--	--	--	75.44
Carbon County	--	85.6	59.52	49.79	34.01
Clinton County	--	98.48	--	120	99.08
Forest County	--	--	--	--	58.33
Fulton County	--	--	--	--	101.96
Huntingdon County	--	76.09	76.09	--	59.86
Jefferson County	--	53.4	--	80.57	140.9

Table 3

Annual Rate of Women on Medical Assistance (MA) with Opioid Use Disorder Diagnoses During Pregnancy per 1,000 Deliveries
Pennsylvania
2016 - 2020

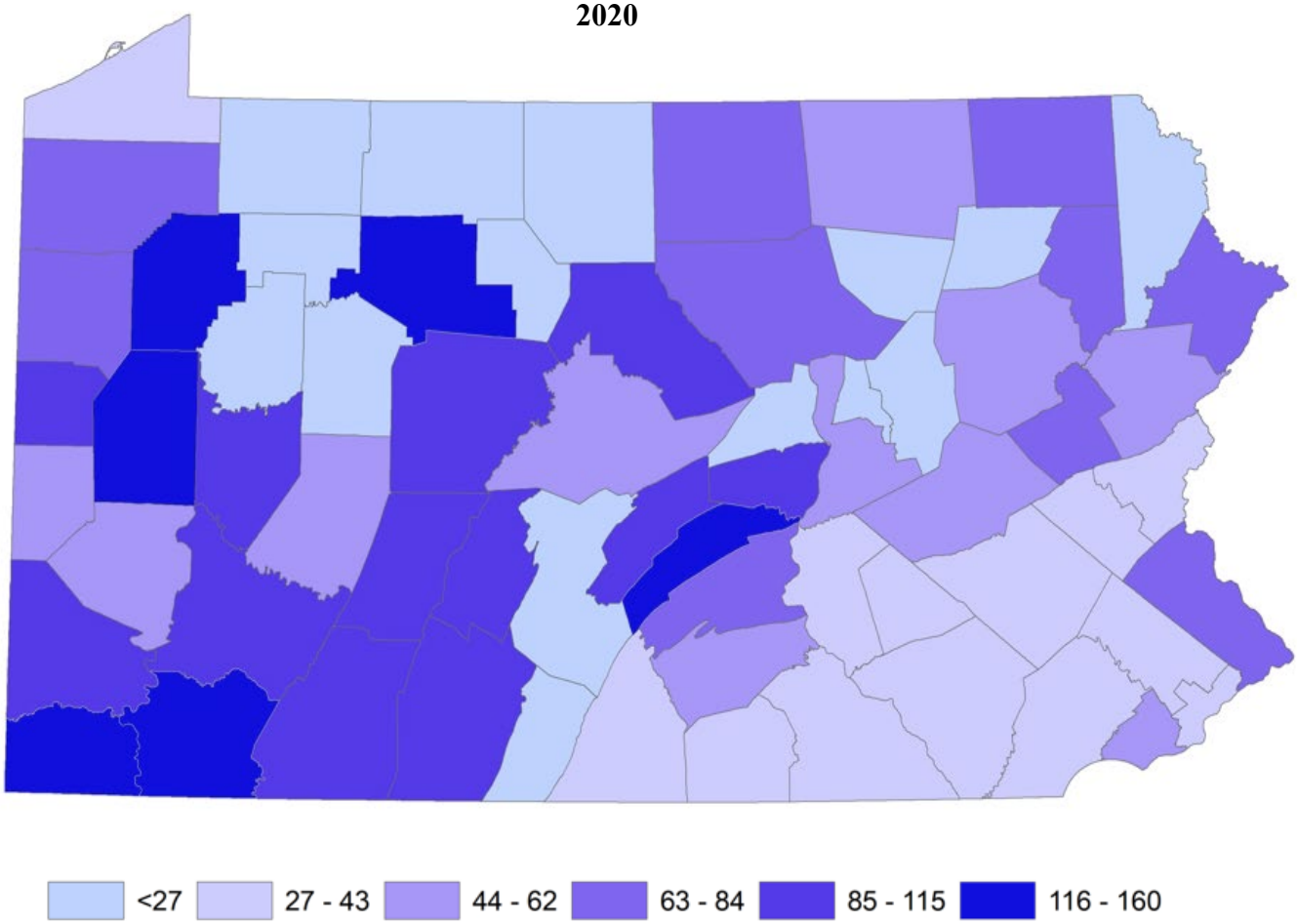
County	2016	2017	2018	2019	2020
Juniata County	--	--	--	--	32.64
McKean County	--	--	--	--	42.73
Mifflin County	95.24	68.81	79.68	106.3	--
Monroe County	42.99	50.3	44.41	43.14	--
Montgomery County	56.89	44.04	46.98	50.38	--
Montour County	--	--	--	--	48.69
Northampton County	27.94	33.62	27.19	31.81	--
Perry County		77.46	101.27	--	93.33
Philadelphia County	26.75	28.31	29.87	27.18	--
Pike County	--	--	--	--	--
Potter County	--	--	--	--	--
Schuylkill County	56.73	68.69	70.72	43.41	--
Snyder County	--	--	--	--	126.44
Somerset County	104.42	121.77	113.79	88.61	--
Sullivan County	--	--	--	--	--
Susquehanna County	--	--	114.65	62.5	80.75
Tioga County	--	--	62.86	--	74.07
Union County	--	--	--	--	--
Warren County	--	--	--	86.33	--
Wayne County	--	--	76.39	82.84	83.33
Westmoreland County	98.15	96.43	96.91	106.58	--
Wyoming County	--	--	--	97.4	--
York County	40.25	147.51	46.01	49.57	--
Commonwealth	67.7614	75.9355	75.1584	76.7288	74.3543

Source: Commonwealth of Pennsylvania, "opendata PA" website, https://data.pa.gov/Opioid-Related/Rate-of-Women-on-Medical-Assistance-MA-Diagnosed-w/mmps-kc6p. Updated August 23, 2022

Map 1 gives a visual depiction of how the 2020 rates of women suffering OUD during pregnancy were worse in the southwest and rural counties, with the problem being most acute in the southwest corner of the commonwealth.

Map 1

Rate of Opioid Use Disorder Pregnancies
Per 1,000 Deliveries
2020



The six counties with the greatest overall increases, Dauphin, Lehigh, Berks, Lancaster, Chester, Crawford, and Beaver Counties had rate increases from nearly 100 percent (Crawford) to 700 percent (Dauphin) greater than the seventh ranked county, Centre. Overall, 16 counties showed increases in the rate per 1,000 deliveries by women on Medical Assistance diagnosed with OUD during pregnancy. See Table 4.

Table 4

Annual Rate of Women on Medical Assistance (MA) with Opioid Use Disorder Diagnoses During Pregnancy per 1,000 Deliveries
Counties with Highest Rates of Increase
Pennsylvania
2016 - 2020

County	2016	2017	2018	2019	2020	Percent Increase
Dauphin	17.37	26.58	24.47	24.59	138.61	698%
Lehigh	15.58	15.86	23.67	24.97	89.62	475%
Berks	21.15	19.84	26.21	23.71	93.64	343%
Lancaster	40.39	35.97	37.91	29.84	159.51	295%
Chester	34.29	35.78	45.28	35.06	105.74	208%
Crawford	55.37	78.13	67.09	107.59	119.05	115%
Beaver	61.48	73.39	49.38	97.90	121.55	98%
Centre	74.22	65.5	50.39	92.74	115.18	55%
Bedford	60.19	86.29	86.49	92.31	91.40	52%
Lackawanna	61.10	50.05	55.88	66.31	88.65	45%
Delaware	42.94	45.76	34.97	50.77	61.39	43%
Northumberland	59.55	63.78	70.97	57.97	83.94	41%
Luzerne	45.43	43.62	60.97	54.54	60.61	33%
Franklin	46.22	43.01	61.84	50.65	56.28	22%
Blair	65.84	86.4	81.46	89.32	76.38	16%
Clearfield	90.91	163.2	126.07	99.46	104.65	15%

Source: Commonwealth of Pennsylvania, "opendata PA" website, https://data.pa.gov/Opioid-Related/Rate-of-Women-on-Medical-Assistance-MA-Diagnosed-w/mmps-kc6p. Updated August 23, 2022.

Fifteen counties reported data for each of the years 2016 through 2020 that showed overall decreases in the rate per 1,000 deliveries by women on Medical Assistance diagnosed with OUD during pregnancy. Armstrong County had a decrease of 72 percent over this period, followed by Elk at 64 percent, Greene at 60, Lawrence at 57, and Allegheny at 52 percent. See Table 5.

Table 5

Annual Rate of Women on Medical Assistance (MA) with Opioid Use Disorder Diagnoses During Pregnancy per 1,000 Deliveries
Counties with Rate Decreases
Pennsylvania
2016 - 2020

County	2016	2017	2018	2019	2020	Percent Decrease
Armstrong	108.49	90.50	82.95	96.33	30.25	-72.1
Elk	131.15	207.21	174.31	185.71	46.98	-64.2
Greene	186.34	156.76	140.13	132.91	74.40	-60.1
Lawrence	89.62	112.87	114.88	104.27	38.53	-57.0
Allegheny	58.75	51.04	54.55	53.06	27.98	-52.4
Lycoming	55.89	58.44	86.96	90.91	31.98	-42.8
Fayette	146.67	120.22	136.36	121.99	89.66	-38.9
Cambria	86.71	113.97	118.34	119.22	54.39	-37.3
Bucks	87.02	96.8	108.82	84.07	55.56	-36.2
Erie	38.44	42.06	47.30	36.85	26.79	-30.3
Mercer	76.27	89.17	119.47	95.67	62.26	-18.4
Cumberland	46.45	44.30	41.15	51.89	39.43	-15.1
Washington	90.63	106.06	107.87	98.20	81.52	-10.1
Lebanon	37.28	29.22	25.36	41.6	33.63	-9.8
Indiana	92.86	79.14	70.37	66.18	84.03	-9.5
Venango	108.33	145.73	137.44	138.61	101.85	-6.0

Source: Commonwealth of Pennsylvania, "opendata PA" website, https://data.pa.gov/Opioid-Related/Rate-of-Women-on-Medical-Assistance-MA-Diagnosed-w/mmps-kc6p. Updated August 23, 2022.

The remaining 29 counties did not report data for all the years 2016 to 2020. All but Montgomery, Philadelphia, Westmoreland, and York are rural.[31]

The case definition for NAS used in Pennsylvania has been established as:

- A newborn with a clinical diagnosis in the neonatal period (birth up to 28 days of life) who has symptoms of withdrawal because of parental exposure to opiate drugs, either via prescription, medical therapy (MAT), or illegal use (ICD-10 codes P96.1 and P04.49 only, if available);

- A resident of Pennsylvania (only infants born to mothers who resided in Pennsylvania before the baby's birth); and

- An infant born on or after 1/10/2018.[32]

[31] Center for Rural Pennsylvania, "Rural-Urban Definitions," website, https://www.rural.pa.gov/data/rural-urban-definitions Accessed October 19, 2022.
[32]. "Neonatal," 4.

The state's overall rate of newborns with withdrawal symptoms or otherwise affected by maternal addictive drug use over the years 2016 to 2020 is shown in Table 5. The data show the extreme impact that OUD has on mothers and infants. The problem reaches all counties in Pennsylvania, whether rural or urban, although it is worse in rural counties, as it is with all OUD. In 2017, more than 1 in 4 infants under the Medical Assistance program who were born in Elk County were somehow affected by their mothers' addictive drug use, showing either symptoms of withdrawal or other related problems. In Greene County in 2018, 23 percent of infants were affected. Over the years specified, the county with the lowest rate was York County in 2020, yet it still had close to 3 percent of infants born under these conditions.

Rates were slowly climbing over the years from 68.19 in 2016 to 70.79 in 2017, to 71.09 in 2018. There appears in the data to be a large drop in 2019 and 2020, to 51.98 and 52.56, respectively. See Table 6.

Table 6

Newborns Covered by Medical Assistance
with Withdrawal Symptoms or Affected by Maternal Addictive Drug Use
Rate per 1,000 Live Births
Pennsylvania
2016 - 2020

County	2016	2017	2018	2019	2020
Adams	50.96	56.85	43.89	34.92	33.54
Allegheny	77.95	67.29	73.17	50.27	48.91
Armstrong	180.56	144.68	120.00	70.59	63.83
Beaver	79.65	75.68	83.19	81.43	65.29
Bedford	70.48	90.00	98.36	92.78	68.18
Berks	43.31	47.06	38.90	26.71	33.22
Blair	65.69	98.90	91.54	82.46	79.37
Bradford	--	54.19	48.08	35.95	--
Bucks	91.19	102.26	109.38	70.39	71.33
Butler	109.79	109.79	122.73	76.74	117.49
Cambria	123.24	147.89	145.25	101.29	85.81
Cameron	--	--	--	--	--
Carbon	129.63	93.96	83.33	58.82	85.17
Centre	56.03	72.34	--	59.93	47.21
Chester	60.11	68.62	91.60	41.67	41.67
Clarion	83.92	--	112.68	95.81	81.63
Clearfield	110.77	168.75	138.36	76.70	100.65
Clinton	--	98.48	--	104.29	--
Columbia	62.26	57.14	50.23	--	--
Crawford	103.24	72.25	85.64	79.02	60.06
Cumberland	59.13	58.28	61.89	35.96	29.61
Dauphin	43.22	43.10	42.43	23.84	40.36
Delaware	102.12	144.82	136.13	87.45	81.46
Elk	--	259.26	207.55	146.79	153.85
Erie	61.08	56.48	86.16	35.74	41.92

Table 6

Newborns Covered by Medical Assistance with Withdrawal Symptoms or Affected by Maternal Addictive Drug Use Rate per 1,000 Live Births Pennsylvania 2016 - 2020

County	2016	2017	2018	2019	2020
Fayette	166.00	140.08	186.99	119.34	87.52
Forest	--	--	--	--	--
Franklin	79.58	84.03	82.91	37.33	37.64
Fulton	--	--	--	--	--
Greene	209.04	197.86	226.99	134.97	167.70
Huntingdon	--	86.42	59.46	--	60.77
Indiana	94.41	132.35	133.80	73.17	93.86
Jefferson	--	72.92	59.14	64.04	--
Juniata	--	--	--	--	--
Lackawanna	84.42	63.81	58.03	56.35	72.85
Lancaster	48.54	58.30	56.55	33.99	40.98
Lawrence	116.22	113.16	102.90	99.06	94.91
Lebanon	57.60	70.49	52.10	36.14	33.44
Lehigh	43.21	34.73	47.00	27.51	41.17
Luzerne	67.65	68.42	75.67	58.59	61.49
Lycoming	46.55	64.72	64.86	54.87	69.61
McKean	88.76	--	--	--	71.82
Mercer	116.67	129.10	125.54	81.86	84.39
Mifflin	72.82	--	83.72	97.78	107.53
Monroe	48.85	55.96	59.17	37.50	50.78
Montgomery	64.20	65.37	53.88	47.22	54.12
Montour	--	--	--	--	--
Northampton	53.96	40.18	36.61	31.02	38.49
Northumberland	63.83	47.98	67.31	81.50	67.42
Perry	--	77.92	98.04	86.96	108.43
Philadelphia	47.32	54.59	51.06	39.20	37.41
Pike	--	--	63.83	--	96.15
Potter	--	--	--	--	--
Schuylkill	108.86	90.15	70.74	57.02	52.86
Snyder	--	--	--	--	--
Somerset	102.19	116.47	106.62	75.00	88.46
Sullivan	--	--	--	--	--
Susquehanna	96.77	--	100.00	--	71.90
Tioga	--	--	--	68.75	60.44
Union	--	--	--	--	--
Venango	107.88	172.25	157.66	94.06	88.79
Warren	--	--	--	--	--
Washington	101.61	119.69	103.70	90.42	90.24
Wayne	72.73	77.84	--	--	--
Westmoreland	135.45	117.28	122.28	99.30	78.85
Wyoming	--	100.00	--	--	--
York	55.37	44.58	46.65	38.44	27.73

Table 6

Newborns Covered by Medical Assistance
with Withdrawal Symptoms or Affected by Maternal Addictive Drug Use
Rate per 1,000 Live Births
Pennsylvania
2016 - 2020

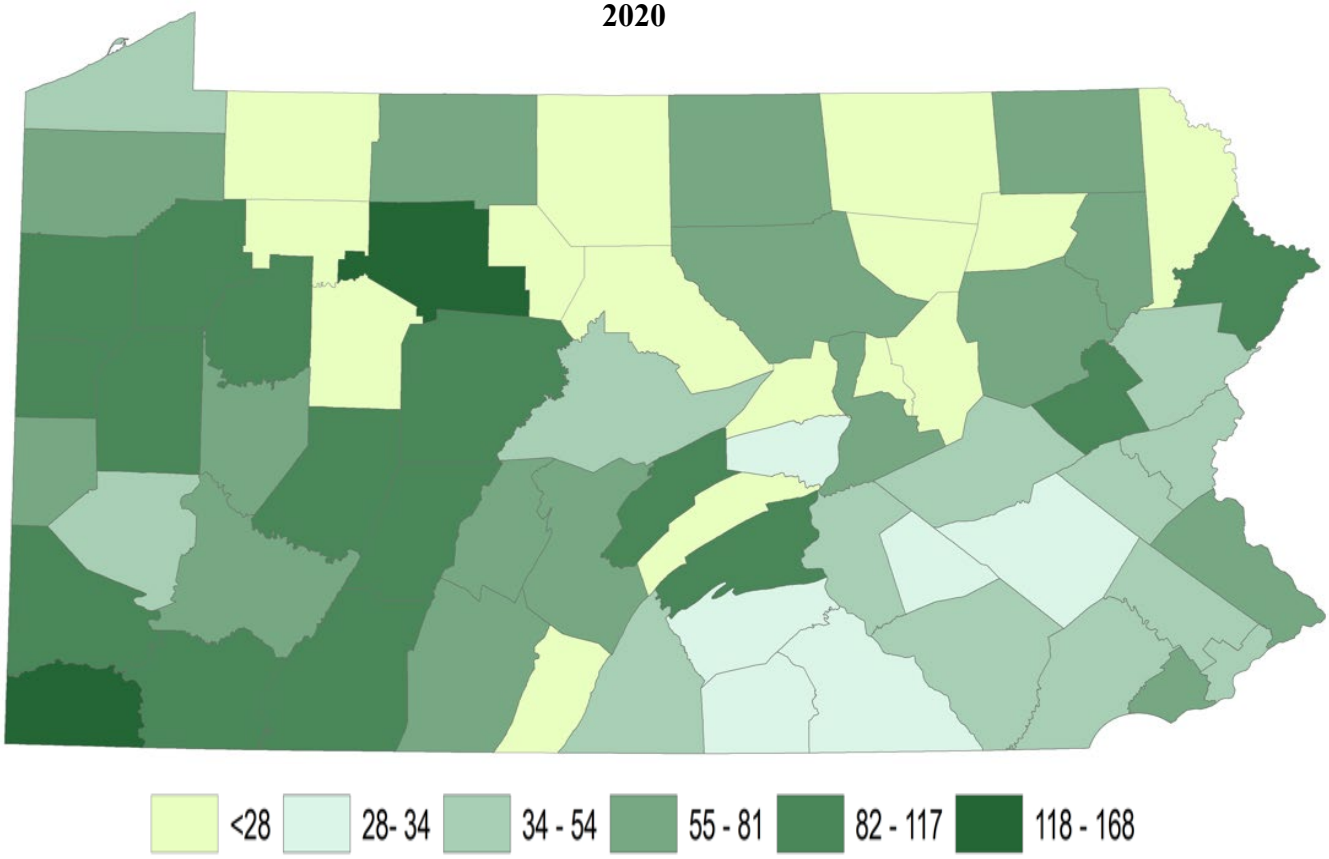
County	2016	2017	2018	2019	2020
Commonwealth	68.18	70.78	71.06	51.56	52.558

Source: https://data.pa.gov/Opioid-Related/Rate-of-Newborns-on-Medical-Assistance-MA-with-Neo/jw44-tcq8

Map 2 shows the counties' 2020 rates of withdrawal among newborns. Not surprisingly, the counties where mothers' OUD are at high rates is where the rates of infants born with withdrawal symptoms are also high. The maps are not identical, which might indicate that some women may travel to counties with more appropriate medical facilities.

Map 2

Rate of Neonate Withdrawal
Per 1,000 Live Births
2020



Forty-two of the 67 counties reported data for each of the years 2016 to 2020. Counties do not report data if there are fewer than 11 births in the category. Of the 42, five reported increases, from Monroe's 4 percent to Lycoming's nearly 50 percent. See Table 7.

