General Assembly of the Commonwealth of Pennsylvania
Joint State Government Commission
Room 108 Finance Building, 613 North Street
Harrisburg, PA 17120
717-787-4397

April 8, 2022

(Act 2) Organizational Meeting of the Opioid Abuse Child Impact Task Force
March 28, 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: Honorable Meg Snead, Robin Adams, Kimberly A. Costello, D.O., Denise A. Johnson, M.D., April Lee, Cheryl Ryan, M.D., Leslie G. Slingsby

Task Force Members: *via* virtual connection: Jamie Drake, Honorable Jennifer Smith, Angela D. Zawisza, D.O.

Department of Human Services Staff: Jon Rubin, Deputy Secretary, Catherine Stetler, Cristal Leeper

Joint State Government Commission Staff: Glenn Pasewicz, Frank Lill, Wendy Baker

Absent: Michael J. Lynch, M.D. (Appointed April 4, 2022)

II. INTRODUCTIONS

The meeting opened with administrative announcements including a statement that future meetings will include an opportunity for public input. Further, a resource account is available to accept questions and comments, ra-pwact2taskforce@pa.gov.

Acting Secretary of Human Services Meg Snead, chair of the Task Force, opened the meeting by asking the Task Force members to introduce themselves.

Following member introductions, Secretary Snead stated that the focus of this initial meeting is to set a path forward to create recommendations and hands-on actions that can be taken to improve outcomes for infants and young children affected by their parents' substance use disorders.

Task Force reviewed its goals, as listed in Sections 104-I and 106-I of Act 2.

(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.

The Task Force will gather input over the course of the project through public meetings, expert input, data review, and soliciting outside testimony. The Task Force will develop a common vision for the future, assess the current state of work happening in Pennsylvania, identify gaps between the current status and the vision for the future, prioritize areas for improvement in the system, and develop recommendations for a final report that will be submitted to the General Assembly and the governor.

III. DISCUSSION

For the purposes of this initial meeting, the discussion focused on setting a shared vision. The starting point was a discussion on what the system would look like if it were already working well to ensure the safety, wellbeing, and permanency of substance exposed infants and other young children affected by their parents' substance use disorders.

Identify Families at risk

A first step would be to identify families at risk. Pennsylvania does not have a standard screening process for parents and families at risk across all of the hospitals. There are approximately 100 birthing hospitals in Pennsylvania. Some of them have robust screening processes (these are not testing processes). Screening should be normalized and standardized just as it is with pre-natal labs. Hospitals should, as they test for various diseases (HIV, syphilis, for example) also test for drug exposure. Further, a woman who is using opioids is probably also using other licit and illicit substances that can cause harm, such as marijuana, alcohol, and tobacco. The screening needs to be broader for other substances that can have a significant impact on the baby. Task Force members agreed that screening ought to begin at the first pre-natal visit and continue through neonatal care. As pregnancy progresses, stress increases, which could cause a relapse or lead to other potentially harmful situations. Because many women do not receive regular pre-natal care, screenings ought to occur at multiple times throughout their pregnancies to help prevent cases from falling through the safety net.

In Pennsylvania, providers use their discretion to choose who to screen. The stigma ought to be taken away by standardizing the protocols so that all families are screened. For example, a robust hospital model would start with a questionnaire for the families. Answers that are flagged can lead to testing such as urinalysis of mothers and newborns and umbilical cord toxicology tests. A hospital with a less robust screening system might pick and choose the families that are screened. The mother could feel the threat of being stigmatized unless she is aware that screening are indeed universal and not based on her particular appearance.

Perceptions of stigma and distrust

There are concerns that screenings and testing could lead to the perception that punitive measures may be taken against mothers and family members who are themselves struggling with substance use disorder. The threat, real or perceived, of losing children to the child welfare system or that other legal or criminal action could result may lead individuals to avoid screenings and create barriers to women seeking pre-natal care altogether. The task force needs to normalize treatment to help alleviate or even eliminate stigma.

There was broad agreement that screenings need to incorporate appropriate tools and be administered and interpreted by staff that is trained to understand screening results and that is able to connect mothers to appropriate helpful resources. One suggestion was that incorporating screening results into electronic health records (EHR) would allow appropriate staff to conduct follow-up care as necessary. The Nurse Family Partnership, among other home visiting programs, could provide a good example of how a helpful screening and resources system could be structured.

