General Assembly of the Commonwealth of Pennsylvania
Joint State Government Commission
Room 108 Finance Building, 613 North Street
Harrisburg, PA 17120
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(Act 2) Meeting of the Opioid Abuse Child Impact Task Force
August 15, 2022, at 1:00 p.m. - 3:00 p.m.,
via virtual and in-person at 2525 N 7th Street, Harrisburg, Pa 17110

SUMMARY OF PROCEEDINGS

I. ATTENDANCE

Task Force Members: Hon. Meg Snead, chair; Robin L. Adams, B.S.; Carolyn Byrnes, (designee of Hon. Denise Johnson, M.D.); Kimberly A. Costello, D.O.; April Lee; Sheryl Ryan, M.D.; Leslie G. Slingsby, L.S.W.; and Hon. Jennifer Smith

Task Force Members: *via* virtual connection: Jamie Drake, B.S;

Department of Human Services Staff: Charles Tyrell, Director of PeopleStat; Cristal Leeper; Catherine Stetler

Joint State Government Commission Staff: Glenn Pasewicz, Executive Director; Allison Kobzowicz, policy analyst; Dan Nguyen, legislative intern.

II. DISCUSSION

The Chair opened the meeting by initiating a discussion about what had been accomplished at the previous meeting. The meeting opened with introductions of the Task Force members and staff, including Charles Tyrell, Director of PeopleStat at DHS, who had been invited by the Task Force Chair to provide information to the Task Force.

Secretary Snead emphasized the importance of finishing the report in a timely manner so that it can be released before the governor's administration ends. Further, it is hoped that the task force will generate momentum that will carry forward from the end of the current gubernatorial administration to the next.

The chair reviewed notes that the Task Force wanted to set goals and policies that focus on prevention. This meeting's discussion was expected to focus on the measurable outcomes intended to reduce the number of Substance Exposed Infants (SEI), on whether the interventions are working, and to promote health, safety, and permanency. Moreover, the outcome measures should observe how long kids are in foster care and track their route to permanency.

A recommendation was made around funding and whether/how more money ought to be allocated to private providers instead of counties and to incentivize different ways to get to the desired outcomes.

Co-locating Services

There was broad agreement that reducing the number of SEI might be helped if certain clinics (MAT, 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 because not all locations are able to provide 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 PHC[4], 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

There was a comment 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 noted that the March of Dimes does have state-specific data. Members questioned whether data exist for successive pregnancies. For example, are there data points for the percent of 2nd or 3rd pregnancies that are unwanted? Ultimately, policy makers would need more universal tracking of pregnancy and parenting.

Task Force members were reminded that PAPQC (Pennsylvania Perinatal Quality Collaborative) is collecting data on this issue, and 80 percent of the birthing hospitals belong to the PAPQC. If they all participate, one of the requirements could be that they submit the data. There could be a simple metric for the number of prenatal visits.

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, 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 counites 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.

<u>Potential Recommendations</u>

Secretary Snead state that the Task Force appears to have coalesced around two main recommendations:

1. Co-locate birth control, counseling, and other related services with clinics and providers where women with SUD are likely to be so that they do not have to travel to multiple locations.
2. Require agencies that provide POSC to report data on outcomes to develop a system of best practices.

She further observed that the discussion seemed to have shifted from prevention to intervention.

There seems to be no 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 of 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 and there are 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 grant is 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.

There was a brief discussion about recommending Eat, Sleep, Console as a best practice. ESC has not yet been recognized as a best practice, but it is one way of providing care. It 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. It really 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 & mortar or room & 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.

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.

Perhaps each Task Force member could email Catherine Stetler with a list of particular data points they would like to see, which could then be communicated to DHS partners at the University of Pittsburgh and Penn State University to see what sorts of data analyses can be done.

It was suggested that the Task Force look at demographics such as race, which plays a significant role in terms of access, how services are accessed, and length of engagement in services. Rates of SUD deaths are skyrocketing among Black people whereas other races' rates appear to be plateauing. It could be important to assessing some solutions.

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III. ADJOURNMENT

The meeting adjourned at 3:00pm. The next meeting is scheduled for 1:00pm Monday, September 19, 2022 at the CoPAHUB, Hilltop Conference Room 115, located at 2525 N. 7th Street, Harrisburg, PA. Contact ra-pw@2TaskForce.pa.gov for virtual connection.

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