Table 7

Newborns Covered by Medical Assistance with Withdrawal Symptoms or Affected by Maternal Addictive Drug Use Counties With Rate Increases per 1,000 Births Pennsylvania 2016 - 2020

County	2016	2017	2018	2019	2020
Lycoming	46.6	64.7	64.9	--	69.6
Blair	65.7	98.9	91.5	--	79.4
Butler	109.8	109.8	122.7	--	117.5
Northumberland	63.8	48.0	67.3	--	67.4
Monroe	48.9	56.0	59.2	--	50.8

Source: https://data.pa.gov/Opioid-Related/Rate-of-Newborns-on-Medical-Assistance-MA-with-Neo/jw44-tcq8.

The remaining 37 counties reported decreases. The five counties with the largest decreases were Armstrong, Franklin, Schuylkill, and Cumberland. Armstrong had the largest with over 64 percent decrease while the other four counties' decreases were closer to 50 percent. See Table 8.

Table 8

Newborns Covered by Medical Assistance with Withdrawal Symptoms or Affected by Maternal Addictive Drug Use Counties With Rate Decreases per 1,000 Births Pennsylvania 2016 - 2020

County	2016	2017	2018	2019	2020
Armstrong	180.56	144.68	120	--	63.83
Franklin	79.58	84.03	82.91	--	37.64
Schuylkill	108.86	90.15	70.74	--	52.86
Cumberland	59.13	58.28	61.89	--	29.61

Source: https://data.pa.gov/Opioid-Related/Rate-of-Newborns-on-Medical-Assistance-MA-with-Neo/jw44-tcq8

Sometimes, infants and children are found in circumstances where the youngsters must live with caregivers other than their parents. These arrangements often find children in kinship care, that is, living in the care of relatives other than their parents. Sometimes infants and children are removed to the foster care system. Whether the children are in out-of-home care because of parents' substance use or for other factors can be difficult to discern because there may be variations in how caseworkers record the circumstances. Further, according to Task Force members, substance use is not often reported as a direct cause for the removal although it might be an indirect cause. For example, a parent's SUD might prevent him or her from adequately feeding, clothing, or providing appropriate living conditions for children in the home. While the SUD may have led to the problems, it is the consequences of the SUD that are listed as causes for removal. The commonwealth tracks data of infants and children who are not living in the care of their parents. See Table 9 and Table 10.

Table 9

Rate of Children in Kinship Care Where Parental Drug Use was a Factor - by County
Pennsylvania
2017 - 2019

County	2017	2018	2019
Adams		0.77	
Allegheny	1.27	0.96	0.91
Armstrong			0.87
Beaver	0.42		
Bedford			
Berks	0.52	0.56	0.24
Blair			0.84
Bradford			0.82
Bucks	0.88	0.57	0.87
Butler	0.93	0.68	0.98
Cambria	0.49	--	--
Cameron	--	--	--
Carbon	--	--	--
Centre	--	--	--
Chester	--	--	--
Clarion	--	--	3.56
Clearfield	2.2	1.42	--
Clinton	--	--	--
Columbia	1.35		2.15
Crawford	1.46	1.26	1.78
Cumberland	0.78	1.22	0.45
Dauphin	0.49	0.71	0.31
Delaware	0.09	0.23	--
Elk	--	--	7.64
Erie	0.88	0.48	0.64
Fayette	3.74	2.5	--
Forest	--	--	--
Franklin	--	--	1.18
Fulton	--	--	--

Table 9

Rate of Children in Kinship Care Where Parental Drug Use was a Factor - by County
Pennsylvania
2017 - 2019

County	2017	2018	2019
Greene	1.81	4.32	3.38
Huntingdon	2.08		1.57
Indiana	--	--	--
Jefferson	--	--	--
Juniata	--	--	4.13
Lackawanna	0.49	0.51	0.26
Lancaster	0.2	0.17	
Lawrence	--	0.74	1.79
Lebanon	--	--	2.15
Lehigh	--	0.55	--
Luzerne	1.68	1.25	--
Lycoming	--	--	--
McKean	1.79	--	--
Mercer	--	--	--
Mifflin	--	--	3.75
Monroe	0.46	0.44	--
Montgomery	0.23	0.16	0.19
Montour	--	--	5.41
Northampton	0.52	0.56	
Northumberland	1.19	0.66	15.2
Perry	--	--	--
Philadelphia	0.91	0.73	--
Pike	--	--	2.69
Potter			
Schuylkill	0.99	0.88	0.57
Snyder	1.26		--
Somerset	1.23	1.81	--
Sullivan	--	--	--
Susquehanna	--	--	2.98
Tioga	--	--	--
Union	--	--	5.95
Venango	--	1.15	--
Warren	--	--	2.84
Washington	2.88	1.57	
Wayne	--	--	6.04
Westmoreland	0.39	0.27	--
Wyoming	--	2.01	--
York	0.4	0.73	--
Total	0.67	0.59	0.57

Source: Commonwealth of Pennsylvania, "opendata PA" website, https://data.pa.gov/Opioid-Related/Annual-Rate-of-Dependent-Children-Removed-from-The/2a6x-aizt

Table 10

Rate of Dependent Children Removed from their Home
Where Parental Drug Use was a Factor
Per 1,000
Pennsylvania
2017 – 2019

County	2017	2918	2019
Adams	1	1.68	0.87
Allegheny	1.6	1.26	1.3
Armstrong	--	0.93	1.42
Beaver	0.54	--	0.34
Bedford	1.31	--	--
Berks	1.63	1.39	0.94
Blair	0.93	0.63	1.07
Bradford	--	1.11	2.01
Bucks	1.42	0.8	1.36
Butler	1.32	1.02	1.4
Cambria	1.18	1.69	0.93
Cameron	--	--	--
Carbon	--	1.04	0.97
Centre	0.53	--	0.74
Chester	--	0.14	0.09
Clarion	1.78	--	--
Clearfield	3.4	2.63	3.63
Clinton	2.87	2.13	1.65
Columbia	2.44	1.7	2.15
Crawford	2.11	2.47	1.9
Cumberland	1.2	1.53	0.89
Dauphin	1.22	1.55	1.05
Delaware	0.45	0.67	0.59
Elk	--	--	--
Erie	1.73	2.01	2.33
Fayette	4.59	3.25	2.37
Forest	--	--	--
Franklin	1.24	0.46	0.52
Fulton	--	--	--
Greene	4.59	9.61	7.88
Huntingdon	3.47	1.79	2.54
Indiana	1.39	1.22	2.42
Jefferson	--	1.39	2.04
Juniata	--	--	--
Lackawanna	1.07	1.16	0.47
Lancaster	0.64	0.48	0.42
Lawrence	--	1.03	1.91
Lebanon	--	0.35	0.44
Lehigh	0.66	0.75	0.58
Luzerne	2.68	1.84	2
Lycoming	0.71	1.1	--
McKean	3.33	2.51	2.07

Table 10

Rate of Dependent Children Removed from their Home Where Parental Drug Use was a Factor Per 1,000 Pennsylvania 2017 – 2019

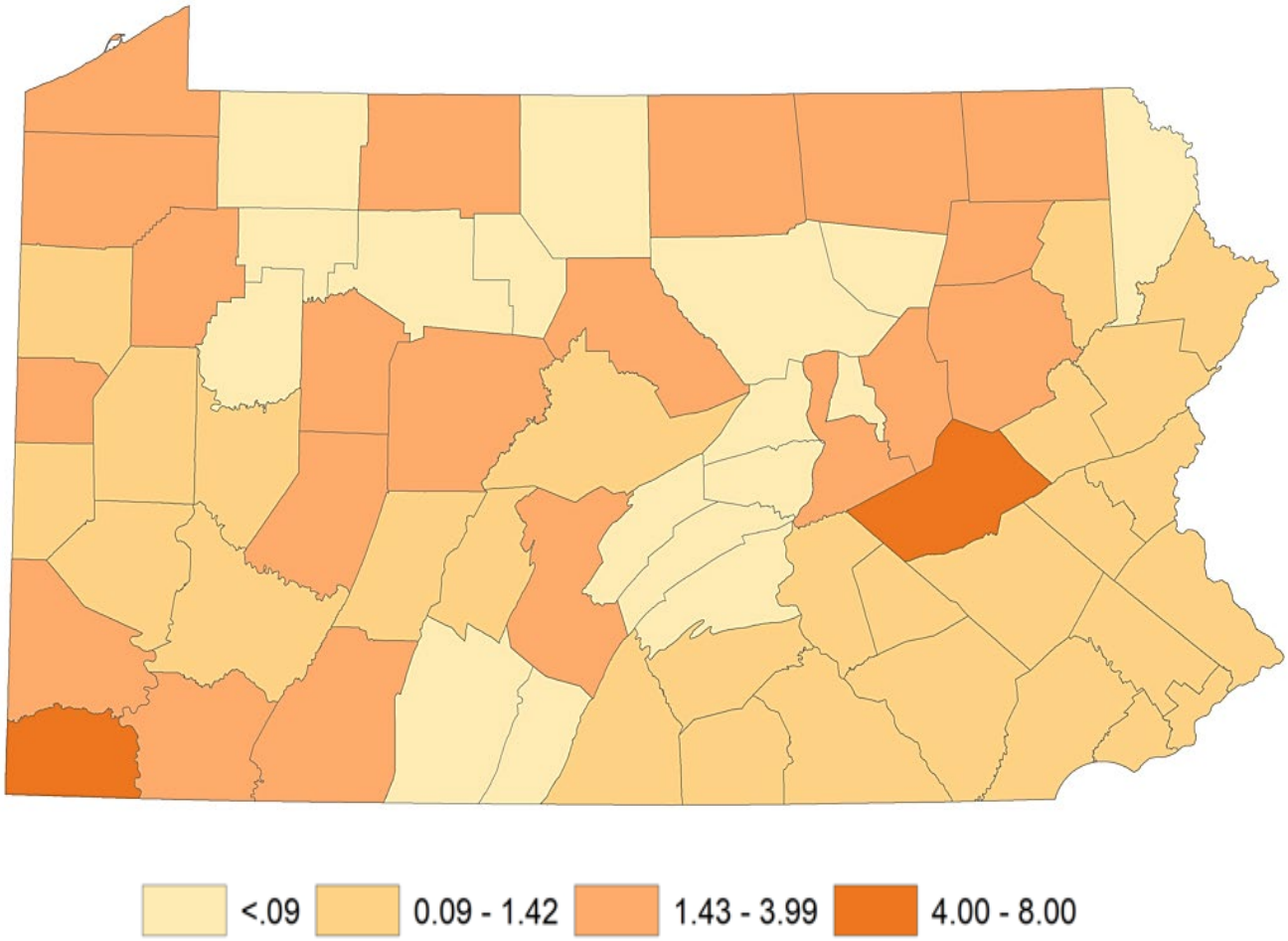
County	2017	2918	2019
Mercer	0.7	--	0.69
Mifflin	--	1.82	--
Monroe	1.25	1.3	0.9
Montgomery	0.44	0.58	0.5
Montour	--	--	--
Northampton	0.83	0.95	0.92
Northumberland	2.38	2.52	2.27
Perry	--	1.1	--
Philadelphia	1.41	1.12	1.19
Pike	--	--	1.1
Potter	--	--	--
Schuylkill	3.14	3.52	4.08
Snyder	1.49	--	--
Somerset	2.45	3.32	2.72
Sullivan	--	--	--
Susquehanna	2	3.06	2.85
Tioga	--	1.34	2.57
Union	--	--	--
Venango	1.5	1.54	3.54
Warren	--	--	--
Washington	3.58	2.4	1.97
Wayne	--	--	--
Westmoreland	0.49	0.62	0.78
Wyoming	3.21	3.29	2.05
York	0.97	1.29	0.89

Source: Commission staff from data through Commonwealth of Pennsylvania, "opendata PA" website, https://data.pa.gov/Opioid-Related/Annual-Rate-of-Dependent-Children-Removed-from-The/2a6x-aizt

Map 3 shows the 2019 rates children who were removed from their homes because of consequences of OUD. As with other measures of the OUD epidemic, rural populations bear the brunt of the problem, particularly in the southwest corner.

Map 3

Rate of Home Removal
Per 1,000 Children
2019



To provide necessary and potentially life-saving services to mothers, infants, and their families who are struggling with OUD and other substance use disorders, the federal government has required since 2003 each state to provide services through a system known as a Plan of Safe Care (POSC). A POSC is "a plan designed to ensure the safety and well-being of an infant with prenatal substance exposure following his or her release from the care of a health-care provider by addressing the health and substance use treatment needs of the infant and affected family or caregiver."[33]

In 2019, 1,608 NAS cases were reported. 80 percent of the facilities that the Department contacted attempted to report NAS cases; this excludes duplicates and cases that did not meet the case definition. Thirteen facilities that previously reported cases in 2018 did not in 2019, including one facility that closed in 2018. Conversely, there were five facilities that reported cases in 2018 but did not in 2019.

The Department of Health found that most infants (77 percent) were born to white non-Hispanic mothers; they also found that 7 percent were born to Black mothers, 13 percent to mothers of other/unknown race/ethnicity, and 3.4 percent to Hispanic mothers.

Additionally, they found that males were slightly more likely to have NAS than females (52 percent and 48 percent respectively). Eighty-six percent of NAS cases involves mothers with Medicaid as the primary payor for delivery.

Compared to all infants born statewide, infants with NAS were more than twice as likely to be underweight, more likely to be born prematurely (10 percent versus 18 percent); mothers of infants with NAS received prenatal care at lower rates compared to the statewide rate (91 percent versus 98 percent). Additionally, 51 percent of NAS cases received care in a NICU and 91 percent of NAS cases displayed at least three symptoms of NAS.

More infants born to Hispanic or Black non-Hispanic mothers were underweighted and premature compared to infants born to mothers of white non-Hispanic or other/unknown race/ethnicity; additionally, Hispanic and Black non-Hispanic mothers received any prenatal care at lower rates compared with white non-Hispanic and other/unknown race/ethnicity mothers. Infants born to Hispanic or Black non-Hispanic mothers more often received care in the NICU. Interestingly, while infants born to Hispanic mothers were more often receiving care in the NICU, they frequently had normal Apgar scores shortly after birth; Apgar score is a test used after birth to assess if an infant needs extra treatment. Compared to infants born to white and black non-Hispanic mothers, infants born to mothers of other/unknown race/ethnicity less often had normal Apgar scores and were treated in the NICU.

Eighty-eight percent of NAS cases were tested for prenatal drug exposure; of those tested, 80 percent tested positive for substance exposure. NAS cases with non-positive results indicate that the mother self-reported opioid use or had other documented history. Non-positives can also result from other drugs that are not included in the drug panel used for testing. Infants tested

[33] U.S. Department of Health & Human Services, Administration for Children & Families, Children's Bureau, "Plans of Safe Care for Infants With Prenatal Substance Exposure and Their Families," https://www.childwelfare.gov/pubPDFs/safecare.pdf.

positive for opioids (82 percent), MAT medications (69 percent), and opiates, oxycodone, or fentanyl (20 percent). The Finnegan scoring method remained the most common way to evaluate NAS severity (92 percent).

Infants born to Black non-Hispanic mothers less often tested positive for opioids and for MAT-associated drugs than infants born to mothers of other races. Additionally, infants born to white non-Hispanic mothers less often tested positive for opiates, oxycodone, and fentanyl than infants born to mothers of any other race.

The most reported NAS symptoms were overactive reflexes (twitching) and tight muscle tone; body shakes (tremors); and trouble sleeping and lots of yawning. Seizures were rare, reported in fewer than 1 percent of total cases.

Morphine was the most reported treatment (38 percent of infants), followed by nonpharmacological treatment (35 percent of infants). 27 percent received no care specifically for NAS and 12 percent had pharmacological treatment involving a drug other than morphine.

The report found that NAS treatments varied by race and ethnicity. Infants born to other/unknown race/ethnicity mothers received non-pharmacological care at lower rates compared to other groups. Infants born to Black non-Hispanic mothers more often received non-pharmacologic treatment and infants born to the other groups of mothers more often received morphine. 'Other drug' was more often used for infants born to Black non-Hispanic mothers than other groups.

In terms of county of facility, the number of cases ranged from zero to 338 cases in Allegheny County. 25 counties did not report cases, and 18 of them lack birthing hospitals and pediatric hospitals in 2019. While more cases are often a reflection of more reporting facilities, counties like Fayette, Washington, and Beaver had higher case counts despite only having one reporting facility each.

In Pennsylvania, NAS occurred in 11.9 cases per 1000 live births. In terms of county of maternal residence, case counts range from zero in Forest, Potter, and Bradford counties to 221 in Philadelphia County. Fayette County had the highest incidence rate of 61.6 cases per 1000 live births.

Data on multiple NAS births is limited; there were only 58 mothers that had multiple births of infants with NAS. Mothers with multiple NAS births were more likely to report using MAT drugs (buprenorphine or methadone) than mothers with a single NAS-related birth.

The statewide rate of NAS dropped about 26 percent from the 2018 rate of 16.0 cases per 1000 births. This could be attributed to fewer facilities reporting cases in 2019 and the inclusion of out of state births in the same year.[34] From January 1, 2018, to April 1, 2022 7,292 cases of NAS have been reported.[35]

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[34]. "Neonatal," 4–17.

[35]. "Opioid Data Dashboard," Commonwealth of Pennsylvania, (2022), https://data.pa.gov/stories/s/Pennsylvania-Opioids/9q45-nckt/.

Care and Treatment

A meta-analysis published in 2018 concluded that the treatment of infants in the NICU can exacerbate NAS severity whereas maternal rooming-in can reduce NAS severity.[36] Moreover, it suggested that incorrectly responding to infant cues or insensitive handling can make NAS worse.[37]

Non-Pharmacological Care

The American Academy of Pediatrics (AAP) recommends that NAS treatment begin with non-pharmacological care or interventions that do not involve medications. This includes changes to the physical environment like darkening the room and quietening the surroundings; techniques like gentle vertical rocking, swaddling, and swaying; providing skin-to-skin contact; pacifier use; and breastfeeding. Additionally, infants should be provided calorie-dense and thickened feeds to prevent growth failure. Usage of partially hydrolyzed formula does not appear to benefit infants with NAS.[38]

While more data are needed on non-pharmacological care, preliminary evidence indicates its benefits. Breastfeeding is the most studied out of the nonpharmacologic interventions; early evidence suggests breastfeeding reduces the severity of NAS and length of hospital stay. While breastfeeding should be encouraged, it should be avoided if the mother had a relapse in the last 30 days, has polysubstance or IV drug abuse, has Hepatitis B or C, is HIV-positive, or is HCV-positive with bleeding or cracked nipples.[39]

Furthermore, mothers being treated for OUD report desiring and attempting to start breastfeeding; however, they face obstacles such as long NICU stays and lack of support and education. Consequently, breastfeeding levels remain low among mothers with OUD. Issues with latching can be a challenge. Furthermore, a lot of mothers with OUD report sexual trauma, which may affect their desire to breastfeed.

Nonpharmacological care should be individually tailored to each infant. Additionally, the mother should be involved in the care of the infant and help her find ways to alleviate the specific dysfunctional behaviors of her baby. There is evidence that keeping the infant and mother together leads to reduced length of stay and decreased the number of days on pharmacological treatment. However, there are barriers to maintaining the important mother-infant dyad: mothers feel guilty or mistrust and feel judged by the staff caring for their baby and providers may not involve the mother in the care.[40]

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[36]. Kathyrn Dee L. MacMillin, Cassandra P. Rendon, Kanak Verma, Natalie Riblet, David B. Washer, and Alison Volpe Holmes, "Association of Rooming-in with Outcomes for Neonatal Abstinence Syndrome," JAMA Pediatrics, no. 172 (February 2018): 346. https://doi.org/10.1001/jamapediatrics.2017.5195.
[37]. Jansson and Patrick, "Neonatal," 354.
[38]. Anbalagan and Mendez, "Neonatal."
[39]. Patrick et al., "Neonatal"; Anbalagan and Mendez, "Neonatal."
[40]. Anbalagan and Mendez, "Neonatal."

Pharmacological Care

Pharmacotherapy will be needed, however, when nonpharmacological care is not sufficient. The optimal medication to treat NAS has not been definitively determined; regardless, opioids remain the most popular option but there is no consensus on which ones to use. Previously, paregoric and dilute tincture of opium were used, but they were discontinued due to high alcohol content, toxic contents with multiple side effects, and very long length of hospital stay.

