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

Updated: 6/16/22

(Act 2) Meeting of the Opioid Abuse Child Impact Task Force

May 23, 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

(13 pages)

I. ATTENDANCE

Task Force Members: Hon. Meg Snead, chair; Robin L. Adams, B.S.; Kimberly A. Costello, D.O.; Hon. Denise A. Johnson, M.D.; 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.; Michael J. Lynch, M.D., Angela D. Zawisza, D.O.

Department of Human Services Staff: Jon Rubin, Deputy Secretary Office of Children, Youth and Families and Catherine Stetler

Joint State Government Commission Staff: Glenn Pasewicz, Executive Director and Wendy Baker.

II. DISCUSSION

The Chair opened the meeting by initiating a discussion about what had been accomplished at the previous meeting.

There were three presentations with information on:

- Perinatal Quality Collaborative;
- MDWISE, CAPTA grants, and plans of safe care
- Neonatal abstinence syndrome

Dr. Johnson recommended that, since the task force's discussions had largely been focused on prenatal and infant care, the task force spend time discussing problems faced by children.

The meeting then proceeded with the first of two presentations.

Marisa McClellan, Administrator, Dauphin County Children and Youth – Safe Plans of Care

Based on discussions at the previous meeting that addressed plans of safe care from the broad, state-level perspective, the Task Force felt it would be helpful to look at plans of safe care from the operational level. It is important to keep in mind that different counties have different approaches to Plans of Safe Care because each is responsible for running its own system.

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. 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.

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 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.

With regard to mental health, there is only one in-patient mental health center for mothers and babies in the U.S. It is located at the University of North Carolina at Chapel Hill and has five in-patient beds. The Task Force needs to keep in focus the importance of keeping mothers and babies together and of providing family support.

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. The majority of families who are prompted do engage with SPOC.

A task force member inquired about the data regarding agreement to participate in programs or being hesitant and refusing the program; additionally, they wanted to know 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.

SPOC recognizes 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 Child Welfare from the meetings so that families are more willing to engage with services and supports without the perceived heavy handedness of Child Welfare 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 Child Line 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.

The Task Force needs to develop recommendations for how CAPTA dollars could easily and quickly move to community-based providers more easily than how it works at present.

<u>Secretary Jennifer Smith, Department of Drug and Alcohol Programs (DDAP)</u>

Secretary Smith's presentation opened with a brief overview of the department and its responsibilities. She highlighted statistics about overdose deaths and how DDAP collaborates with DHS in prevention and intervention initiatives, and the Parent Advisory Council.

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 delivery 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.

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).[1] DDAP's stigma reduction initiative is driven by a partnership with Penn State University, PGP, and addiction treatment provider Shatterproof.[2] 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 as a result 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.

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.

[1] "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

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

Secretary Smith discussed data showing the successful outreach of the initiative that is presented in the meeting handouts. 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.

271 Pennsylvanians have shared their stories for the campaign. There are 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 is some data on how the first year of the campaign went. It was found 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. If it becomes easier to establish a treatment facility in a neighborhood that previously hadn't and that is a result of the campaign, that is indicative of actual behavior and attitude change—permanent change in how people feel and willing to act. Prior to the campaign, there was significant research done; surveys were administered, and public opinion taken to find where stigma was the most pervasive, breaking it down by groups like age groups, demographics like urban versus 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 capacity is the big issue, not having the right capacity in the right places. Overall, Pennsylvania probably has adequate capacity but it is not always in the right places. Insurance coverages are complicated, 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 MAT, is a better and easier course of treatment. People's treatment decision 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.

There was discussion regarding the use of the Life Unites Us data that links areas of need with birthing hospitals. It would be extremely valuable 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 will 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 are improving. However, problems remain with regard to 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 have to be connected to some type of system. It suggested that this is a potential area of 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.

Data

A discussion of the data sources, availability, and applicability was tabled until the next Task Force meeting. For example, there is no current data system that can filter fatalities from SAI notifications, and the Task Force might recommend that a system be constructed to allow for cross-walked data manipulation, or longitudinal studies. There should also be a discussion about

how the systems communicate across program and department lines. A question for discussion could be, "If you had all the data available, what would you want to know?" It would also be helpful to look at the systems by identifying what is working well and why it is working well to see if the lessons learned can be applied to areas of need.

Future discussion could direct toward whether the systems cross-lock and talk to each other or data stops flowing abruptly between agencies. As an example of difficulties with data, there are six-month data (by county) reports on kids in foster care but immediate access to data is unavailable.

There are "hard stops" between agencies. For example, one department may stop collecting data without it being picked up by another department. This problem probably occurs even within departments.

Concluding Discussion

It was suggested that for the next meeting Dr. Lind and Dr. Corr from Penn State might be able to share insights on medical data. Also mentioned was DHS statistician Chuck Tyrell, who could discuss DHS data. It was noted that the Task Force needs to know what it would want do with the data—it does not want to ask for too many parameters and get overwhelmed. Reliability of data is also a concern. There is also consideration that data may not be used immediately but hopefully is still usable years from now.

A task force member brought up how cross-systems collaboration with regards to data already exists in places like Philadelphia. When recommendations come out, they have teeth to them. Policy makers have a good sense of what is working and what is not.

A task force member found the slide in Secretary Smith's presentation about programs for pregnant women or women with dependents interesting. With deaths decreasing, more babies are being born. Now there is the issue that there is no way to fund keeping child and parent together; a parent has to make a decision to either get support or stay home with child. Some organizations do provide those types of services. Sustainability is a concern. Someone mentioned that the Family First Prevention Service Act included a specific provision related to family-based residential treatment, in which Pennsylvania had declined to participate. This program may be worth revisiting in a discussion. Utah and Delaware have been supportive in upscaling these types of programs, and it may be possible to learn about the braided funding is and if it is possible in Pennsylvania.

III. ADJOURNMENT

The meeting adjourned at 3:00pm. The next meeting is scheduled for 1:00pm Monday, June 27, 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.

Last updated: 6/16/22 at 2:00PM