In an ideal situation, screenings would be done in a non-biased way that would be followed by non-punitive support to build trust in the system. Further, universal screening cannot be synonymous with cookie-cutter assessment and cookie-cutter treatment. In other words, just as substances are not all equally harmful, not all instances of their use necessitate the same methods of treatment and potential consequences. Rather, the term universal implies that screening is provided to all mothers seeking pre-natal and neonatal care and that appropriate resources, including trauma specific care, is provided to all who need them. People will have to know that there will be appropriate help provided to mothers and babies and that the screening tools are not leading toward family separation and increased trauma for mothers and babies. Otherwise, stigma, uncertainty, and fear increase the chances that submitting to screenings risk becoming a deterrent rather than an incentive. If perceived as a deterrent, people will hide their substance use, which will lead to worse problems.

Discussion followed about whether and how often doctors make reports to the child welfare line. The perception should be that referrals made through a screening system would strengthen rather than threaten family relationships. It is unlikely that calls are made by OBs during pre-natal visits. However, the surveillance begins with the OB visits. This is somewhat more common when mothers are known to be clients of MAT programs, despite that their participation is medically necessary.

An aspirational goal would be to have all the systems, for example criminal justice, child welfare, healthcare, and public safety work together to keep families together and healthy. Efforts to improve one or more of those systems become all the more challenging without a holistic approach. The reality is that a mother's fear might not be with the healthcare system itself but with the other systems that might become involved. Yet, perceived notions that these systems communicate with each other and perhaps even conspire with each other could lead to resistance and mistrust of the systems that are ostensibly designed to help.

Pilot programs and insurance coverage

DHS expanded the Medicaid coverage period from 60 days to a full year following the birth of a baby. While this expansion does not address the actual supports and services needed, the insurance coverage provides a starting point for accessing resources. It is possible for pilot programs to be matched with insurance coverage through the use of Medicaid waivers. One particular type of support being considered by DHS is in the area of providing insurance coverage or payments for doulas. The department recently established a pilot doula program at SCI Muncy.[1] Seven women who are either pregnant or recently gave birth are participating in the program that provides a doula to each woman and her baby for one year of supports and services. Hopes are that the program can be scaled up to other institutions.

There have been other pilots, doula and peer support, that have shown themselves to be successful models for helping mothers navigate the insurance, medical, and child welfare systems. There is tremendous value in having someone trusted and reliable who is available to mothers as they work through their treatment, relapses, and who believes in the women's positive outcomes.

Members noted that pregnancy prevention might be part of an ideal plan. Most of the mothers who are suffering substance use disorder, as many as 80 percent, are experiencing unplanned pregnancies. One particular data element that might be worth checking is the uptake in long acting reversible contraceptives (LARCs) that may be offered to women with SUD.

An example of a successful program is "Eat, Sleep, Console" which, over the course of a year, reduced admissions from the newborn nursery to the NICU by 58 percent and length of stay by two days. Consequently, the NICU could be used for babies who really needed NICU care while NAS babies stayed with their mothers and then were either discharged home or admitted to NICU. Many hospitals that do not have resources to provide such supports are relying on medications for NAS, which can themselves lead to future problems. Excessively long stays in neonatal NICUs are a form of family separation and are not good places for babies to be for long periods of time. Task Force members recognized that more hospitals can do it with appropriate training and education. The hospitals that are providing the services need systemic supports, as currently hospitals, nurses, and staff have limited resources for providing help after delivery.

A lot of the supports being discussed by the Task Force are not directly reimbursable through insurance programs. Peer support and a lot of the activities that can eliminate stressors and other conditions that exacerbate substance use disorder are not paid for through insurance. The challenge for policy makers will be to find ways to pay for them.

Medicaid can fund demonstration projects, however. DHS could help break down barriers by testing whether or not a program works and then possibly scale up. The MCOs have value-based purchasing agreements that match targets with how much risk they assume.

[1] The State Correctional Institution at Muncy is a medium/maximum security facility for adult female offenders. https://www.cor.pa.gov/Facilities/StatePrisons/Pages/Muncy.aspx

The drug and alcohol field operates from the perspective of a continuum: prevention, intervention, treatment, recovery, support. The Task Force ought to considered recommendations in these different modes. The services and the supports should be multi-generational to include the whole family context.