Short-acting morphine is the most commonly used opioid in pharmacological care. Dosage occurs every three to four hours, facilitating adjustment in management; however, the timing results in more frequent disturbances for the infant. Dosage depends on the severity of the symptoms. Morphine treatment is associated with longer length of hospital stay, ranging from 5.9 to 42 days.

Methadone, which is a long-acting synthetic opioid, has been assessed as an alternative. It has a less frequent dosing of twice daily, but that frequency limits the dose's frequent titration. Length of stay ranged from 16 to 44 days when using methadone. However, caution is needed since it interacts with other medications such as phenobarbital or antiviral medications.

Another option that is gaining attention is buprenorphine due to its associated length of stay, which shorter than morphine's and methadone's, and is easier to administer because it is sublingual. However, more robust data are needed to support buprenorphine as a treatment alternative.[41]

There are two approaches to dosing—weight-based and symptom-based. In the first approach, higher doses are administered for heavier babies. In the second approach, higher doses are administered for more severe symptoms.[42]

If the initial drugs do not help abate NAS symptoms, then second-line medications are needed. The two popular options are phenobarbital and clonidine. There is no consensus over which is more effective. Both drugs can be used in combination with first-line opioids in cases of severe NAS. Phenobarbital may better in cases of polydrug exposure and opioid plus benzodiazepine exposure. Its usage must be carefully evaluated due to its side effects like oversedation, unknown long-term neurodevelopmental outcomes, and high alcohol content. There is evidence that clonidine is effective in reducing the duration of pharmacotherapy. There is a low chance of hypotension and bradycardia with its usage. Regardless, the safety profiles of both drugs have not been adequately established.

When NAS signs and symptoms are under control based on the scoring tool used, the infant should be weaned off the medications. There is no consistency among institutions on weaning protocols.[43] Some institutions opted to do medication weans at home, but this "should be avoided unless in a rigorous, closely monitored, and comprehensive program for infants with NAS."[44]

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[41]. Anbalagan and Mendez, "Neonatal."
[42] Jansson and Patrick, "Neonatal," 360.
[43]. Anbalagan and Mendez, "Neonatal."
[44]. Jansson and Patrick, "Neonatal," 361.

Alternative Treatments

Other alternative treatments have been evaluated. These include massage therapy, foot and auricular acupressure therapy, and Reiki. Evidence suggests associations of soothing effects and positive changes in the baby's vital signs through these treatments. There are also ongoing studies evaluating aromatherapy and music therapy.[45]

Location of Treatment

As mentioned earlier, treatment in the NICU often results in longer length of care than does rooming-in. However, most infants with NAS are treated in the NICU. According to data from the Pediatric Health Information System, 87 percent of NAS case were treated in the NICU. While sometimes it is necessary to treat the infant in the NICU, the environment is unideal because it can be overstimulating to the infants. Rooming-in, however, promotes mother-infant relations, skin-to-skin contact, and breastfeeding; evidence suggests it can reduce the length of pharmacotherapy and length of stay.[46]

Postoperative and Rehabilitation Care

Follow-ups after discharge and monitoring are essential to detect problems like late onset of NAS symptoms and ensuring positive long-term outcomes. To identify and manage long-term problems that can arise in NAS infants, they should be followed-up by subspecialty clinics. These infants should be referred to early intervention. It is critical to have a safe plan of care in place. Child welfare services should only be used when there is child neglect, abuse, or harm. There should also be adequate support for the mother.[47]

Long-Term Prognosis

There is ongoing research on poor long-term outcomes correlated with infants with prenatal opioid exposure. Research areas include adverse changes in neurodevelopment, cognition, school performance, behavior, vision, and mortality. However, many of these studies are observational and thus the conclusions are not as rigorous as in other types of studies. The presence of other confounding variables makes it difficult to definitively attribute prenatal opioid exposure to poor outcomes.

Studies have consistently shown gaps between opioid-exposed infants and their non-exposed counterparts in neurodevelopmental outcomes, though this difference does not emerge until after 12 months of age. Visual-motor problems and visual impairment are common among infants with NAS. Problems like lower IQ scores, poor verbal performance, impaired short-term memory, and executive function have been found in children more than three years of age who had prenatal opioid exposure. Some studies found evidence of lower mean academic test scores in

45. Anbalagan and Mendez, "Neonatal."
46. Anbalagan and Mendez, "Neonatal."
47. Anbalagan and Mendez, "Neonatal."

every grade and domain for children with a history of NAS.[48] Another study found that a history of NAS can lead to education disability, including speech or language impairment.[49]

Children with a history of NAS may also develop psycho-behavior problems such as ADHD, conduct disorders, and adjustment disorders; additionally, they can be more aggressive and more likely to develop anxiety disorder. Infants with NAS are more likely to be hospitalized during childhood due to maltreatment, trauma, and behavioral problems. Opioid-exposed infants have higher mortality rates.

A large, randomized control trial called MOTHER (Maternal Opioid Treatment: Human Experimental Research) study found conflicting results regarding long-term outcomes. The study followed babies who were prenatally exposed to buprenorphine and methadone until they were three years old regularly to assess their neurodevelopment using many tests. "The authors found no significant difference in neurodevelopmental and growth outcomes among opioid-exposed infants"; however, some argue that the lack of difference may be an effect of the constant follow-ups with health professionals, which provided support for the mother and facilitated the normal development of infants.[50]

[48]. Anbalagan and Mendez, "Neonatal."
[49]. Mary-Margaret A. Fill, Angela M. Miller, Rachel H. Wilkinson, Michael D. Warren, John R. Dunn, William Schaffner, and Timothy F. Jones, "Educational Disabilities among Children Born with Neonatal Abstinence Syndrome," Pediatrics (Evanston) 142, no. 3 (2018): e20180562.
[50]. Anbalagan and Mendez, "Neonatal."

PENNSYLVANIA'S PERINATAL QUALITY COLLABORATIVE

Perinatal Quality Collaboratives (PQCs) are state or multistate networks of teams working to improve the quality of care for mothers and babies and are supported by the US Centers for Disease Control and Prevention (CDC).[51] Slightly more than half of the states are participating. Pennsylvania's PQC began in 2019 after several years of work in reporting neonatal abstinence syndrome (NAS) that originally began at Pennsylvania Health Care Cost Containment Council (PHC4).[52] There is continued support from DDAP, DHS, DOH, and other stakeholders. The PQC is administered by the Jewish Healthcare Foundation and WHAMglobal.[53]

Currently, ten workgroups including over 200 individuals are part of the state's PQC. The PQC works under the auspices of the DOH Maternal Morbidity and Mortality Review Committee (MMRC).[54] Other participants include providers, patients, and managed care payors because the latter pay for the services and care management that are provided after mothers and babies leave the hospital.

The PQC's focus was and remains on identifying women with opioid use disorder and on NAS. Since inception, PQC has expanded areas of focus and collaboration. Currently there are 52 birthing hospitals, including NICUs, and 14 health plans that participate. Eighty-one percent of babies born in Pennsylvania are born in hospitals that participate in PQC.

A key PQC focus was on opioids because 30 percent of the maternal mortality rates are caused by accidental poisoning, which are many times related to substance overdose. There was also a notable gap in care that was being rendered to mothers and babies both prenatally and post-partum (including NICU babies). Baseline data showed a huge opportunity for improvement.

Few systems provided sensitivity training for appropriate care, especially with how providers addressed stigma associated with substance use disorder (SUD). In the beginning, only 15 percent of large health systems offered opioid use disorder (OUD) sensitivity training. With PQC the training rate has increased to almost 75 percent of health systems, which is nearly a quadruple increase. The health systems' use of a validated, self-report screening tool to screen mothers for substance use in pregnancy more than doubled from 44 percent to an estimated 100

[51] U.S. Centers for Disease Control and Prevention, "Perinatal Quality Collaboratives," https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pqc.htm

[52] Dr. David Kelley, M.D., OMAP (DHS Office of Medical Assistance Programs) Chief Medical Officer – Perinatal Quality Collaborative

[53] More information can be found at the PQC's website https://www.whamglobal.org/papqc.

[54] Established by Act of May 9, 2018, P.L. 118, No. 24. "The Pennsylvania Maternal Mortality Review Committee's goal is to systematically review all maternal deaths, identify root causes of these deaths and develop strategies to reduce preventable morbidity, mortality and racial disparities related to pregnancy in Pennsylvania." Pennsylvania Department of Health, https://www.health.pa.gov/topics/healthy/Pages/MMRC.aspx.

percent of providers. There is also evidence that medication assisted treatment, or MOUD, (medications for opioid use disorder) is the standard of care for pregnant women. At the time of PQC establishment, 67 percent of health systems were able to provide MOUD. Currently, 85 percent of systems can provide MOUD, which is a growth of approximately 27 percent. Providers need to be sensitive to the concerns of how patients want to be treated; there had not been the opportunity, however, to provide that type of treatment.

There are a lot of ways to improve quality of care, particularly in standardized care. At the start of the PQC, 33 percent of systems had appropriate clinical pathways, or order sets, for pregnant women with OUD. Currently, 85 percent of PQC providers have developed unique clinical order sets for care, which is a growth of over 150 percent since the initiative was started.

When PQC started, about half (53 percent) of participating providers had NICU or well-baby nurses trained in the use of validated NAS assessments. As of October – December 2021, about 83 percent of providers had provided the training to nurses. The whole idea is about quality improvement to make mothers and babies as healthy as possible, and that services continue after they go home from the hospital. PQC has expanded into other areas of care, including pre-natal and post-partum depression. At present there are about 30 health systems that are standardizing an approach to maternal depression screening. There are also hospitals focusing on hypertension in pre-natal and perinatal women, which is a contributor to maternal mortality.

The participating health systems agreed to standardized surveys to measure whether their efforts are successful, and an incentive program was set up for systems that meet objectives. The work continued through the COVID-19 pandemic and the expectation is that future meetings will move back to being in-person with some hybrid of virtual arrangements.

PQC's goal is to have 100 percent participation of the major health systems to reach as many newborns as possible. A major focus is to drive quality improvement. PQC has helped participants standardize how they treat mothers and babies and it is hoped further training will reduce the stigma associated with SUD. Efforts also focus on Safe Plans of Care to make sure that mothers and babies go home and are safe and get the resources they need after they are home. A lot of efforts have been focused on reducing maternal mortality. DHS's extension of post-partum coverage is a major step forward. Maternal morbidity many times happens from problems months after birth.

Data and participation

Task Force discussion of Pennsylvania's PQC led to comparisons with West Virginia's PQC data collection, particularly whether there are data showing use of screening tools and their success, and Plans of Safe Care. West Virginia has been working with a PQC for ten years longer than Pennsylvania. In 2009 West Virginia did an umbilical cord tissue sample study of 759 babies born and was able to identify substances in the baby stream for a one-month period. West Virginia's prenatal prevention efforts were targeted based on data findings from the study. The most common substance was THC and the second was opioids. Task Force members wondered if it would be possible and what would it cost for PA to conduct a similar study. Each state's initiative's responsibility is data collection and PA PQC is currently going through a survey of

which hospitals use Plans of Safe Care. A lot of data are being collected and are not yet ready for publication. Because of variations in the definition and treatment of NAS, coding of observations and procedures, and IT systems, PQC is working to get doctors, nurses, and other staff to work from the same definition of NAS to collect baseline data to determine how many are affected by NAS, how many are exposed to different substances, and what it looks like in different communities.

Task Force members questioned the lack of hospitals' 100 percent participation in PQC and what would prevent an institution from participation. There is a variety of obstacles to 100 percent participation. The COVID-19 pandemic created staffing challenges for many providers. Nonetheless, there is an effort to bring more facilities on board and there will be further opportunities to do so when COVID-19 is having less of an impact. The pandemic also created a huge financial and economic burden for hospitals. Participation takes time, energy, and money and many hospitals were unable to commit scarce resources. Moreover, participation is based on hospital goodwill because hospitals are not robustly funded to join the effort. Some rural communities have challenges because they do not offer NICU services, for example. PQC leadership hopes that eventually 100 percent of hospitals will establish Plans of Safe Care programs.

Hospitals are required to participate in the Plans of Safe Care (POSC) program, but there are those who find it difficult to implement and comply with the POSC guidelines. PQC is constructing a flow chart to provide to hospitals to assist them. Joining PQC is very resource-intensive for hospitals, which is why not all hospitals have joined. Participation a struggle for small hospitals in particular. Hospitals must pay staff to attend all-day meetings, and there are hospitals in Pennsylvania that do not have the resources to participate at the necessary level. Each hospital needs to understand its needs and then assign staff to do the PQC work. The hospitals must continue to provide day-to-day coverage while participants are at PQC meetings, for example. Hospitals face ongoing staffing problems, especially with nursing. PQC is looking at ways to help hospitals participate.

Task Force discussed PQC as a peer support model where hospitals help each other and sharing opportunities for best practices. The Alliance for Maternal Health (AIM) promotes innovations in maternal care by providing implementation support and data tracking assistance to adopt patient safety bundles which promote evidence-based practices that improve patient outcomes. In October of 2021, the PQC rolled out a version of AIM Severe Hypertension in Pregnancy Bundle and AIM Racial/Ethnic Disparities Bundle called PA AIM Bundle to improve outcomes for racial disparities for preeclampsia/eclampsia.[55]

Stigma

The Task Force discussed stigma extensively, and whether PQC has protocols of checks and balances to combat stigma. Everyone roundly recognized that there is continued need to educate healthcare professionals and families about the stigma surrounding maternal opioid use disorder (MOUD). SUD is a disease that needs proper treatment, yet misinformation abounds

[55] https://www.whamglobal.org/list-documents/273-pa-aim-initiative/file

about MOUD and pre-natal health. Some organizations have anti-stigma training for staff, but training is not universal.

Community health centers have teams, and most, if not all the time, there are team members involved who have lived experience. Some teams have community health workers who are out in the community. Having community health teams is essential in making stigma reduction as effective as possible.

Screening tools

Screening tools are widely used to identify risks for NAS. All the PQC health systems have tools in place but whether it is happening with every mother is unknown. The Task Force felt that salient questions about the use of screening tools include those about barriers to screening, use of results, and whether people are comfortable with being assessed and are they getting appropriate care.

There are strong objections to universal screening because of the stigma associated with SUD. "Vast unintended consequences" are commonly cited if screening and diagnostic forms and processing are handled by biased screeners who do not have trauma-informed training and who do not have stigma training. A family's screening results could look much different from one conducted by someone with appropriate stigma training and by someone without such training. The resulting unintended outcomes are not always healthy for the children involved and are more likely to occur when the person making the diagnosis is not operating from a trauma-informed perspective. Those risks being understood, there remains the risk that a mother might, without universal screening, go undiagnosed and not get the treatment she and her family deserve. The consequences of mothers not being treated is a grave concern and are particularly dangerous for an infant's prognosis.

DEPARTMENT OF HUMAN SERVICES: PLANS OF SAFE CARE

The primary mechanism through which Pennsylvania healthcare providers and government agencies seek to mitigate the consequences for substance exposed infants (SEI) through age 1 is through the Plans of Safe Care program. Administered by the Department of Human Services, each Plan of Safe Care is tailored to the needs of individual infants and their families and is initiated after a call is made to ChildLine informing DHS that POSC services might be needed. Thereafter, a family's participation in the program is voluntary. POSC is unique among service plans because it includes services for both the affected infant and the family/caregiver and can include substance use treatment services for the parent. More formally, "a Plan of Safe Care is a document that lists and directs services and supports to provide for the safety and well-being of an infant affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder (FASD)."[56] As a best practice, health care providers and other professionals are encouraged to begin developing Plans of Safe Care in the prenatal period if the pregnant person agrees to the process.

The Child Abuse Prevention and Treatment Act (CAPTA), established in 1974, is the main federal legislation regarding child abuse and neglect. CAPTA has progressed through several iterations including updating the definitions of child abuse, neglect, and sexual abuse, providing funding for states to prevent child abuse and neglect, and outlining the Federal role in this issue.[57] CAPTA supplies grants to states for child abuse or neglect prevention and treatment programs, provided states meet eligibility requirements. States that receive a grant through CAPTA must submit an annual report that includes various statistics on children serviced by the child welfare system.[58]

The Comprehensive Addiction and Recovery Act of 2016 (P.L. 114-198, 7/22/2016) (CARA), title V, section 503 amended sections 106 (b)(2)(B)(ii) and (iii) of CAPTA to require the governor of each state provide an assurance that the state has policies and procedures to address the needs of infants affected by exposure to both legal and illegal substances. CARA specifically requires that Plans of Safe Care (POSC) address the needs of both infants and their families or caretakers. CARA requires that states submit an assurance in the form of a certification by each governor that the state has laws or statewide programs relating to child welfare including:

> (ii) policies and procedures (including appropriate referrals to child protection service systems and for other appropriate services) to address the needs of infants born with and identified as being affected by substance abuse or withdrawal symptoms resulting from

[56] PA Department of Human Services, "Plans Of Safe Care," website, https://www.dhs.pa.gov/KeepKidsSafe/Resources/Documents/POSC-FAQ_5_13_2022.pdf.
[57] *About CAPTA: A Legislative History* (Child Welfare Information Gateway, February 2019).
[58] 42 U.S.C. § 5106a (d)(18).

prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder, including a requirement that health care providers involved in the delivery or care of such infants notify the child protective services system of the occurrence of such condition in such infants, except that such notification shall not be construed to—

(B) establish a definition under Federal law of what constitutes child abuse or neglect; or

(II) require prosecution for any illegal action;

(iii) the development of a plan of safe care for the infant born and identified as being affected by substance abuse or withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder to ensure the safety and well-being of such infant following release from the care of health care providers, including through—

(B) addressing the health and substance use disorder treatment needs of the infant and affected family or caregiver; and

(II) the development and implementation by the State of monitoring systems regarding the implementation of such plans to determine whether and in what manner local entities are providing, in accordance with State requirements, referrals to and delivery of appropriate services for the infant and affected family or caregiver.[59]

In Pennsylvania, Act 54 of 2018 amended the Child Protective Services Law to achieve compliance with CARA. Act 54 requires healthcare providers to notify the Department of Human Services when they are involved in the delivery or care of a child under one year of age who the health care prover has determined, based on standards of professional practice was born affected by:

1) substance use or withdrawal symptoms resulting from prenatal drug exposure; or
2) a Fetal Alcohol Spectrum Disorder (FASD)."[60]

Act 54 is clear that notification to the DHS is for the purpose of assessing the child and the child's family for a plan of safe care and shall not constitute a report of child abuse. Act 54 also requires the development of plan of safe care protocols, in conjunction with the Departments of Health and Drug and Alcohol Programs, that include: definitions and evidence-based screening tools, collection of data as required by Pennsylvania and federal agencies, identification of the proper lead agency for a child's case, and engagement of the child's parents and caregivers in order to identify the need for access to treatment for any substance use disorder or other physical or behavioral health condition that may impact the safety, early childhood development, and well-being of the child. A family's participation in a POSC is voluntary.

[59] 42 U.S.C. § 5106a (b)(2)(B)(ii).
[60] Act 54 of 2018, P.L. 375, No. 54, Cl. 23, https://www.legis.state.pa.us/cfdocs/legis/li/uconsCheck.cfm?yr=2018&sessInd=0&act=54.

Pennsylvania guidance defines "affected by" as an "infant with detectable physical, developmental, cognitive, or emotional delay or harm that is associated with maternal substance use or withdrawal, as assessed by a health care provider."[61]

In March of 2019, the PA Department of Health (DOH), Department of Drug and Alcohol Programs (DDAP), and Department of Human Services (DHS) collaborated with MDWISE (Multi-disciplinary Workgroup for Infants with Substance Exposure) to release the Pennsylvania Plan of Safe Care Guidance. The document includes background information on Neonatal Abstinence Syndrome (NAS), an explainer of CAPTA and CARA requirements, and guidance on preparation for plans of safe care and individual plans of safe care.[62]

The Pennsylvania guidance names the local county planning teams, the multi-disciplinary teams (MDTs), and the family as the major partners in the development of each family's plan of safe care. Local county planning teams are responsible for creating policies and protocols that align with CAPTA, CARA, and Act 54 requirements. These local policies provide guidance to MDTs, the members of which work collaboratively to establish an individual plan of safe care that accounts for all the needs of a specific child and family. The MDT can include any combination of:

> County children and youth agencies, substance use disorder and mental health treatment agencies, health care providers, judicial officers and attorneys, public health agencies,…obstetrician/gynecologist, pediatrician, neonatologist or other hospital provider; professional home visitor; substance use treatment clinician and medication-assisted treatment clinician; mental health clinician; county children and youth caseworker; representatives from local community-based organizations; and the family or caregiver.[63]

The Plan of Safe Care Guidance recommends the use of an evidence-based screening tool that will assess risk to pregnant mothers through nonthreatening questions. While there are different screening tools that may have different strengths and weaknesses for individual providers, the most recommended tools were The Institute for Health and Recovery's "Integrated 5 P's Screening Tool" and NTI Upstream's "4P's Plus." The latter has fees associated with it, whereas the former is free. These tools require minimal training and can be administered by social service staff as well as healthcare practitioners and allied professionals.[64]

While not required by law, universal screening for NAS in newborns is also recommended in the POSC Guidance to avoid bias and involves watching for symptoms of withdrawal and scoring with a specialized tool, two examples being the Modified Finnegan's Neonatal Abstinence Scoring Tool and the Lipsitz Tool. Either tool is generally accepted, provided it is used correctly by the administering staff.[65]

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[61] *Pennsylvania Plan of Safe Care Guidance* (Pennsylvania Department of Health, Pennsylvania Department of Drug and Alcohol Programs, Pennsylvania Department of Human Services, March 2019), https://www.dhs.pa.gov/KeepKidsSafe/Resources/Documents/POSC_Guidance.pdf, 42.
[62] Ibid., 2.
[63] Ibid., 14.
[64] Ibid., 17.
[65] Ibid., 18-19.

Pennsylvania law requires DHS to be notified through ChildLine when a substance affected infant has been identified through these screening, assessment, and testing tools, though the notification in itself does not constitute a child abuse report.[66] Each notification is classified as either Information Only or General Protective Service (GPS) referral. See Table 10. No identifying records are kept for those calls that are classified Information Only. The POSC Guidance suggests the initial MDT be convened by the health care-provider who makes a notification. During the initial MDT meeting, the members determine which agency will lead the plan of safe care, how often the MDT will meet, and next steps in the process.[67]

Table 10

Plans of Safe Care
Notification by Substance Type
Pennsylvania

Substance	Procedure
Alcohol	MUST be a General Protective Service (GPS)
Appropriate use of legally prescribed medication (excluding OUD/SUD Treatment)	Will be Information Only unless there are other GPS concerns which would be unrelated to the substance exposure
Illegal Substance(s)	MUST be a GPS
Medication Assisted Treatment -Substance Use Disorder or Opioid Use Disorder	Will be Information Only unless there are other GPS concerns which would be unrelated to the substance exposure
Misuse/Abuse of legal medication (prescribed or un-prescribed)	MUST be a GPS
Unknown Substance(s)	MUST be a GPS

Source: "Substance Affected Infants, Department of Human Services, Office of Children Youth and Families," presentation to the Task Force by Dr. Michele Walsh, Ph.D., L.S.W. April 25, 2022.

There were 710 notifications to ChildLine in 2021 that resulted in referrals to General Protective Services. See Table 11. Information Only notifications were classified from 304 calls. It is critical to note that the number of POSC includes only those that were developed through GPS referrals. Plans of Safe Care were developed for 587 of the notifications. Data are not kept for Information Only calls and DHS neither maintains nor tracks information regarding those families.

[66] The primary means of reporting child abuse in Pennsylvania is through ChildLine. Pennsylvania Department of Human Services website, "ChildLine," https://www.dhs.pa.gov/KeepKidsSafe/Resources/Pages/ChildLine.aspx.
[67] Ibid., 20-21.

Table 11

Substance Affected Infant Notifications by Type 2021

Substance Affected Infant	Notifications
Medication-assisted treatment (Substance Use Disorder or Opioid Use Disorder)	535
Illegal Substances	376
Appropriate use of legally-prescribed medication (excluding SUD/OUD treatment)	156
Misuse/abuse of legal medication (prescribed or un-prescribed)	100
Unknown substance(s)	< 20
Alcohol	< 20

Source: "Substance Affected Infants, Department of Human Services, Office of Children Youth and Families," presentation to the Task Force by Dr. Michele Walsh, Ph.D., L.S.W. April 25, 2022.

Federal and state guidance

Federal guidance provides the requirements for a Plan of Safe Care and Pennsylvania guidance gives a definition of a plan of safe care:

> A Plan of Safe Care is defined as a document that lists and directs services and supports to provide for the safety and well-being of an infant affected by substance abuse, withdrawal, or FASD, including services for the infant and their family/caregiver. A Plan of Safe Care should specify the agencies that provide specific services, outline communication procedures among the family and provider team and guide the coordination of services across various agencies with the family.[68]

The Pennsylvania guidance lists several qualities of effective plans of safe care:

- Interdisciplinary across health and social service agencies
- Based on the results of a comprehensive, multi-disciplinary assessment of physical, social-emotional, health and safety needs of the infant and the parents or caregivers

[68] Ibid., 22.

- Family-focused to assess and meet the needs of each family member, as well as overall family functioning and well-being by building on each family member's strengths, challenges and, for the mother and father, parenting capacity

- Completed, when possible, in the prenatal period to facilitate early engagement of parents and communication among providers or, when not possible, before the infant's discharge from the hospital

- Easily accessible to relevant agencies with the appropriate confidentiality safeguards to facilitate information sharing

- Collaborative in identifying appropriate lead agencies to be accountable for the care management and for plan development, implementation, management, communication and data submission

- Grounded in evidence-informed practices, such as a preference that infants, mothers and families remain together whenever possible.[69]

Plans of safe care differ from other treatment plans by approaching the issue from a broader scope, offering methods of support to impacted family members struggling with substance use as well as supporting the health of the infant. Of those who can receive plans of safe care, there are a few categories noted by DDAP. Categories include: women who are using prescribed opioids or other medications for chronic pain and do not have substance use disorders; women who are undergoing medication assisted treatment for a substance use disorder; and those who are either using illegal substances or misusing prescription drugs, might have a substance use disorder, and are not currently in treatment. For the first two categories, the MDTs will decide what agencies should be responsible for the plan of safe care. In the third category, the county children and youth agency is responsible for addressing the situation.[70]

In order to create an appropriate plan of safe care for an individual, the MDTs should take into account:

- Child abuse and neglect risk and protective factors,
- Infant health and development,
- Mother's medical history,
- Mother's co-occurring treatment history and symptoms,
- Family members' and caregivers' need for substance use disorder treatment,
- Education and employment history,
- Family and social relationships,
- Current legal issues and history, and
- Other health and social service supports in place or needed.[71]

[69] Ibid., 23.
[70] Ibid., 24.
[71] Ibid., 26.

The plan should always include the infant's family as a partner, emphasizing that the goal of a plan of safe care is the safety and health of the infant. To maintain equal stake from different kinds of MDT members, cross-systems training must be utilized. Important elements of any training include:

> Identification of substance abuse, the establishment of partnerships among entities and strategies for linkage to beneficial community resources,… treatment options for SUD, including MAT, reducing stigma, relapse management, confidentiality, accessing community resources, EI, risks to the infant, family engagement, discharge planning, home visitation programs, mandatory reporting laws and child welfare mandates.[72]

A prenatal plan of safe care can be developed by a pregnant person and their social worker or healthcare provider but cannot include child welfare until after the infant has been born. These are the elements usually included in a prenatal plan of safe care:

- A release of information to allow for the collaboration among entities;
- Referrals to treatment programs, mobile engagement and peer recovery specialists;
- Education on NAS, effects of substance use during pregnancy and reporting requirements for substance exposed infants;
- A relapse plan that includes child safety considerations and identified family supports;
- Coordination between the obstetrician and the prescribing practitioner(s);
- Development of a birth plan, including pain management options;
- Education and guidance on breastfeeding and substance use;
- Stigma reducing practices designed to engage the patient in consistent prenatal care;
- Referrals to Family Strengthening, Early Head Start, Family Check Up for Children, Healthy Families America, Nurse-Family Partnership, Parents as Teachers, Family Group Decision Making (FGDM), Women Infant Children (WIC), public assistance, transportation assistance, counseling, housing assistance, domestic violence programs and/or food banks;
- Referral to ChildLine if there are concerns with mother's ability to be a caretaker for other children.[73]

[72] Ibid., 28-29.
[73] Ibid., 29-30.

The plan of safe care can be altered at any time due to a change in circumstances. The level of substance use of the mother should be taken into consideration in the formation of the plan.

Once the child is born, the mother and infant will undergo screening. If the child is identified as a substance affected infant, the things addressed in the first MDT meeting include which agency will take the lead for future action, and:

- Engagement of family supports;
- Identification of family strengths;
- Signing of releases for mother's and caregiver's providers;
- Identification of type of substance use, duration, prescribing practices, treatment history, considerations for maternal impairment;
- Relapse plan for mother and infant;
- Considerations for breastfeeding;
- Medical conditions of mother and post-partum follow up, including options for birth control;
- Medical considerations for infant and follow up plan;
- Education on safe sleep practices;
- Assessment of housing needs;
- Assessment of household support system;
- Determination of lead entity in developing the Plan of Safe Care.[74]

Once a child is discharged from the hospital, the plan of safe care can include these aspects:

- Arrangements for face-to-face contact with the infant, parents and all caregivers and household members;
- Identification of involved support system, both personal and community based and a discussion of Family Finding efforts, a proven strategy within the child welfare field to locate and engage relatives of children living in out-of-home care;
- Execution of releases to allow the county children and youth agency worker to contact all involved providers: medical, mental health, D&A treatment, probation, etc.;
- Identification of infant's medical needs and plans for follow up, including the name of medical provider and plan for transportation;

[74] Ibid., 30-31.

- Plans for a visit to or an assessment of the family home to determine its appropriateness/stability;

- Breastfeeding supports if breastfeeding;

- Discussion on safe sleep practices and the presence of a safe infant sleeping environment, in accordance with the American Academy of Pediatrics recommendations;

- Post-partum follow-up including depression screening and discussion of family planning/birth control access;

- Assessment of the safety and well-being of older children including medical, dental, educational, developmental and mental health;

- Relapse plan, including family support for recovery, identification of triggers, signs and symptoms of relapse, increasing level of care and appropriate caregivers for infant;

- Identification of supports: mobile engagement, treatment, peer recovery support, Family Group Decision Making (FGDM), Family Engagement, Family Strengthening, Healthy Families America, Nurturing Parents, evidence-based home visitation programs, WIC, housing, public assistance, Early Intervention, Family Preservation, medical providers, transportation, Planned Parenthood, educational and employment;

- Identification of barriers to accessing services: transportation, financial and/or language along with strategies to overcome these;

- The identification of safety plan supervisors and a schedule of 24/7 supervision if Safety Plan implementation is necessary.[75]

These possible components should all include an explanation of which agency will assume responsibility for that step. The plan should be written out and distributed to each responsible agency.[76]

The best practice suggestions included in the POSC Guidance recommend that to make a change to a plan of safe care or determine that the MDT is no longer needed, the MDT must come to a consensus. Though MDTs can create their own requirements for each individual case, MDTs should meet at least once a month to discuss the continuance of the plan.[77]

The Pennsylvania POSC Guidance includes in the appendices considerations for each of the involved parties in a plan of safe care: infant, mother and other caregivers. The Guidance also includes a plan of safe care template.[78]

[75] Ibid., 31-32.
[76] Ibid., 32.
[77] Ibid., 33.
[78] Ibid., 34-41.

Greene County's Office of Children and Youth has created a new position titled "Caseworker III" that will manage the substance exposed infant notifications. In order to best promote the health and safety of the child and properly support parents of a substance exposed infant, Caseworker III has previous experience with CYS and is also a certified drug and alcohol evaluator. This experience allows the worker to better understand the nuances of assisting families affected by addiction. In Greene County, this worker is the point of contact for all substance affected infant notifications and is responsible for setting up and either leading or participating in the MDT meeting. Greene County Office of Children and Youth believes having a single point person for all substance exposed infants will strengthen relationships between birthing hospitals and social services and allow for better collaboration between all members of the MDT.[79]

Allegheny County OCYF has created several service delivery paths that can be utilized upon the identification of a substance affected infant. The Children's Institute Care Coordination Program was established in 2016. A team consisting of a medical director, care coordinator, and health coach from The Children's Institute serves the family to ensure that they receive the appropriate resources. Participation in this program is voluntary, but upon a substance affected infant notification OCYF must refer the infant to The Children's Institute. Another program is the Home Based Family Recovery 2018 Connecticut Model. This model is a home-based intensive program which utilizes recovery-oriented trauma informed substance use disorder treatment. After an assessment by a DDAP facility staff of POWER staff, if the parent or caregiver is approved for outpatient care, they can be referred to this program. This program is aimed at families with a child under 36 months at home. If the child is not living at home, the program has a plan for reunification of families. The In Home Family Recovery program by Family Residential provides evidence based recovery supports in a residential setting that supports the whole family. The program hopes to accomplish: "reduction or elimination of referred parent's substance use; recovery maintenance; improved child safety and parent-child relationship; and out of home placement prevention or reduction."[80] Lastly, ARIA: Family Links is a rental assistance program to support those families for which homelessness is a barrier to OCYF services. Once the family is placed in stable housing, Family Links will help the family access addiction services, employment, and other community resources.[81]

All Pennsylvania counties have been encouraged to participate in the Plans of Safe Care program. Currently, CAPTA Grants are funding Plans of Safe Care in 41 counties. Thirty-five entered the program in July 2021 and six additional joined in January 2022. The grants are for two-year terms. A total of $3,230,000 has been encumbered.

[79] Ibid., 57.
[80] Ibid., 56.
[81] Ibid., 56.

Dauphin County Children & Youth – Safe Plans of Care[82]

The Task Force felt it would be helpful to look at plans of safe care from the operational level because different counties have different approaches to Plans of Safe Care, and each is responsible for running its own system. Marisa McClellan, Administrator of the Dauphin County Safe Plans of Care program was invited to present the county's program to the Task Force.

Dauphin County's Safe Plans of Care (SPOC) stakeholders initiated its program in June 2019 and began been meeting monthly. With rare exceptions, mothers and families are referred to SPOC through the health care system.

In the oversight team's now bi-monthly meetings, it discusses how the safe plans of care have been going so far as well as open cases. The data it uses does not including identifying information due to the varying levels of confidentiality. The meetings help detect issues like process issues. For example, it found that new hires for the Department of Drug and Alcohol Programs did not receive pertinent training regarding safe plans of care; this resulted in inaccurate information being relayed back after meeting with families. Afterwards, the new hires were followed up and received additional training. These meetings are valuable because they provide cross-systems engagement, so issues that arise in one area become known to everybody.

SPOC's three objectives, in keeping with the statewide objectives, are to support families, help people find services to prepare for parenthood, and to keep children healthy and safe. The major stakeholders are Dauphin County Children & Youth, Dauphin County Department of Drug & Alcohol Services, Dauphin County Early Intervention Program, Penn State Health, and UPMC Magee-Womens Hospital. The cross-systems engagement has led to information sharing about processes and operations, for example, which led to improvements in staff training.

The Safe Plans of Care response plans follow a general protocol.

1. Initial meeting within 24 hours of receipt of notification or referral, happens at the hospital or at the home.

2. Initial plan is developed, including safety assessments; may include child welfare investigations.

3. Work directly with family members to identify formal (programs and services) and informal supports (other family members or neighbors, for example.

4. The Multi-Disciplinary Team (MDT) meets within ten business days (would include CYS, Drug & Alcohol, nursing, and sometimes doctors.

5. Case management.

[82] Dauphin County's POSC program is referred to as Safe Plans of Care.

The program serves three populations:

1. Women who are using legally prescribed medications, including opioids for pain or are on medications that can result in withdrawal symptoms and do not have a substance use disorder.

2. Women who are receiving medication assisted treatment for an opioid use disorder and/or are actively engaged in treatment for a substance use disorder.

3. Women who are misusing prescription drugs or are using other legal or illegal substances, may meet criteria for a substance use disorder, and are not actively engaged in a treatment program.

For the second and third populations, Dauphin County Social Services for Children and Youth meet with the family within 24 hours of receipt of notification or referral. This usually occurs in the hospital after birth. However, meetings can also occur at the family's home if the child was already discharged. In that meeting, an initial plan is put together. If child welfare had previous involvement with the family, a safety assessment is done. They work with family members to identify formal and informal supports. Formal supports could be a service that's available like a community-based service. Informal supports include family members, friends, neighbors, etc. After the initial meeting, the multidisciplinary team (MDT) meets with the family within 10 business days. This meeting is required and DHS and OCYS checks that they are occurring. Also present at this meeting is early intervention, drug and alcohol, a social worker from the hospital can be there and a nursing entity too; sometime doctors get involved but not usually. There is case management after those initial contacts are made that the team follows up on.

Dauphin County created an early youth unit by using grant funding. The unit can provide or coordinate wraparound services. At the least, it tracks and monitors babies who are born drug affected as they grow and develop. Based on experience, by the time a child reaches school age, problems have often snowballed to the point that needs that have not been met are more severe. Tracking and monitoring can help the program meet the children's needs. Even a practice as simple as community-based check-ins can make a big difference with outcomes.

The Family's Role

A Safe Plan of Care is supposed to be voluntary in both the initial and MDIT meetings, although it can be involuntary if it is court-ordered. The purpose of the family's involvement is to identify appropriate supports (both formal and informal), to discuss strengths as well as concerns, and to develop appropriate timeframes to assure plan completion.

Penn State Health's Role

Penn State Health, in its role with the county's Safe Plans of Care program performs universal screening that commences with the first prenatal visit. Positive tests are referred to the outpatient social worker to initiate the Plan of Safe Care, if indicated. Penn State Health

Children's Hospital (PSHCH) is collecting meconium from all deliveries and testing samples if there is a known maternal drug history or suspicion of drug use or withdrawal. Fentanyl was recently added to the drug screening. Screening is being expanded for other clinics where prenatal care is provided, and training is being provided to other clinics, such as Pain Management, of the Plans of Safe Care requirements and processes.

Post-delivery, a PSHCH social worker meets with the family to complete psychosocial assessment and discuss Plans of Safe Care process. The social worker works with the MDT to monitor the infant's condition and care during the admission. A Childline report is completed if the child needs to be treated with medication of if the mother or infant tests positive for illicit or unprescribed substances. PSHCH completes an Early Intervention referral for any newborn with prenatal substance exposure. Babies treated for NAS in PSHCH NICU will have follow-up assessment and treatment in the Penn State NICU Developmental Clinic.

Dauphin County Drug & Alcohol's Role

Dauphin County Drug & Alcohol's (DCDA) role at the initial meeting is to have a discussion with the family, complete a screening and determine if they need to complete a level of care assessment, the best location to complete the level of care assessment, or determine and connect directly to treatment services. They will provide contact information and let the family know that there will be follow-up contact.

There is a variety of levels of care that can be provided through DCDA, including outpatient, intensive outpatient, partial hospitalization, halfway house, residential treatment, withdrawal management, and MAT. DCDA is challenged because a lot of individuals on MAT do not have counseling attached to their treatment plans. Further, inpatient MAT is not a good plan for new mothers because inpatient MAT programs do not include care or accommodation for infants. Some of these obstacles were not foreseen when the plans were envisioned. It is apparent, however, that mothers who receive the right mix of services are much more likely to be successful in overcoming substance use disorders.

Support Services

In terms of support services, there is ongoing case management through DCDA; housing resources are available; Hamilton Health's Baby Love ICM; Nurse Family Partnership; the RASE Project.

Dauphin County Mental Health/Autism/Developmental Programs

Dauphin County Mental Health/Autism/Developmental Programs (DCMH) Early Intervention Program provides a lot of services through the Case Management Unit's Early Intervention, which can supplement the work being done by caseworkers and DCDA. Early Intervention services to pregnant women and infants include:

- Providing information for ongoing health care and health insurance

- Proving information on comprehensive services such as nutritional counseling, food assistance, oral care, and social services
- A newborn visit with each mother and baby
- Prenatal and postpartum information, education, and services
- Addressing needs for emotional well-being, caregiving, and father engagement

Nurse-Family Partnership and *Baby Love* are also part of the wraparound services that overlap each other.

Their involvement with safe plans of care is through the early intervention unit. Early intervention can do a lot of things and there is a concern they are not being used to their fullest extent. For example, they can go out monthly and check in with families supplementing the case workers or Drug and Alcohol workers that are working with the mom. Having constant contact, while it could be overwhelming for the family, can provide valuable support. With the shortage of caseworkers, they will not be able to spend as much time with each family, so having early intervention come in can help make up for that.

Early intervention can provide services to pregnant women and infants such as nutritional counseling, mental health counseling, and so on. While there is overlap with other members of the MDT, having each member with the same training and education allows messaging to be consistent. Consistent messaging is helpful for families.

The Nurse-Family Partnership involves individuals going out into the home doing follow-ups, assisting with healthcare, childcare, job training and offering other supportive services. Baby Love does these things too along with other programs. As mentioned before, Baby Love overlaps with other services.