Data

There was discussion about what sorts of data would be useful for the task force to consider as it moves forward, especially in terms of data and data sharing. If the task force wants data it will need a catalog of what is readily available to policy makers and what other data elements need to be collected. It would be extremely important to see data on what happens to post-partum women with SUD, especially, those who are in MAT programs.

Another area worth considering would be data and information about children beyond the newborn stage to find out what happens to them. Some children might be in out-of-home or out-of-family placements, some may with their biological parents. There could be research into whether they made their well-baby visits, or how they are progressing in school, for example. It could be helpful to know how many NAS babies met their well-baby visits, and if there are health problems that they experience that non-NAS babies do not suffer. With eighty percent of NAS babies being medical assistance eligible, real time Pennsylvania data are available.

One weakness in Pennsylvania is that there is not adequate data sharing across hospital systems. Market competition prevents data sharing from one system to the next. It would be valuable if hospitals would work together to learn from one another about what works. A hospital that has excellent results with length of stay, knowing how many are diagnosed with NAS, what types of treatment they receive could partner with a hospital that is struggling. There could be incentives for hospitals that direct resources to those that share their knowledge. Other data elements to consider are the families' economic environment, poverty, their community settings, status, class, race, and other social components of health. It will be important to gather as much demographic data as possible because the data are likely to illustrate outcome disparities. Also, it would be helpful to have aggregate data on successful outcomes to help show what types of interventions and supports work. From a systems perspective, it will be important to know what local resources are available and what can be matched to local needs. The Centers of Excellence might be resources for supports.

Task Force members considered if the market share issue can be eliminated if systems are in place so that there exists no economic impact for providing services. There might be an opportunity to make a recommendation to make a pilot program that allows a hospital to provide services without being placed at an economic disadvantage.

Bucks County has a group of hospitals that collaborate in the Bucks County Community Partnership. The partnership was established to benefit of the community through community-wide planning. A similar program is to the Pennsylvania Perinatal Collaborative, through which hospitals are able to share information. Hospitals might find a unifying source for collaboration where they address the opioid epidemic in their community needs assessments. There has to be

an incentive for the hospitals to participate. Perhaps criteria need to be set to motivated hospitals to get the programs in place.

Education and plans for mothers and families

Task Force members' experiences are there is little to no information available to parents, particularly foster parents, who care for NAS babies. As it turns out, new parents are largely on their own to learn how to appropriately care for their babies. Parent kits with information and contact information for help and supports could be vitally helpful. Kits could be attached to an existing vehicle, such as are available through the DOH. The information would look different for parents who are in different stages of SUD treatment and recovery, and have perhaps slightly different information depending on the child's and parents' needs.

It will be necessary to consider which supports are needed that are outside the scope of what might simply be "a referral to services." There are resources out there but matching resources and the connection to the resources is not available. For example, a person in treatment might need childcare, or might not have transportation, or might not be able to take time from work. Oftentimes basic, inexpensive solutions are overlooked when those could be what is really needed to allow the overall system work.

What families need are plans that are understandable, that are co-created with support staff, and that meets basic needs and then build. Plans need to be realistic and achievable. The goal should be to keep families together and the objectives should be to create plans, based from the family's perspective, that include the supports they need.

Treatments need to be individualized. The system needs to be flexible to meet the needs of the individuals it serves. There needs to be consistency in how people are treated, with some sort of universal criteria, an unbiased template such the need identifies the resources that are needed. There may even need to be instructions and supports to make treatment achievable. One potential model to follow may exist in the mental health field, which seems to have made strides in reducing stigma. Further, DDAP has integrated stigma work in the SUD space that is research and evidence based. DDAP is developing a multipronged approach, the first in the nation, that elicits behavior change as opposed to simply targeting stigmatizing language. The efforts grew out of evidence-based pilots that had been run in mental health. The pilot studies social media habits and works with social media influencers to get word out to people. It also works with community-based organizations to reduce stigma. It might be achievable to make a program shift from a destigmatizing the general SUD population to helping parents suffering from SUD and substance-exposed children. This might be where peer supports are most helpful.

IV. ADJOURNMENT

The meeting adjourned at 2:55PM. The next meeting is scheduled for April 25, 2022, at the CoPAHUB located at 2525 N 7th St. in Harrisburg.