The oversight team, using the grant money, also created a feedback survey for families after completing safe plans of care. Information on the survey is provided on a handout. The survey can be completed by scanning a QR code, which helps increase response rates. The questions ask about the process and how it went. Data is not available yet as the survey was just launched. The survey inquires how satisfied the families are. Phone numbers to services can be found on the handout too.

The definition of "affected by" captures only a portion of the children that are being seen in SPOC program. There are trends that are appearing outside of SPOC. Data on fatalities from 2020 and 2021 are showing that 75 percent of fatalities had THC use: asphyxiation, co-sleeping, unsafe sleep were THC related. The information shocked the SPOC team and they are investigating how to address these fatalities from a perspective of safety and prevention. If it is a trend in Dauphin County it is likely that it is trending in other counties.

Task Force members asked if THC was the only drug indicated in the fatalities, how THC was implicated, and the incidence of fatalities that do not involve THC. The THC is evident in the mother (and/or father) but not in the infant. THC was the only drug involved for five fatalities. One fatality involved THC and alcohol; one involved THC and heroin. It appears that mothers use THC, and during co-sleeping might roll over and smother the child without realizing what is happening. As part of SPOC's regular safe-sleeping campaign, pack-n-plays are provided as part of education and prevention efforts. Co-sleeping fatalities rarely occur when drugs are not involved.

Task Force members questioned how referrals to SPOC are made and what happens if mothers do not agree to participate voluntarily. Referrals to SPOC come only through the health facilities and health care system. Further, by law, referrals are made only after birth and not prenatally. The only time a referral might be child welfare driven is if the mother had been in contact before birth. There are no prenatal referrals due to legal barriers such as the Juvenile Act and Child Protective Services Law – the definition of child is at birth. Regarding voluntary participation, there are some who refuse services. The Child Welfare programs (and possibly the courts) get involved in instances when problems are severe and a mother declines to participate. Most families who are prompted do engage with SPOC.

Further Task Force discussion concerned the data about parental agreement to participate in programs or being hesitant and refusing the program. The discussion led to questions about what happens when someone is not interested in participating. Assessments are done at each level of care. If a case is severe, then regardless of whether the family agrees to participate, child welfare will get involved and potentially the court. There are different levels of voluntariness going from solely voluntary to children needing to be removed from the care of the adult. The ones that do not want to engage often require high levels of involvement like court-ordered services.

Task Force members recognized the importance of having a system that includes a feedback loop to ensure that families do receive the services that they agree to participate in so that they do not fall between the cracks. SPOC includes such a monitoring system, and Task Force members felt that it would be valuable to have a statewide standard that includes follow-up monitoring to ensure that families get the services that they agree to. It would be important to have standardized information across the commonwealth, so that all families are aware of what services are available. Further, there should be a way of measuring how families are matching with the services and supports they need.

Dauphin County's SPOC administrators recognize that are holes in the available data. For example, it is not known how many times a parent declines a drug and alcohol evaluation. A lot of cases do not reach a level of needing a SPOC plan but nonetheless are experiencing problems; the system is thus unaware of what is happening to these families. Moreover, there is an effort to reduce the presence and influence of the county's child welfare agency from the meetings so that families are more willing to engage with services and supports without the perceived heavy handedness of the agency driving the process. SPOC uses the Family Engagement Initiative process, as Dauphin County participates in the Family Engagement program.

The Family Engagement Initiative is currently used by 15 counties. The reason not all counties do this is because it requires a lot of technical assistance from the Administrative Office of Pennsylvania Courts (AOPC) and there is an application process, too.

Each participating county administers the program, which is a collaboration between county services, the courts, and the guardians ad litem with the goal of making proceedings less traumatic for the children involved. The judges, family lawyers, etc. need to come together to work out the best solutions with the best interest of the children at the heart.

Early Intervention screening could be a great referral point to other providers in the system, particularly for those families who do not reach a point of needing SPOC. Early Intervention can also be court ordered. Drug courts, custodial matters, and others might be ways to introduce Early Intervention to cases.

Regarding the SPOC being housed in the Child Welfare system, the plans of safe care need not be centered in the Child Welfare system. The original intent of MDWISE was to remove the plans of safe care from Child Welfare and instead run them through other providers, which could include community-based providers to lessen the blow of ChildLine receiving the referrals.

A significant improvement in the system would be to decouple plans of safe care referrals from CAPTA funding with the objective of` avoiding the stigma and perceptions associated with having Child Welfare make decisions for new mothers and young families. Community based providers, along with other stakeholders, could shoulder some of the burden that now falls on Child Welfare. A new mother, instead of seeing a community-based providers, sees the heavy weight of Child Welfare. The community-based providers could receive training from the counties, with guidance from MDT, Early Intervention, and other players could all make contributions without the perception that decisions are being made by "the county." Retention and voluntary participation could increase substantially. To be successful, however, the partners need to be sufficiently resourced.

Child Protective Services Law

A child over one year of age is no longer eligible for a Plan of Safe Care and therefore the approach to the discovery of substance use by parents or children follows Pennsylvania's Child Protective Service Law (CPSL). Under CPSL, parental substance use can be reported through ChildLine if the parent is using substances and there are safety risks or risks of harm to the child because of their parent's substance use.

Upon the receipt of a child abuse report through Childline, the appropriate county agency will conduct an investigation immediately if there is need for emergency protective custody, or within 24 hours if emergency protective custody is not necessary. The investigation will cover:

1. A determination of the safety of or risk of harm to the child or any other child if each child continues to remain in the existing home environment.

2. A determination of the nature, extent and cause of any condition listed in the report.

3. Any action necessary to provide for the safety of the child or any other child in the child's household.

4. The taking of photographic identification of the child or any other child in the child's household, which shall be maintained in the case file.

5. Communication with the department's service under section 6332 (relating to establishment of Statewide toll-free telephone number).[83]

If the investigation determines that the report is unfounded, the records from that report will be maintained for one year and then expunged.[84] If the investigation determines a need for social services, demonstrated by the child "being harmed by factors beyond the control of the parent or other person responsible for the child's welfare,"[85] the agency will take steps to coordinate services for the child and family.[86]

As a result of the investigation, some voluntary services may be offered by the county agency to the family. The agency must explain that such services are voluntary and they cannot legally compel families to participate. If the service is refused and the agency makes a determination that it is in the child's best interest for court-ordered action, the agency can initiate a court proceeding.[87]

Counties are required by PA code to make the following services available:

(B) Emergency medical services which include appropriate emergency medical care for examination, evaluation and treatment of children suspected of being abused.

(2) Self-help groups to encourage self-treatment of present and potential abusers.

(3) Multidisciplinary teams composed of professionals from a variety of disciplines who are consultants to the county agency in its case management responsibilities as required by Chapter 3130 who perform one of the following functions:

(i) Pool their knowledge and skills to assist the county agency in diagnosing child abuse.

(ii) Provide or recommend comprehensive coordinated treatment.

(iii) Periodically assess the relevance of the treatment and the progress of the family.

(iv) Participate in the State or local child fatality review team authorized under section 6340(a)(4) and 6343(b) of the CPSL (relating to release of information in confidential reports; and performance audit), convened by a professional,

[83] Pa C.S. 23 Chapter 63§6368(c)
[84] Pa C.S. 23 Chapter 63 §6337(a)
[85] Pa C.S. 23 Chapter 63 §6368(k)
[86] Pa C.S. 23 Chapter 63 §6368(k)
[87] Pa C.S. 23 Chapter 63 §6370

organization and the county agency for the purpose of investigating a child fatality or the development and promotion of strategies to prevent child fatality.[88]

General protective services are provided in non-abuse cases in order to prevent future abuse. A child could receive these services if he or she:

1. Is without proper parental care or control, subsistence, education as required by law, or other care or control necessary for his physical, mental, or emotional health, or morals.

2. Has been placed for care or adoption in violation of law.

3. Has been abandoned by his parents, guardian or other custodian.

4. Is without a parent, guardian or legal custodian.

5. Is habitually and without justification truant from school while subject to compulsory school attendance.

6. Has committed a specific act of habitual disobedience of the reasonable and lawful commands of his parent, guardian or other custodian and who is ungovernable and found to be in need of care, treatment or supervision.

7. Is under 10 years of age and has committed a delinquent act.

8. Has been formerly adjudicated dependent under section 6341 of the Juvenile Act (relating to adjudication), and is under the jurisdiction of the court, subject to its conditions or placements and who commits an act which is defined as ungovernable in subparagraph (vi).

9. Has been referred under section 6323 of the Juvenile Act (relating to informal adjustment), and who commits an act which is defined as ungovernable in subparagraph (vi).[89]

If a family is approved for GPS, the county agency will create a family service plan and continue to monitor the effectiveness of the plan. The family will also have access to the same services the county must provide for child abuse cases. The family will be periodically monitored by a county agency worker to ensure that the child is safe and being served effectively according to the level of risk.[90] County agencies must make available: "multidisciplinary teams, instruction and education for parenthood and parenting skills, protective and preventive social counseling, emergency caretaker services, emergency shelter care, emergency medical services, part-day services, out-of-home placement services, therapeutic activities for the child and family directed

[88] 55 PA Code § 3490.60
[89] 55 PA code §3490.223
[90] 55 PA code § 3490.235

at alleviating conditions that present a risk to the safety and well-being of a child and any other services required by department regulations."[91]

In severe cases, county agencies can take children into protective custody. An informal hearing must be held within 72 hours, and if this hearing determines that the child is alleged to be a dependent child, the agency must file a petition with the court within 48 hours alleging that the child is a dependent child.[92] Under section 6332 of the Juvenile Act, a child is considered dependent if he or she is:

> Without proper parental care or control, subsistence, education as required by law, or other care or control necessary for his physical, mental, or emotional health, or morals. A determination that there is a lack of proper parental care or control may be based upon evidence of conduct by the parent, guardian or other custodian that places the health, safety or welfare of the child at risk, including evidence of the parent's, guardian's or other custodian's use of alcohol or a controlled substance that places the health, safety or welfare of the child at risk.[93]

County agencies are only to use protective custody measures in severe situations where "the immediate safety and well-being of the child requires removal from the setting in which the alleged child abuse occurred."[94] Once protective custody is initiated, the county must notify the child's parents. Within 48 hours of the initiation of protective custody, the county agency is required to:

> (B) Meet with the child's parents to assess their ability to assure the child's safety if the child is to be returned home.
>
> (2) Meet with other individuals who may have information relating to the safety of the child in the home if the child is to be returned home.
>
> (3) Determine if services could be provided to the family which would alleviate the conditions necessitating protective custody.
>
> (4) Provide or arrange for necessary services.
>
> (5) Meet with the parents to advise them of the decision to do one of the following:
>
> (B) Return the child to the child's home.
>
> (ii) Explain to the parents the reasons why the child will continue to be held in protective custody and the nature of future legal proceedings including the rights provided under sections 6337 and 6338 of the Juvenile Act (relating to right to counsel; and other basic rights) which are:
>
> (B) The right to counsel.
>
> (B) The right to introduce evidence and cross examine witnesses at the Juvenile Court hearing.[95]

In 2021, there were 127,162 valid GPS concerns. A report may contain more than one concern, therefore there are more valid concerns recorded than the 43,757 valid reports. The largest

[91] Pa C.S. 23 Chapter 63 §6375(f)
[92] 55 PA code § 3490.57(a)
[93] 6332 of the Juvenile Act
[94] 55 PA code § 3490.57(b)
[95] 55 PA code § 3490.57(f)

portion of the concerns, with 26,112, revealed caregiver substance use. A small portion of concerns covered child substance use disorder, amounting to 1,828 valid concerns in 2021.[96]

[96] https://www.dhs.pa.gov/docs/OCYF/Documents/2021-CPS-REPORT_FINAL.pdf, 30.

The Department of Health (DOH) is addressing NAS through three approaches:

1. Surveillance Initiatives
2. Prevention and Treatment Initiatives
3. Thriving Families Learning Opportunity

Each approach plays a critical role in either informing other departments' efforts or in coordinating directly with them.

Surveillance Initiatives

DOH has developed, after consultation with other states' health departments and reviewing the literature, a definition of an NAS surveillance case as including:

- A newborn with a clinical diagnosis in the neonatal period (birth up to 28 days of life) who has symptoms of withdrawal because of prenatal exposure to opiate drugs, either via prescription, medical therapy (MAT), or illegal use;

- A resident of Pennsylvania (only infants born to mothers who resided in Pennsylvania before the baby's birth); and

- An infant born on or after October 10, 2018.

Based on these criteria, there were 1,608 Pennsylvania infants born with NAS in 2019, which was a decrease of 33 percent from the 2,140 born in 2018. When compared to babies born without NAS, the infants were approximately one-and-a-half times more likely to have had their birth covered by Medicaid and have low birthweight. They were also more likely to be born prematurely. Importantly, their mothers were less likely to have received prenatal care.

Cases by County Facility and Maternal Residence

When case counts are mapped to county facilities, Allegheny County had the highest number with 338 in 2019. Overall, 25 of the counties (37 percent) reported no cases. Notably, 18 of the 25 had neither birthing nor pediatric hospitals in 2019. In other words, case counts for some counties could be inflated by nonresidents having to travel for health and birthing care. The data show that most counties with higher case counts also had more reporting facilities. DOH data from the department's Bureau of Epidemiology show that some counties reported zero cases among residents (Forest County and Bradford County) while others reported much higher numbers.

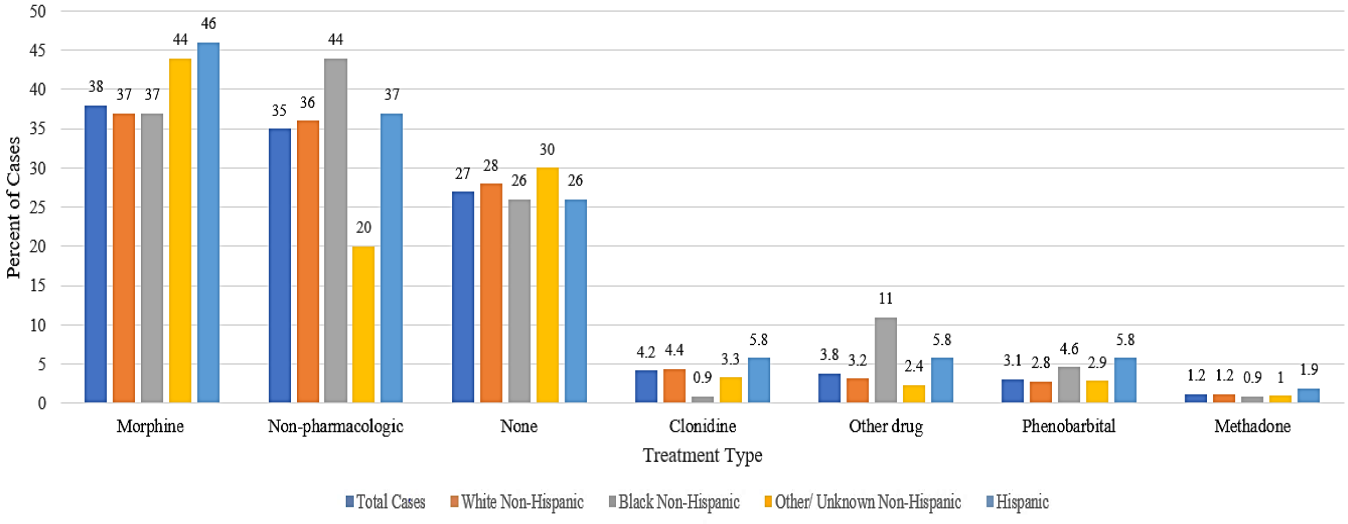
Philadelphia County reported 211 NAS cases. Incidence rates per 1,000 live births ranged from zero to as many as 61.6 (Fayette County)[97]

Treatment Type by Race

Different types of treatments, including pharmacologic and non-pharmacologic are prescribed for NAS, and infants may receive one or more types. Non-pharmacologic treatment was the most common for infants with Black non-Hispanic mothers. Morphine was the most common for infants born to white non-Hispanic, other/unknown race/ethnicity, and Hispanic mothers. See Graph 1.

Graph 1

Treatment Types for NAS by Race
Pennsylvania
2019



Source: Commission staff from presentation to the Task Force, "Department of Health: Neonatal Abstinence Syndrome," by Dr. Denise Johnson, M.D., FACOG, FACHE, Acting Secretary of Health, April 25, 2022.

[97] Presentation to the Task Force, "Department of Health: Neonatal Abstinence Syndrome," by Dr. Denise Johnson, M.D., FACOG, FACHE, Acting Secretary of Health, April 25, 2022.

Pregnancy Associated Deaths by Cause

The Pennsylvania Maternal Mortality Review Committee (MMRC) reviews deaths of women who have died during pregnancy of within one year after the end of a pregnancy.[98] According to 2018 data, the leading cause of maternal mortality was accidental poisoning, including overdose, in Pennsylvania. Out of 85 maternal deaths (excluding Philadelphia County), 43 were attributed to accidental poisoning. Other causes of death included Other Obstetric Deaths, Transportation Accidents, Assault, Other Pregnancy Related, and Intentional Self-harm. See Table 8.

Table 8

Top Causes of Death for All Maternal Deaths (Excluding Philadelphia County) in 2018 (N=85)

Cause of Death	Number of Deaths	Overall Percentage
Accidental Poisoning	43	51%
Other Direct Obstetric Deaths	9	11
Transportation Accidents	8	9
Assault	7	8
Other Pregnancy Related	4	5
Intentional Self-Harm	4	5

Source: Commission staff from presentation to the Task Force, "Department of Health: Neonatal Abstinence Syndrome," by Dr. Denise Johnson, M.D., FACOG, FACHE, Acting Secretary of Health, April 25, 2022.

MMRC Recommendations

The MMRC made recommendations to address what it views as the most pressing issues that can contribute to maternal mortality in Pennsylvania. Overall, the MMRC recommends that policy makers consider:

1. Mental Health
2. Substance Use
3. Comprehensive Medical Care
4. Intimate Partner Violence

[98] Established by Act of May 9, 2018, P.L. 118, No. 24. "The Pennsylvania Maternal Mortality Review Committee's goal is to systematically review all maternal deaths, identify root causes of these deaths and develop strategies to reduce preventable morbidity, mortality and racial disparities related to pregnancy in Pennsylvania." Pennsylvania Department of Health, https://www.health.pa.gov/topics/healthy/Pages/MMRC.aspx.

General Assembly and Commonwealth Agencies

MMRC recommendations to the General Assembly and state agencies regarding substance use are:

1. Safeguard continuous Medicaid eligibility for individuals during pregnancy and up to one year postpartum (*Effective April 1, 2022).

2. Address the privacy laws around substance use disorder (SUD) treatment to improve care coordination and communication by allowing providers to share relevant information with each other for pregnant and postpartum patients. Considerations should be made to require transparency to facilitate patient autonomy.

3. Decriminalize all substance use for pregnant people and promote mental health and substance use treatment.

4. Increase public education on SUD to decrease stigmatization of pregnant and postpartum individuals.

Healthcare Providers and Hospital Systems

Similarly, the MMRC made recommendations for actions that can be taken by Healthcare providers and hospital systems in Pennsylvania. These recommendations include:

1) Refer pregnant and postpartum patients with substance use concerns for behavioral health and substance use treatment.

2) Promote standards of care and guidelines for treatment of substance use disorder (SUD) by:
    a) Providing ongoing training/education for providers on substance use among pregnant and postpartum individuals.
    b) Implementing universal screening in pregnant and postpartum individuals for substance use using a validated screening tool.
    c) Developing guidelines around frequency and timing of substance use screening for pregnant and postpartum patients.
    d) Developing plans for care coordination and communication for all pregnant and postpartum patients.
    e) Increasing work force capacity of substance use treatment providers to support a potential increase in pregnant and postpartum patient referrals due to universal screening for SUD.

3) Standardize discharge plans for all hospitals stays for pregnant and postpartum patients with OUD, or a prescription for an opioid, to include distribution or prescription for naloxone, instructions on how to use and where to get naloxone when needed.

OB/GYNs and midwives are dispensing fewer opioid prescriptions than they had been in the past. Since 2017 both the number and opioids as a proportion of controlled substances dispensed have decreased. Between 2017 and 2020, the number of opioid dispensations dropped by 9.23 percent and the proportion dropped by over 17 percent.

Community Organizations

The MMRC recommended that community-based organizations could make a strong impact on maternal mortality by expanding their communities' knowledge and access to naloxone. DOH provides funding for county and municipal health departments for home visiting services for women, some of which have become national models of home visiting. These include Partners for a Healthy Baby, Healthy Families America, Bright Futures, Parents as Teachers, and Nurse Family Partnership. Evidence and experience show that group prenatal care can have positive effects to reduce healthcare disparities, promote healthy behaviors, provide peer support, improve pregnancy outcomes, and reduce infant mortality. These benefits also accrue to women with SUD.

An example of such a program is offered as Lancaster General Hospital's Centering Pregnancy, which provides for women with SUD/OUD. At the state agency level, DOH partnered with the Northwestern Pennsylvania Neonatal Abstinence Syndrome Coalition and the Ohio Perinatal Quality Collaborative to develop a Family Guide Toolkit. The guide was written to serve the purposes of:

- Helping parents learn about NAS
- Encouraging parents to share their substances or medication history with their doctor and nurse
- Answering parents' questions about NAS so they can take good care of their baby
- Help parents help their baby be healthy safe

Another example of local agencies providing supports for NAS is the Crawford County NAS Baby Basket Initiative. In 2021, the DOH's Division of Newborn Screening and Genetics partnered with Crawford County Drug and Alcohol Executive Commission to distribute baby baskets and an NAS Family Guide tool kit to families affected by NAS in northwest Pennsylvania. Distribution of the baskets began in February 2022. A Plan of Safe Care Coordinator delivers the NAS Baby Basket to the mom during their initial visit. To facilitate the program, the Crawford County Drug and Alcohol created an online assessment tool, which collects demographic data and feedback from families receiving the baskets and NAS Family Guide tool kit. This information will be utilized to assess the impact and effectiveness of the pilot project.

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DEPARTMENT OF DRUG AND ALCOHOL PROGRAMS

The Department of Drug and Alcohol Programs' (DDAP) mission is to engage, coordinate and lead Pennsylvania's efforts to prevent and reduce drug, alcohol, and gambling addiction and abuse and to promote recovery, thereby reducing their devastating toll on the people of Pennsylvania and its economy. To achieve its mission, DDAP is at the forefront of the opioid crisis by leading, partnering, and collaborating with stakeholders across the commonwealth and beyond. Mitigating the effects of OUD on infants, children, and their families is a critical priority of the department.

Overdose Deaths in Pennsylvania

There were 2,132 overdose deaths in Pennsylvania in 2012, and the incidence increased steadily until the addiction crisis peaked with 5,425 in 2017. There was a decrease in overdose deaths to 4,451 in 2018 but a slight increase again in 2019. The onset of the pandemic coincided with another steady increase, although somewhat flatter than the 2012-2017 trend. The preliminary figure for 2021 is 5,224 overdose deaths. Although not all the deaths were attributed to opioids, they are clearly the dominant substance associated with overdose deaths. Moreover, fentanyl was associated for 85 percent of overdose deaths. It appears that many of the deaths occurred with fentanyl being mixed in with other substances, such as cocaine and marijuana, and users were neither expecting nor prepared for the consequences. Drug use in general has increased across substances.

Prevention and Support

In terms of prevention, over $11 million has been allocated to the Single County Authorities' (SCAs) various programs to operate prevention efforts. These programs include:

- Student Assistance Program (SAP) liaison services
- Evidence-based school curricula to build skills (e.g. Botvin LifeSkills Training, Too Good for Drugs)
- Parenting programs (including home visiting programs)
- Youth leadership development/advocacy
- Supporting prevention coalitions
- Cognitive Behavioral Intervention for Trauma in Schools

The counties are allowed to determine what their needs are rather than have them dictated by the state, although all schools are required to have an SAP program.

Pennsylvania Youth Survey (PAYS)

- Survey youth in 6th, 8th, 10, 12th grades
- Administered in fall of odd-numbered years
- Collects data on substance use, mental health and other problem behaviors
- Measures risk and protective factors that influence
- Behaviors
- 2021 Findings: Continued decline in teen substance use

The good news is that personal substance use among teens is dropping, but this does not mean that teens are not exposed to substance abuse at home or in school. Every public school in Pennsylvania must have a Student Assistance Program (SAP) available. SAP is not responsible for delivering treatment. The SAP is a group of individuals in the school who are tasked with identifying potential risks, identifying children who need to be referred to services, and need to be offered access to early intervention services or treatment services. They are trained on how to make referrals, how to identify students, and are given the resources they need to make the referrals. Anecdotally, there may be a lot of students identified through this program as needing services but there are not a lot of students or parents on the student's behalf who accept those services. It is more likely for parents to be receptive of students seeking resources for mental health issues as opposed to substance use disorder issues.

Women-Women with Dependent Children Network

Pregnant women and women with children are a priority population for purposes of federal funding. The implication is that there needs to be round-the-clock ability to connect them with services and supports.

The Women-Women with Dependent Children Network's (W3DC) purpose is to:

- Represent the "voice" of women in identifying barriers and establishing solutions to improved service delivery
- Improve collaboration among partners providing services to pregnant and parenting women
- Identify needs and improve access to resources

In Pennsylvania, there are 28 licensed in-patient and residential programs that specifically serve women and women with children. There are about 400 available beds for women and pregnant women. There are some programs in Pennsylvania that will allow children to be present for residential treatment. SAMHSA grant funding has been available for the past several years to increase and improve services for the populations. There are, however, no beds available for men with children, although there are efforts to change the availability. There has been an expansion of funding and availability to treat children for substance use disorders. At present, children and adolescents are only provided with services if they are involved with the criminal justice system. One reason for the dearth of supports for children is because parents are far more likely to address and take action for mental health than substance use problems. DDAP recently put out an RFP and is developing a relationship with a provider in NEPA who might be able to fill the needs there.

The Women and Children's 2019-2020 Annual Report issued by the Pennsylvania Department of Drug and Alcohol Programs includes a listing of residential treatment programs in Pennsylvania that serve women. As different programs have different capabilities, DDAP specifies which programs are residential or Halfway Houses, serve pregnant women, serve women with dependent children, and have a gender specific track or unit for women. As of FY 2019-2020, there were 44 Women's Residential Treatment Programs. Of residential programs, 14 served women, pregnant women, and women with dependent children, three served women and pregnant women, and three served only women. For Halfway Houses, three served women, pregnant women, and women with dependent children, 13 served women and pregnant women, and two served only women. There were five residential programs that served both men and women but had a gender-specific track or unit and did not serve pregnant women. One residential program that served both men and women but had a gender-specific track or unit did serve pregnant women.[99] See Table 8.

Table 8

FY 2019 – 2020, Pennsylvania Residential Programs for Women, Pregnant Women, and Women with Dependent Children

County	Program Name	Women Residential & Halfway House	Pregnant Women	Women with Dependent Children	Gender specific Track/Unit for Women
Allegheny	CeCe's Place	Halfway House			
Allegheny	Family Links	*	*	*	
Allegheny	PA Organization for Women in Early Recovery, POWER	Halfway House	*		

[99] *Women and Children's Annual Report: State Fiscal Year 2019-2020* (Pennsylvania Department of Drug and Alcohol Programs, 2020), https://www.ddap.pa.gov/Documents/Agency%20Reports/State%20Plan%20and%20Annual%20Reports/2019-20%20Women%20and%20Children%27s%20Report.pdf., 10.

Table 8

FY 2019 – 2020, Pennsylvania Residential Programs for Women, Pregnant Women, and Women with Dependent Children

County	Program Name	Women Residential & Halfway House	Pregnant Women	Women with Dependent Children	Gender specific Track/Unit for Women
Allegheny	Sojourner House	*	*	*	
Allegheny	The Program for Offenders, Inc.	*	*		
Berks	Caron's Grandview Women's Program				*
Blair	Pyramid Tradition House	Halfway House	*		
Bucks	Libertae Family House	*	*	*	
Bucks	Libertae Liberty House	Halfway House	*		
Bucks	Penn Foundation				*
Bucks	Pyramid Langhorne Women's Trauma Focused Residential				*
Chester	Bowling Green Brandywine		*		*
Chester	Gaudenzia Kindred House	*	*	*	
Chester	Samara House CWYA	*	*	*	
Dauphin	Evergreen, Catholic Charities & Diocese of Harrisburg, Inc.	Halfway House	*		
Dauphin	NASR	*			
Erie	Gaudenzia Community House	Halfway House	*	*	

Table 8

FY 2019 – 2020, Pennsylvania Residential Programs for Women, Pregnant Women, and Women with Dependent Children

County	Program Name	Women Residential & Halfway House	Pregnant Women	Women with Dependent Children	Gender specific Track/Unit for Women
Erie	Gaudenzia House of Healing	*	*	*	
Fayette	Good Works Life Recovery House	Halfway House	*		
Greene	Greenbriar Treatment Center	*	*		
Lancaster	The Gate House for Women	Halfway House	*		
Lancaster	Gaudenzia Vantage	*	*	*	
Lawrence	The Highland House, Inc.	*	*		
Lehigh	Treatment Trends Halfway Home Women's Program	Halfway House			
Luzerne	Clem-Mar House	Halfway House	*		
Luzerne	Graniteville House of Recovery	Halfway House	*		
Montgomery	RHD Family House	*	*	*	
Philadelphia	Gaudenzia New Image	*	*	*	
Philadelphia	Gaudenzia Washington House	Halfway House	*		
Philadelphia	Gaudenzia WINNER	*	*	*	
Philadelphia	Interim House	Halfway House	*		

Table 8

FY 2019 – 2020, Pennsylvania Residential Programs for Women, Pregnant Women, and Women with Dependent Children

County	Program Name	Women Residential & Halfway House	Pregnant Women	Women with Dependent Children	Gender specific Track/Unit for Women
Philadelphia	Interim House West	*	*	*	
Philadelphia	RHD Family House NOW	*	*	*	
Philadelphia	RHD Womanspace	*			
Philadelphia	My Sister's Place, Thomas Jefferson University	*	*	*	
Philadelphia	Teen Challenge for Ladies	*			
Schuylkill	Gaudenzia Fountain Springs	*	*	*	
Schuylkill	Gaudenzia New Destiny	Halfway House	*	*	
Snyder	Conewago Snyder Residential				*
Somerset	Twin Lakes Center Residential				*
Venango	Freedom Center for Women at Turning Point	*			
Washington	Abstinent Living at Turning Point, Washington	Halfway House	*		
Washington	Turning Point at Washington, Julie's House	Halfway House	*	*	
Washington	Lighthouse for Women of Greenbriar Treatment Center	Halfway House	*		

Source: *Women and Children's Annual Report: State Fiscal Year 2019-2020* (Pennsylvania Department of Drug and Alcohol Programs, 2020), https://www.ddap.pa.gov/Documents/Agency%20Reports/State%20Plan%20and%20Annual%20Reports/2019-20%20Women%20and%20Children%27s%20Report.pdf.

Parent Panel Advisory Council

The Parent Panel Advisory Council was established in DDAP by House Resolution 585 of 2006 (Pr.'s No. 4032). It is the mission of the Pennsylvania Parent Panel Advisory Council, working in collaboration with DDAP, to advocate for and promote individual and family recovery, hope, and healing by improving the understanding and access to, a continuum of care and supports for those who are impacted by substance use and substance use disorders throughout Pennsylvania. Pennsylvania used to have 10 residential programs for youth and for a myriad of reasons almost all of them went out of business. One of the main reasons is that parents are less willing to send their child to substance use disorder treatment—they are more willing to acknowledge mental health issues than admit substance use disorder, which demonstrates the pervasiveness of the stigma surrounding substance use disorder. There were also issues with improper relationships between adolescent clients and the counselors. Many of the counselors were younger and felt they were more connected to the youth—however they were a little too close in age and inappropriate relationships resulted.

The individuals who comprise the panel include parents of adult and adolescent children with SUD, parents who have lost children to SUD, and grandparents who are caring for grandchildren because their ow child has an SUD. It is a group that represents the geographic diversity and backgrounds of Pennsylvania residents. The panel meets three times per year to share recommendations on how to improve access to services, break down barriers, and address stigma.

Stigma Reduction Campaign

DDAP began a stigma reduction campaign about a year ago. Typically, a stigma reduction plan focuses on traditional forms of advertising. In this case, the initiative's approach is a public health approach that is modeled on a mental health program developed by The Public Goods Projects (PGP).[100] DDAP's stigma reduction initiative is driven by a partnership with Penn State University, PGP, and addiction treatment provider Shatterproof.[101] The initiative is based on three sequential steps: increase knowledge, improve attitudes, and improve behaviors. It is a strategic process to not only change perception but also their behavior because of the changed perceptions.

The campaign is based on a Collective Impact Model that includes five steps:

1. Connect and strengthen stakeholders (organizations and individuals) already responding to the crisis. DDAP collaborated with over 80 organizations across Pennsylvania who endorse the campaign.

[100] "PGP (The Public Good Projects) is a public health nonprofit specializing in large-scale media monitoring programs, social and behavior change interventions, and cross-sector initiatives. PGP applies the best evidence and practices from the public and private sectors to create bold projects for health. PGP's programs and initiatives are evidence-based, tailored for particular populations, employ a collective impact model, and are scientifically evaluated. PGP is led by experts in public health, marketing, journalism, media, and business. We deploy our considerable resources and relationships to support communities and partners in their mission to make a healthier and more equitable world." https://www.publicgoodprojects.org/about

[101] "Shatterproof is a national nonprofit organization dedicated to reversing the addiction crisis in the United States." https://www.publicgoodprojects.org/about

2. Integrate with Pennsylvania's existing plan. Expanded messaging from only OUD to poly-use and stimulant education as state priorities shift.

3. Educate the public using channels and messengers that meet them where they are. Published over 270 stories on Life Unites Us social channels and story library. Activated 50 influencers for a larger reach of messaging.

4. Evaluate the entire effort as a public health intervention, not a media campaign.

5. Evaluate stigma reduction every 6 months.

Data show the initiative's successful outreach. Importantly, the work is based on research and surveys targeted at specific areas of the state where stigma is the most pervasive. Pennsylvania is the first state to use this approach. At this point, Kentucky, Oklahoma, and (possibly) Florida, have seen Pennsylvania's success and are moving toward initiating their own stigma reduction campaigns based on Pennsylvania's Collective Impact Model. The Collective Impact Model basically means that the issue is approached from numerous angles, using different organizations to support that approach. The first year of the campaign was focused on opioid use disorder because funding was tied specifically to opioids. In the second year, the campaign expanded to cover all other substances.

There are around 270 stories of individuals in recovery or family members of individuals in recovery that are shared as part of the campaign. The videos are recorded with the individual who is telling the story along with a trauma-informed trained public health professional. They sit down and have a conversation in advance of the recording; they do the recording in a safe space; they edit the video to make sure they are not divulging information that the speaker does not want to share; and then the story is published. The public health professional follows up periodically after publishing the story to see how the person is doing, if they are experiencing negativity as a result, and if they want the video taken down. A survey was administered prior to the start of the campaign and readministered every six months after. With this survey, DDAP can monitor changes in behavior and attitudes over time.

The campaign partners with community-based organizations (CBO) that help share content and the videos. A Community Impact Committee meets to talk about how the campaign is doing, reimagine it, and what audiences they need to visit. Additionally, technical training through webinars is offered to the public; topics are determined by the public.

The campaign has gathered 4.8 million impressions on social media, which include 900,000 video views, 106,000 engagements, and 2,000 followers across Facebook, Twitter, Instagram, and YouTube. Additionally, the campaign worked with 50 social media influencers to share key messaging and use #lifeunitesus, which added an additional 1.2 million impressions. These influencers were Pennsylvania residents and were contacted and asked if they could partner with the campaign; if they agreed to do 1 to 3 posts spread out over a period specifically related to SUD; and write the post. Public health professionals would edit the posts to remove any stigmatizing language before it was posted.

There are some data on the outcomes of the campaign's first year. Results show that there was a greater willingness to either live with or have a relationship with someone with an OUD: people who were exposed to the campaign were 20 percent more likely to be willing to live with an individual with an OUD. People had a greater openness to having a treatment facility located near their home if they were exposed to the campaign. Evidence of actual behavior and attitude changes may be found when a new treatment facility is sited in a neighborhood that had previously been reluctant to have such a facility. There was significant research done prior to the campaign. Surveys were administered and public opinions reviewed to find where stigma was the most pervasive. Data were broken down by age groups and other demographics like urban and rural. The campaign targeted specific areas where stigma was the most pervasive. In some of the 271 stories, the first people that the campaign contacted were from areas with the most pervasive stigma. It is easier for people to change behaviors when they are familiar with the person telling the story.

Discussion

Task Force members asked about the biggest obstacles faced by mothers and fathers for substance use disorder treatment. Secretary Smith responded that, while Pennsylvania probably has adequate capacity overall, capacity is a big problem because it is not always adequate where it is most needed. Other challenges include complicated insurance coverages, although the SCAs are often able to help, and despite the availability of funding, people often defer treatment because of affordability. Sometimes barriers are based on clients' choices about where and what types of resources they want to access. For many years, clients and family members self-assessed their needs and their treatment options. For example, it had been for many years the standard practice that in-patient services were necessary. More commonly, however, a lower level of care, particularly with MOUD, is a better and easier course of treatment. People's treatment decisions tend to be influenced by family members or friends more so than by clinical evaluations. Some obstacles might stem from health care professionals own lack of familiarity with available services.

Further Task Force discussion concerned the use of the Life Unites Us data that links areas of need with birthing hospitals. Members agreed that Life Unites Us would greatly benefit if even a few of the Life Unites Us stories involved pregnant or post-partum women. In praising the Life Unites Us campaign, Task Force members expressed a desire to borrow findings and suggested areas of collaboration. For example, data from the campaign could be utilized for PSA campaigns regarding safe sleep and stigma reduction in pregnant women. It was then noted that if Life Unites Us had pregnant women telling stories, it would help influence other pregnant women. There is an ongoing process of tagging the stories and pregnant is one of those tags.

A Task Force member shared thoughts regarding the Philadelphia Health Department programs regarding OUD and SUD in pregnant people. There is progress, with children becoming healthier and outcomes improving. However, problems remain regarding adolescents and treatment. At a certain age, DHS or juvenile justice would have to get involved. Treatment for teenagers is not done in isolation: they must be connected to some type of system. It was suggested that this is a potential area for legislation. It was also noted that an adolescent in treatment has certain rights to share certain information with their parents. For example, a parent cannot call and ask if their child is still getting treatment.

Doula programs are known to be very helpful and are a potential source that could be leveraged into initiatives.

Co-locating Services

There was broad agreement among Task Force members that reducing the number of SEI might be helped if certain clinics (MOUD, for example) partnered with services that offer birth control to make it more widely available to people in vulnerable populations. The recommendation should be for more co-located services so that women do not have to travel to multiple locations for more than one service. DHS is working on expanding access to reproductive health, birth control, and STD testing whenever possible to reduce the stigma of people having to ask for those things from their healthcare provider. In the Medicaid program, the challenge is that some services, such as pregnancy tests, require a determination of medical necessity for them to be covered by Medicaid. The point made is that a broader overall recommendation is around more preventative birth control, and pregnancy related counseling should be more widely available across the board. From a data perspective, DHS gets the data as procedure codes and can track utilization rates.

It may be possible to co-locate reproductive services in methadone clinics and drug and alcohol clinics, so that people would be better informed about their options. It was suggested that most women suffering from SUD do not want to be pregnant at that point in time. The challenge is to develop partnerships between different providers because not all locations are able to deliver the services being discussed.

An effort to co-locate services could begin with data reviews. For example, it would be helpful to learn the percentage of SEI babies who received prenatal care and what services are available where the prenatal care was provided. Another recommendation could be to collect data from private insurers; Medicaid data alone would not provide a complete view.

Pregnancy is a condition that is eligible for Medicaid. A lot of times, there is a 3–4-month lag between when a mother becomes eligible for Medicaid coverage and when coverage begins. According to PHC4, 30 percent to 35 percent of Pennsylvania births are covered by Medicaid, but 80 percent to 85 percent of infants with NAS come from that Medicaid population.

Education

The Task Force sought to look at doula programs, such as southeast Pennsylvania's Maternity Care Coalition, that focus on pregnant women with OUD/SUD. Providers like the Maternity Care Coalition can engage with mothers to see what they need and what their goals are. Another route could be to offer hospitals more resources so that they can develop and sustain similar programs. Providers should be educated to communicate effectively and from a thoughtful,

trauma-informed framework, to explain what services are available and how they can be accessed. Groups like the Maternity Care Coalition can educate other care providers.

At DHS the current thought is that education for providers and health systems should be framed in the context of the Roe decision with the thought that significantly more babies will be born, and the infrastructure needs to have the capacity to provide SUD services to the moms and the substance exposed babies, including more resources for foster care. It was suggested that a recommendation could be to create a curriculum around pregnant women. Members suggested the creation of a comprehensive department program of guidelines for pregnancy and parenting people. However, SAMHSA (Substance Abuse and Mental Health Services Administration) has a course, spearheaded by Pennsylvania, called Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants.

The commonwealth's prescription drug monitoring program, Achieving Better Care by Monitoring All Prescriptions (ABC-MAP) has a contract for education pieces, with one on stigma and another on mortality. Data analysis of those pieces is in the works.

Task Force members discussed whether medical education around the target populations could be attached to licensing requirements. There is certainly room for improvement, especially to make the resources more available and more robust.

Task Force members took a step back to reframe the discussion by asking "What are we preventing? What are our prevention efforts? Unplanned pregnancies? To prevent them from using at all? Or is prevention a win if they move from illicit substances to MAT?" The answer was, ultimately, all of them, whether preventing the pregnancy or preventing illicit substance use. The goal is to prevent poor outcomes in each of the many different facets. For example, recommendations could be specific to substance exposed children, to medical education for obstetrics, or how to co-locate services. There might be data out there, perhaps from the March of Dimes, that show what interventions have been carried out that are successful.

Policy makers need to know what is available in terms of clinical guidelines for women in general and who are pregnant. Perhaps a recommendation would be to form a group to find out what is available now (data and information) and then determine how to tailor it to Pennsylvania.

Data

Task Force members were reminded that PA PQC (Pennsylvania Perinatal Quality Collaborative) is collecting data on the topic of multiple pregnancies and NAS, and 80 percent of the birthing hospitals belong to the PA PQC.

Among data "asks," members want to know the full universe of babies who were born substance exposed and what percentage received prenatal care, which received post-partum care. There were questions about whether birth certificates include data on prenatal visits. Further, members wanted to know if the state is collecting information about babies born with MAT or

illicit drugs in their system. Part of the answer is that there are demonstrated differences between the type of drug and the severity of NAS. It depends on the type, the dose, the severity, and the mother's metabolism. There are some drugs that do not show anything at all, cocaine for example. The research and literature on neurodevelopmental responses to exposure to illicit substances is incomplete.

There could be a lot of factors (mother's diet and nutrition, prescribed vs illicit opioids, etc.) that play roles. There is still discussion about what is defined by "affected by." One thing that providers have learned is that some people are trying to avoid the diagnosis of NAS to avoid the repercussions of being drawn into the child welfare system. Not only is there confusion about what it really means, there is avoidance of the diagnosis.

Further, a diagnosis of NAS can be overly broad, and all drugs, whether legally prescribed or not, can result in recommendations for Plans of Safe Care (POSC). POSC are tailored to each individual families' situation, but there can be bias on the part of the staff processing the information whether it comes in as a "soft" notification or not, and consequently the child welfare system could get involved regardless of its necessity.

The Philadelphia Department of Health maintains an alternate phone line that healthcare providers and families can call for services without reporting it to the child hotline. The program, run through the Philadelphia Department of Health, is Philly Families CAN. DHS is providing partial funding. The program is designed to help people take the step of accessing help when they are concerned that they could face unintended consequences from the child welfare system. Members felt that it would be useful to look at data from that initiative to see if a non-punitive outlet drives different outcomes, or if there is a way to track what comes from there as opposed to ChildLine.

There should be data on offered and accepted POSC, which might help show if families are more likely to say no if they think they are going to the child welfare system.

Regarding the administration of POSC, it appears, when Dauphin County testified, there was a lack of guidance and best practices from the state. Administration of POSC should not depend on where parents live. It should be universal. One problem with encouraging families to accept POSC is that the plans are administered by county child welfare offices, rather than by community social service agencies. A program that is housed inside a county Children &Youth office might be perceived by mom differently from one that comes through Philly Families CAN despite that it is the same program. Because POSC are supposed to be voluntary, and the agency is supposed to close the file if a mother or family declines to participate in a plan. The agency might report that a certain number of referrals were made to WIC or other supports, but the protocol is that the case is closed out. Despite the voluntary nature, the reality is that DHS hears anecdotal information that a family declining services sparks the entity to conclude that the family is in trouble and needs help. There is also a fear and worry among families that it is going to happen that way, whether or not it does.

Conversely, there are families that decline services who appear in the system some months later because of a child's potentially fatal accidental ingestion. Such events can happen one or two times per month in a large county. Part of the frustration is when a family declines a Plan of Safe Care and a subsequent adverse event occurs, the mother, family, and especially the child suffer dire consequences.

The Plan of Safe Care voluntary component was established by Act 54 of 2018. What the Task Force can do is find ways to engage as many women and families as possible to foster good outcomes and make sure that the system is not punitive. The Task Force could a recommendation around looking at the efficacy of POSC and how they align with outcomes.

Recommendations could rely on county partners now that the initial rounds of CAPTA dollars have gone out, and policy makers could find out from moms who went through POSC and see what the outcomes are. It seems that there are some counties where PSCO are running through community-based services rather than county C&Y systems, and comparisons can be made to see which systems are working better in terms of uptake and engagement and develop a best practice model.

Members asked if there is a way of finding out how many cases of POSC end up in child welfare. This is an important component, and the data should be able to link POSC that go to a General Protective Services (GPS) referral, how long it takes to go to a GPS intake and an out-of-home placement.

Referrals enter through ChildLine either as Information Only (IO) or General Protective Service cases. Information is not collected on IO, only on GPS. The DHS system does not gather information about IO families that accept PSOC. Some counties might be able to get some of the information but it would not be a comprehensive data set. The recommendation could be that policy makers do get the data so that agencies know whether the systems' and POSC are working. There needs to be data coming back for accountability for the funding that is going in. Some counties were declining the funding because of the reporting requirements.

There seems to be a lack of infrastructure for women with acute behavioral health challenges related to their pregnancy or post-partum. DDAP started a pilot "mom-baby" program for acute care being set up at Western Psychiatric Hospital and Allegheny Health Network in Pittsburgh. Medicaid is being helpful. Typically, the mom's coverage can be paid for 24-hour care. The baby's care is not paid for. To have coverage for the baby, it must be proven that the baby needs to be with the birthing parent. Such programs are prolific in the UK, Australia, and New Zealand with good outcomes. The Pittsburgh program will eventually provide six beds. It is a modern way of thinking about treating mothers and babies together.

Pennsylvania has a large number of SUD treatment facilities that allow mothers and babies to stay together and has been working to increase capacity in that space. The task has been just as difficult as it is to provide beds for adolescents. From a business perspective, it is simply too difficult to recover costs. A key obstacle is the difficulty in staffing parent and baby residential programs, although there is a lot of federal funding available. Twenty percent of federal funding block grants are set aside for pregnant women and mothers and babies, but the commonwealth has

trouble meeting the requirements to be able to spend the money because there are not enough providers who are willing to open. Another problem is that Pennsylvania is a Medicaid expansion state. The women that get in the programs are often either covered by private insurance or Medicaid, and so don't meet the state's definition of uninsured.

A treatment method growing in popularity is known as "Eat, Sleep, Console" (ESC), which is "based on the basic function of infants, the family's involvement in the infant's care, and maximizing the non-pharmacological treatments before starting medications."[102] ESC is noted for its ease of use and simplicity; however, it has not been studied outside of quality improvement initiatives.[103] ESC allows more babies to not be exposed to morphine later, keeps family together, and keeps babies out of the NICU and allows babies to go home sooner. Its use depends on the hospitals' practices and the physicians' education, and in following up with current research. Beginning in late 2017 early 2018 a model was developed in DHS for residential pediatric recovery centers, based on Eat Sleep Console, where the moms and babies stay together for up to three months to get the "fourth trimester" of care, and allows for visits from fathers, grandparents, and others. The protocol takes care of babies' physical needs, and moms' physical and behavioral health needs. There are seven or eight such facilities in different states. There might be ways to link these pediatric recovery centers to the available Medicaid money in DDAP. One caveat, however, is that the Medicaid money cannot be used for brick-and-mortar construction and cannot be used to supplant existing programs. The challenge, when developing and establishing programs like this one, is that the federal funding is not guaranteed from year to year which makes planning and sustaining very difficult for providers.

Medicaid does not provide for bricks and mortar or room and board. The mom and baby unit that will be standing up and scaling will be limited to people with acute behavioral crises. There were 3,500 cases of post-partum psychosis last year, and no available beds to support those women. Outcomes are terrible, of course. There have been discussions in terms of reimbursement and how providers are incentivized to do the work. It is why hospital systems are closing labor and delivery because it is not cost effective. The question arose if the funds could be used for reimbursement for physicians, OB in general, so that funding is available for eligible portions of the operations.

It is important for the Task Force to look holistically from both the insurance component and also the diagnosis, and how to incentivize providers to help support not only mothers and babies but also fathers and siblings.

The Philadelphia Department of Health is supporting mom and baby programs that are operated through private providers that are already providing some of the services that are being discussed by the Task Force. Examples of providers operating in Philadelphia are Gaudenzia and Interim House West, which have on-site childcare, for example. They give people the flexibility to live their lives while they do what they need to do to help their recovery.

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[102]. Anbalagan and Mendez, "Neonatal."
[103]. Patrick et al., "Neonatal."

It was recommended that the task force have an inventory of programs across the state that allow families to stay together, and the programs' associated outcomes, how programs are replicated, and how other providers are incentivized to get into the business. Information should include if the programs accept NAS infants.

There are a lot of resources and funding available, in POSC, for example, that are being unused because of the requirements and obligations that are either tied to their use or act as obstacles.

Task Force members began a discussion of universal screening in prenatal and birth care, noting that a doctor would seemingly want the information to provide appropriate care. A screening is not necessarily a referral. The American College of Obstetricians and Gynecologists (ACOG) recommends universal screening, but data show that actual screening rates are low. Task Force members stated that the literature and research point to universal screening as having a beneficial effect on outcomes. Screening might be better received if there were more stigma training and more trauma-informed training so that people do not change their voice when they see a positive test result. Doctors do need to know test results because babies are discharged home and there is often a ripple effect of emergency department visits that could be avoided.

However, the stigma and bias are embedded in every aspect of universal screening, and Task Force members argued that universal screening cannot be recommended while the stigma still exists when it comes to substance use, let alone by parents. Referrals to ChildLine are known to happen when, post-partum, a mother tells her doctor that she had been using illicit substances during pregnancy and then stopped. Doctors cannot make a referral during pregnancy but can do so post-partum.

The question arose about how many calls are made based on a positive screening and how many are made based on reported use by mothers. The utility of asking the question is important, but it needs to be asked in a way that does not stigmatize the mom. The data cannot be recorded anonymously, but there might be ways that privacy can be protected. The doctor is already supposed to keep the information confidential.

It was suggested that universal substance testing could work because so many other conditions are universally tested. Perhaps everyone could be counseled following those same protocols, with no assumptions about whether a person is using substances or not. Counseling about opioids could be included along with nutrition counseling, counseling about the dangers of alcohol, etc. Then it would be up to the mother as to whether she chooses to access services. Her choices do not have to go on "the chart." Another approach could be to get away from universal screening and move toward universal education and provide information about available resources.

Members liked the idea but are worried about the tone coming from the doctor. Oftentimes office staff, an educator, or a nurse does a better job communicating than does the doctor. There are ways to include the education. Along with improved patient education, there should be improved doctor and provider education to reduce stigma and bias with the goal of moving toward universal screening. Task Force members felt that the state needs to do more work to further understand how universal screening affects people, how to do universal screening in the most

effective and least stigmatizing way, and in education for providers. It was thought that approximately 40 percent of states do universal screening. One question to ask is whether universal screening deters mothers from accessing pre-natal care.

Not all Task Force members agree with a recommendation that includes universal screening.

Health, Safety, Permanency

The last time the Task Force met there was discussion of gathering data about how long children remain in foster care. Task Force members asked about how many parents with SUD lose their child in the dependency court system within the first year of life with alcohol and drug use being the reason for removal. Without such basic information, what seems to be the big elephant in the room might not be in the room at all.

A difficulty in gathering such data is that information is reported to DHS by counties' children & youth agencies that might apply and interpret the criteria differently. Sometimes parental drug use is not listed as the removal factor. It could say inadequate housing, or inadequate supervision. Underlying those things could be SUD that is not being captured in data reports, although it might be in the social workers' individual notes. The official number may not tell the entirety of the picture because there are other reasons that could be listed. There might be a lot of cases where substance use is the root cause of the problem but is not evident in the data because consequences of substance use are more readily observed and acute (inadequate supervision, inadequate housing, etc.).

Members asked if it is known how many children born in 2021 that have a Plan of Safe Care or a NAS diagnosis and were removed by child welfare because parental substance use was the main factor, and how many were reunified. It was stated that it is unlikely a child would be removed because of SUD itself. There are always other factors such as neglect, abuse, inadequate housing, mental health, etc. A further question was about how stigma ties back to parents whose children are being removed for addiction if addiction is not the reason they are being removed.

The situation can play out that the mother or father has a history of substance abuse, which is enough to be considered an aggravating circumstance that would lead children & youth to require the mom or dad to prove that they are no longer using or are now in MAT or are taking medication under doctor supervision.

Members discussed the suggestion that training for medical personnel who handle NAS cases include training from treatment providers so that everyone is familiar with protocols and planning and how the different systems need to work together. The current system is siloed, and medical staff and behavioral health staff rarely understand what is happening in the other systems.

Lancaster County co-located a peer recovery support person who is employed with the county's child welfare agency within an outpatient treatment facility. It was suggested that the

Task Force reach out to Lancaster County to see what data are available. Bucks County has a similar program.

Community Based Services

The Family First Prevention Act, signed into law in February of 2018, accelerated a shift in policy that mirrored growing research supporting the importance of preserving the family unit through utilization of addiction social services. One goal of the legislation was to reduce the need for foster care by placing children in kinship care instead.[104]

The other goals included "keeping children safe with their families through prevention services and treatment…, reducing overreliance on group care, addressing the opioid crisis, and supporting youth transitioning out of foster care."[105] Under Family First, reimbursement funds from Title IV-E of the Social Security Act can be used for social service programs that focus on prevention and treatment of substance use. These programs must be trauma informed and include evidence-based programming. Foster care reimbursement funds can also be used for a "trauma-informed, residential, family-based treatment program with the parent, for up to 12 months in duration."[106]

Pennsylvania's Title IV-E Prevention Services Plan from April of 2022 states a goal of using opportunities from Family First "as a catalyst for Pennsylvania's broader vision for prevention by building upon existing efforts and expanding the array of community-based programs and services available to families."[107] One of the priorities listed in this document is the support of kinship care when possible and the use of a higher level of care only if it is "safe, trauma-informed, and focused on children safely returning home and attaining permanency and positive outcomes for the whole family."[108]

Pennsylvania's Child Welfare Practice Model includes three outcomes that relate to the strengthening of families:

- Enhancement of the family's ability to meet their child/youth's well-being, including physical, emotional, behavioral, and educational needs.

- Support families within their own homes and communities through comprehensive and accessible services that build on strengths and address individual trauma, needs and concerns.

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[104] "About the Law," *Family First Act.org*, accessed November 3, 2022, https://familyfirstact.org/about-law.
[105] Center for Advanced Studies in Child Welfare, *Understanding Substance Use Interventions in Child Welfare* (University of Minnesota School of Social Work, Spring 2019), https://cascw.umn.edu/wp-content/uploads/2019/04/360WEB_2019.temp_.pdf, 8.
[106] Ibid., 8.
[107] Pennsylvania Department of Human Services, *Pennsylvania Title IV-E Prevention Services Plan* (DHS, April 2022), https://www.dhs.pa.gov/KeepKidsSafe/Resources/Documents/PA%20Title%20IV-E%20Five%20Year%20Prevention%20Services%20Plan%20v.%202%20April%202022.pdf, 3.
[108] Ibid., 4.

- Strengthen families that successfully sustain positive changes that lead to safe, nurturing, and healthy environments.[109]

Statistically, SUD-related child welfare cases see longer separations from parents, recurrent involvement in the child welfare system, and less family reunification than children involved in the child welfare system for other reasons. The impact of parental substance use can span multiple generations, as children of parents with SUDs were four times as likely to struggle with addiction in 2009.[110] Teaching family skills could improve child welfare services outcomes for these families.[111]

Treatment strategies that teach parenting skills and provide family supports alongside addiction services like family centered treatment facilities have been demonstrated to provide women with more confidence in their parenting and stronger relationships with their children. These relationships caused women to be more motivated to stay in treatment and engage with the process.[112] Ten mothers interviewed in 2020 on their experience in a family centered treatment center all indicated that they joined a treatment program because they were aware of the benefits of being able to remain with their children during treatment. Several women indicated that if given the choice between seeking treatment alone and remaining with their families, they would have remained with their families and not sought treatment at all. Women identified the support of staff and other mothers, parent-child activities and parental skill learning, and mental and physical resources for their children as beneficial features of family centered treatment.[113] The results of the interviews of these ten women indicated the importance of parental skill building in treatment to learn alternative parenting method while sober, resources to facilitate emotional and physical development for children while their parents received treatment, and compassionate care from treatment center staff.[114]

Several studies have found that women whose children are removed from their home are more likely to have another substance-exposed birth. Allowing mothers to remain connected to their children and parental role improves their recovery. Family centered programming also often teaches family planning practices, which reduce the risk of additional substance-exposed births.[115]

Although federal and state policy and procedures set an intention of family preservation or reunification, not all participants experience the child welfare system the same way. Before the age of 18, over 50 percent of Black children will likely be the subject of a child welfare

[109] Ibid., 5.
[110] *Understanding Substance Use Interventions*, 21.
[111] Ibid., 21.
[112] Jessica L. Chou, Shannon Cooper-Sadlo, Rachel M. Diamond, *et al*., "An Exploration of Mothers' Successful Completion of Family-Centered Residential Substance Use Treatment," *Family Process* 59 (2020): 1115, DOI: 10.1111/famp.12501.
[113] Ibid., 1119-1120.
[114] Ibid,. 1124-1125.
[115] Therese Grant, Janet Huggins, J. Christopher Graham, *et al*., "Maternal Substance Abuse and Disrupted Parenting: Distinguishing Mothers Who Keep their Children and Those Who Do Not," *Children and Youth Services Review* 33 (2011): 2184, DOI: 10.1016/j.childyouth.2011.07.001.

investigation.[116] A Special Committee on Child Separations in Philadelphia released a report in April of 2022 that recounted instances in Philadelphia involving:

- Children removed from the home based on false court orders, or anonymous allegations
- Taking of children from family custody for foreign adoption
- Lack of transparency by DHS in providing documentation for the basis of removal
- Loss of custody due to an abusive father or boyfriend
- Lack of adequate representation of families in Family Court[117]

Though these unwarranted separations do not make up the majority of child welfare interventions and many children benefit from intervention, anecdotal evidence in communities heavily affected by child welfare investigations causes some women to avoid treatment for fear of losing custody of their children. Because of the negative perception of the child welfare system in some communities, the Task Force highlighted programs that do not involve child welfare but offer nonjudgmental services from trusted community sources for women looking to receive treatment without unwarranted consequences to their children and families. Community-based services utilize the familiarity and trust staff build with participants. Community-based services can relieve some of the burden of the child welfare system, especially in prevention services. Aspirational models would allow families to own their own information but have qualified professionals in their community pointing them toward helpful resources that are appropriate for their needs.[118]

One community-based program is Philly Families CAN. This program receives funding from DHS but is not connected to Childline. Philly Families CAN provides support for mothers and babies from their pregnancy to when their child is three years. Each participant is assigned a support professional that will make home visits to prepare a mother for childbirth, help with the adjustment to parenthood, connect mothers with resources for their child's development, and connect mothers with resources for their own employment and healthcare. These services are offered for free. Philly Families CAN also offers a Doula Support System that focuses on mothers with a history of SUDs. The service offers support throughout pregnancy, the process of creating a birth plan, lactation support and education, advocacy for those mothers involved in the child welfare system, resources like diapers and wipes, and a virtual support group with other participating mothers.[119]

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[116] Hyunil Kim, Christopher Wildeman, Melissa Jonson-Reid *et al*., "Lifetime Prevalence of Investigating Child Maltreatment Among US Children," *American Journal of Public Health* 107, no. 2 (February 2017): 274, DOI: 10.2105/AJPH.2016.303545.

[117] David Oh, *Special Committee on Child Separations in Philadelphia: Report and Recommendations* (City Council of Philadelphia, April 2022), https://drive.google.com/file/d/1j-wwn2V1VRt7FHvHqGtDSONXxv6cYu5z/view, 4.

[118] September 19, 2022 Task Force Meeting

[119] "Welcome to Philly Families CAN," *Philly Loves Families, Philadelphia Department of Health*, accessed November 3, 2022, https://www.phillylovesfamilies.com/philly-families-can.

The Task Force also emphasized the importance of community-based services that build upon the familiarity and trust staff build with participants. Community-based services can relieve some of the burden of the child welfare system, especially in prevention services. Aspirational models would allow families to own their own information but have qualified professionals in their community pointing them toward helpful resources that are appropriate for their needs.[120]

[120] September 19, 2022 Task Force Meeting.

The Task Force made two overarching recommendations that frame each of those that follow.

First, every effort to connect families to necessary resources should focus on eliminating the stigma commonly associated with substance use disorder. This is generally achieved through training and education of healthcare and service providers at each touchpoint.

Second, the Department of Health, the Department of Human Services, and the Department of Drug and Alcohol programs should form a Work Group to collaborate among themselves and partner with healthcare providers, community-based organizations, schools, and other entities to work with mothers, infants, and families in the commonwealth's diversity of communities. The Work Group's principal guide is that existing resources should be utilized where possible, redirected where necessary, and that new resources be funded where needs cannot otherwise be met.

Co-Located Services

1. The Task Force recognizes that co-located services would help ensure that women do not have to travel to multiple locations for more than one service. Services to be co-located could include referrals and access to supports such as birth control and counseling, education about risks to substance exposed infants, early intervention services, and home visitation in places where parents are receiving treatment and rehabilitation for substance use disorders.

   Services, particularly education, should be community-based. That is, the information and services should be tailored to and provided by members of the community. In many places there are multiple touchpoints in the community that the family could access voluntarily. For example, nurse-family partnerships, doula programs, mentoring programs, and community-based programs currently exist and can be tapped to co-locate with treatment and rehabilitation providers.

   To meet this challenge, the Work Group formed by the Department of Health, the Department of Human Services, and the Department of Drug and Alcohol Programs should partner with healthcare and community service providers to create systems and the means by which local needs can be met with co-located services.

   An effort to co-locate services could begin with data reviews. For example, it would be helpful to learn the percentage of SEI babies who received prenatal care and what services are available where the prenatal care was provided. Another recommendation

could be to collect data from private insurers; Medicaid data alone would not provide a complete view. Services and resources should be accessible at healthcare providers, community services agencies, and others The Departments of Health, Human Services, and Drug and Alcohol Programs should, in partnership with service providers, coordinate efforts to deliver what is needed where it is needed.

DDAP Hotline

2. The Department of Drug and Alcohol Programs' SUD crisis hotline should be expanded to help families impacted by substance use disorder in crisis connect to services and supports without involving ChildLine in situations where abuse is not suspected. The Philadelphia Department of Public Health's Philly Families CAN program might be useful to guide the DDAP hotline's expansion into the new responsibilities. The phone line could be advertised to families through social media or with something as simple as a sticker on the papers and brochures families collect when they are discharged after birth of a child. The phone line's broadened responsibilities are not intended to replace ChildLine.

DHS KinConnector, Schools, and Families

3. The Department of Human Services' Office of Children, Youth, and Families should, in partnership with the Department of Health and the Department of Drug and Alcohol Programs, expand its current KinConnector program. The expansion would include a toolkit for educating grandparents, those providing kinship care, and foster parents on how to care for substance exposed infants and children, including information about available resources and supports. Education needs to address self-care and not solely focus on what to expect from the infant/child but what the caregivers can expect from themselves. The education and supports should include foster parents of teenagers, as well. An emphasis should be an intentional focus on preventing the next generation from suffering from SUD.

4. Existing resources should be used at multiple touchpoints, such as healthcare visits, daycares, and schools identify and help infants, children, and teenagers who have experienced substance exposure. In the case of healthcare providers, services should be eligible for reimbursement to encourage their participation.

   The Work Group should cooperate with the Department of Education to ensure that school-based Student Assistance Programs (SAPs) and school counselors have the information and tools necessary to identify and help students with SUD in their families. The Work Group's initial steps would include taking inventory of existing resources and identifying the schools' needs. Similarly, the departments should communicate with daycare programs to assist them as well.

   To achieve good outcomes through these touchpoints, the commonwealth must commit ongoing funding to positions that are solely dedicated to addressing behavioral health.

5. The Work Group should investigate opportunities for longitudinal studies that would help determine the effectiveness of Plans of Safe Care.

Naloxone Distribution and Lockboxes

6. The Department of Drug and Alcohol Programs and the Department of Health should work together to provide naloxone to at-risk families at discharge after a baby is born and make it available at subsequent home visits and medical appointments. Training on naloxone could be provided through the Department of Health or as part of WIC.

   Some hospitals do not have the resources, like an on-site pharmacy, to provide naloxone for at-home use. One potential solution would be to have patients sign up at discharge for at-home delivery of naloxone through the Department of Drug and Alcohol Programs.

7. The Work Group should, through interagency cooperation at state, county, and municipal levels and through education of healthcare and community providers, reinforce the importance of prescribing and providing MOUD for pregnant women. Many pregnant women diagnosed with SUD are not receiving MOUD when it would be an appropriate treatment modality. Further, the Work Group should address the particularly wide disparities in prescribing MOUD for pregnant women of color.

   The most effective way for the Work Group to reach medical professionals might be by adding training modules to existing training curricula or conferences.

8. The Work Group can help provide medication lockboxes to families to prevent accidental or unintentional poisonings. Strategies to broaden the accessibility and availability of lockboxes could include working with pharmacies, at discharge along with naloxone distribution, among others.

9. The Work Group should study the increase of incidents of ingestion, both fatal and non-fatal, and develop strategies to address it. Lockboxes are only part of the solution.

Workforce Development

10. The Work Group should identify strategies of how to direct resources and collaborate with Pennsylvania's colleges and universities to expand the state's human services workforce overall. Potential ideas include development of recruitment strategies to attract younger workers, to provide opportunities for training and certification, and the establishment of paid internships or apprenticeship models.

Universal Screening

11. The topic of universal screening of pregnant women, infants, and children was discussed extensively by the Task Force. There was general acknowledgement that universal screenings are an important tool widely recommended by healthcare organizations. There remained, however, significant concern that biases, inadequate training, and miscommunication can lead to unnecessary involvement of child welfare authorities and, consequently, damage the families involved.

    In response, the Task Force recommended that the proposed Work Group continue working on the subject of universal screenings.

APPENDICES

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OPIOID ABUSE CHILD IMPACT TASK FORCE

Act of Jan. 26, 2022, P.L. 5, No. 2 **Cl. 72**

Session of 2022

No. 2022-2

HB 253

AN ACT

ARTICLE I-I

OPIOID ABUSE CHILD IMPACT TASK FORCE

Section 101-I. Declaration of policy.

The General Assembly finds and declares as follows:

(1) This Commonwealth is one of the states which has been hardest hit by an epidemic of heroin and prescription opioid abuse and addiction that is plaguing American society.

(2) One of the more tragic consequences of this epidemic is the devastating impact it has had and continues to have on infants and children.

(3) Newborns are suffering through withdrawal from opioids because of prenatal exposure to these drugs.

(4) Fatalities and near fatalities of infants and young children have been linked to parental substance abuse.

(5) Cases of child abuse and neglect linked to parental substance abuse are increasing, as are the number of children being removed from their homes and placed in protective custody because of their parents' drug addiction.

(6) The Commonwealth has a responsibility to protect its residents, especially children.

Section 102-I. Definitions.

The following words and phrases when used in this article shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Task force." The task force established in section 103-I.

Section 103-I. Establishment.

A task force on the opioid abuse epidemic's impact on children is established. The task force shall focus on improving the safety, well-being and permanency of substance-exposed infants and other young children affected by their parents' substance abuse disorders.

Section 104-I. Responsibilities.

The task force is responsible for:

(1) Identifying strategies and making short-term and long-term recommendations to prioritize the prevention of substance-exposed infants.

(2) Improving outcomes for pregnant and parenting women who are striving to recover from addiction.

(3) Promoting the health, safety and permanency of substance-exposed infants and other young children at risk of child abuse and neglect or placement in foster care due to parental alcohol and drug use.

(4) Ensuring that the Commonwealth is compliant with the Child Abuse Prevention and Treatment Act (Public Law 93-247, 42 U.S.C. § 5101 et seq.) related to identifying substance-exposed infants and is developing multidisciplinary plans of safe care for these infants.

Section 105-I. Members and meetings.

(a) Members.--The task force is comprised of the following members:

(1) The Secretary of Human Services or a designee who shall be an employee of the Department of Human Services. The designee shall be appointed by the Secretary of Human Services in writing, and a copy of the appointment shall be submitted to the chairperson of the task force.

(2) The Secretary of Health or a designee who shall be an employee of the Department of Health. The designee shall be appointed by the Secretary of Health in writing, and a copy of the appointment shall be submitted to the chairperson of the task force.

(3) The Secretary of Drug and Alcohol Programs or a designee who shall be an employee of the Department of Drug and Alcohol Programs. The designee shall be appointed by the Secretary of Drug and Alcohol Programs in writing, and a copy of the appointment shall be submitted to the chairperson of the task force.

(4) Three members appointed by the Senate, as follows:

(i) two members appointed by the President pro tempore of the Senate, one of whom shall be a layperson who is a biological parent, foster parent or adoptive parent of an infant or young child with current or previous involvement in the child welfare system as a result of a parent's substance abuse; and

(ii) one member appointed by the Minority Leader of the Senate.

(5) Three members appointed by the House of Representatives, as follows:

(i) two members appointed by the Speaker of the House of Representatives, one of whom shall be a layperson who is a biological parent, foster parent or adoptive parent of an infant or young child with current or previous involvement in the child welfare system as a result of a parent's substance abuse; and

(ii) one member appointed by the Minority Leader of the House of Representatives.

(6) Two members appointed by the Governor.

(b) Qualifications.--Except for laypersons appointed under subsection (a)(4)(i) and (5)(i), individuals appointed under subsection (a)(4), (5) or (6) must possess professional experience and expertise in:

(1) obstetric medicine;

(2) pediatric medicine;

(3) behavioral health treatment;

(4) early intervention programs;

(5) county children and youth agency services;

(6) child advocacy; or

(7) neonatal intensive care unit nursing.

(c) Chairperson.--The Governor shall select the chairperson of the task force.

(d) Appointment.--The members of the task force shall be appointed within 25 days after the effective date of this section.

(e) Quorum.--The physical presence of seven members constitutes a quorum of the task force.

(f) Majority vote.--An action of the task force shall be authorized or ratified by a majority vote of its members.

(g) Meetings.--

(1) The task force shall meet as necessary but no fewer than five times during the period ending two months prior to the issuance date of the report. The first meeting shall be convened within 45 days following the effective date of this section.

(2) Additional meetings may be called by the chairperson as necessary.

(3) The chairperson shall schedule a meeting upon written request of eight members of the task force.

(4) A member not physically present may participate by teleconference or video conference.

(h) Compensation.--Members of the task force shall not receive compensation but shall be reimbursed for reasonable and necessary expenses incurred in service of the task force.

Section 106-I. Duties.

The task force has the following duties:

(1) To examine and analyze the existing practices, processes, procedures and laws relating to the diagnosis and treatment of substance-exposed infants.

(2) To review and analyze the existing practices, processes, procedures and laws relating to the safety, well-being, permanency and placement of children at risk due to their parents' substance abuse disorders.

(3) To hold public hearings for the taking of testimony and the requesting of documents.

(4) To make relevant recommendations for improving the safety, well-being and permanency of substance-exposed infants and other children adversely affected by their parents' substance abuse disorders.

(5) To issue a report in accordance with section 109-I.

Section 107-I. Hearings.

The task force shall hold public hearings as necessary to obtain the information required to conduct its review.

Section 108-I. Agency cooperation.

The Department of Human Services, the Department of Health and the Joint State Government Commission shall cooperate to provide administrative or other assistance to the task force.

Section 109-I. Reports.

(a) General rule.--The task force shall prepare and submit, two months prior to the expiration date of this article, a final report on its activities, findings and recommendations to the Governor, the Senate and the House of Representatives. The task force may file status reports and updates with the Governor, the Senate and the House of Representatives as it deems appropriate.

(b) Adoption of report.--A report under this section shall be adopted at a public meeting.

(c) Public record.--A report under this section shall be available to the public.

Section 110-I. Expiration.

This article expires 12 months after the effective date of this section.

APPROVED--The 26th day of January, A.D. 2022.
TOM WOLF

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REMARKS FOR
CHILDREN AND YOUTH COMMITTEE MEETING

Provided via email on Sept. 14, 2022 to the Act 2 Opioid Abuse Child Impact Task Force by Erin O'Brien, Deputy District Attorney for the Child Abuse Unit, Chester County District Attorney's Office.

Remarks for Children and Youth Committee Meeting
on Trends in Child Fatalities and Community Responses, 9/14/22

Good Morning Members of the Children and Youth Committee,

Thank you for this opportunity to speak to you today about trends in child fatalities and how we, as a community, can respond and hopefully work to prevent these deaths. My name is Erin O'Brien and I am the Deputy District Attorney for the Child Abuse Unit at the Chester County District Attorney's Office and I've been handling investigations and prosecutions of crimes against children for the last sixteen years. I started working in Chester County five years ago and previously served for twelve years in the Philadelphia District Attorney's Office, handling crimes of child abuse and neglect for nearly eleven of those years. For the last decade, my responsibilities have included reviewing every child fatality and near fatality in the jurisdiction, first in Philadelphia and now in Chester County. In this capacity, I've had the opportunity to see how the trends in child fatalities have changed and evolved during this time and how different, or similar, these trends are in urban, suburban and rural communities.

Over the last few years, and particularly as we have experienced the COVID-19 pandemic, law enforcement in Pennsylvania has seen subtle and tragic changes in the types of child fatalities observed.

Statistics show that youth suicide rates have been trending higher for the last fifteen years, increasing nearly sixty percent in the time period between 2007 and 2018. Before the pandemic, research from the Centers for Disease Control and Prevention (CDC) showed that 21 percent of teens experienced a major depressive episode. In 2018, suicide was the second leading cause of death for youths aged 10-24. Among youth in the U.S. who die, more than 25 percent die by suicide, according to the American Academy of Pediatrics (AAP). The isolation, fear and uncertainty of the pandemic drastically increased these numbers. Between 2020 and 2021, the number of teens experiencing a major depressive episode increased to 44 percent, with 20 percent admitting to seriously contemplating suicide. Nearly half of all youth suicide attempts involve a firearm, according to a recent report by Everytown for Gun Safety. The rapid and drastic increase in these numbers prompted the American Academy for Pediatrics to declare a national emergency in children's mental health in October 2021.

While these numbers are undeniably heartbreaking, law enforcement has only a limited role when a suicide occurs, often as the first responders to these tragic events. Our mandate is to investigate when children die under unexplained or suspicious circumstances or at the hands of another. When the circumstances raise concerns for abuse or neglect, the law requires a report to Childline, our state child abuse reporting hotline, and an investigation by both law enforcement and child protective services. Pursuant to Act 33, these deaths are also reviewed by a multi-disciplinary panel comprised of state and local representatives, for the purpose of identifying systematic changes that may improve outcomes for children in the future.

Children in this Commonwealth die under a variety of sad circumstances, far too often at the hands of the adults trusted with their care and safety. A review of the child fatalities in Pennsylvania includes a review of the deaths caused by physical abuse and torture, where children suffer repeated physically abusive acts at the hands of those charged with their care while also being deprived of the necessities of life, often including care, food, water, and proper shelter. In this Commonwealth, each year we see infants who die after being shaken, slammed, struck and thrown for such transgressions as waking too frequently or crying and disrupting a caregiver's online activities. We see children killed by parents and caregivers in horrific incidents of physical abuse, often disguised or explained away as physical discipline. And tragically we see incidents of child torture where children suffer a combination of physical and mental or emotional abuse, combined with neglect and depravation, hidden away from the protections of society and the assistance of those tasked with the health and safety of children. These incidents are unmistakably criminal and our laws are clearly meant to punish those who choose to commit these heinous acts.

In recent years, we have begun to see a new trend in the child fatalities of the Commonwealth, deaths by neglect or lack of supervision and deaths by ingestion. While certainly the phenomenon isn't entirely new, one need only look to the published child fatality reports for 2020 and 2021 to see a disturbing and significant upward trend of children dying after either the child or parent ingested a controlled substance. In February 2020, a three year old male in Carbon County died after ingesting illegal drugs while in the care of his parents and caregivers who later admitted leaving drugs and paraphernalia around the home. In July 2020, a 14-year old male in Dauphin County died after overdosing on illegal narcotics which his caregivers knew he was using to excess and did not attempt to address. In September 2020, a one-year old child in Allegheny County died after ingesting illegal substances left around the house by his caregivers, who had previously been the subject of multiple reports regarding their substance use and failure to protect their children. In March 2021, a two-month old Bucks County child died after being found unresponsive in bed with her parents who tested positive for illegal substances. At the time of her death, the parents' contact with the child was required to be supervised by the maternal grandmother due to previous reports regarding the parents' substance use and inability to protect. These incidents are just some examples of a trend we are seeing across the Commonwealth, an unanticipated byproduct of the opioid epidemic. In Chester county, we've seen children die both from ingesting illegal substances, or the drugs meant to assist with addiction to these substances,

and children who have died due to the substance use and abuse of their caregivers which rendered them unable to supervise or even to wake up when their children are in distress. We've learned about the developing research into the levels of these substances in the blood of children who die from ingestions nationwide and that substances like Narcan, which can immediately reverse the effects of an overdose in an adult, are far less effective when the patient is a child who has ingested fentanyl or suboxone. We've seen children killed by a parent who knowingly and intentionally gave the child illegal substances, perhaps in an attempt to make the child sleep, and too many children who die in bed with adults under the influence of illegal substance who suffocate during the night. Between 2019 and 2020, drug overdose and poisoning increased by 83.6 percent (including a 110 percent increase in unintentional poisonings), becoming the third leading cause of death among children and adolescents.

Another disturbing fatality and near fatality trend related to neglect and lack of supervision has also begun to emerge, child deaths by firearm. In 2020, firearm-related injuries became the leading cause of death among children and adolescents in the United States. Nearly 2/3 of the 4,368 U.S. children who were killed by guns in 2020 were homicide victims. Of the remainder, 30 percent were suicides, and 5 percent were accidental or of undetermined origin. Male youths are significantly more likely to be killed by firearms than females and the firearm death rate for black children is more than four times higher than for white children, for whom auto accidents are still the leading cause of death. A 2015 study comparing the United States and 28 other highly-populated countries found that the US accounted for the overwhelming majority of firearm-related deaths in children, including 97 percent of deaths of children 4 and under and 92 percent of deaths of children aged 4-17. In Pennsylvania, we see children dying from gun violence in the community and children dying from gun-related accidents in the home. In January 2020, a four-year old Philadelphia child shot himself inside his parent's bedroom with his father's firearm which had been left in an unsecured location. In January 2021, a nine-year old Philadelphia child was shot to death in her home by a 12-year old sibling with the father's unlocked and unsecured firearm. In February 2021, a 16-year old Beaver County girl died after being shot by her mother, who reported planning the homicide in advance. In May 2021, an eleven-year old Monroe County child died after being shot by an older sibling playing with a firearm believed to be unloaded. Just a few months ago in Chester County, a 4-year old boy shot himself in the face, fatally, after finding his older brother's gun unsecured in his bedroom. An older sibling found the victim and tried to perform CPR after hearing the gunshot. Again, these are just a few examples of the incidents of Pennsylvania children dying as a result of firearm-related injuries in recent years.

As a community, we can respond to these trends and work toward preventing these deaths, just as safety measures and responses aided in driving down the number of automobile-related deaths in children. Community members are key in addressing and preventing all child fatalities, especially suicide deaths and those caused by lack of supervision or neglect. Adults who work with or interact with children regularly in the course of their employment are trained to look for the signs of abuse or neglect, or signs that the child is in distress, and for reporting concerns so that children may be protected. A key part of ensuring that those trusted adults can assess and evaluate is making sure that children have connections in the community beyond their own homes, with schools, doctors, community members, and others tasked with the protection of children. When these protections were severely curtailed during the pandemic, we immediately saw consequences for the children who need them most.

No doubt there are many things that can be done at the state and local level to help mitigate these tragedies. But it is also very important that we all first understand the nature of the problems, as well as the trends we are seeing. I appreciate you allowing me to discuss what we are seeing currently. There is too much tragedy, and it has only gotten worse. I am happy to answer any questions and to work with you going forward.