



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

May 5, 2022

---

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

April 25, 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: Robin Adams, Denise A. Johnson, M.D., April Lee, Cheryl Ryan, M.D., Leslie G. Slingsby, Honorable Jennifer Smith

Task Force Members: *via* virtual connection: Kimberly A. Costello, D.O. Jamie Drake, Michael J. Lynch, M.D., 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 and Frank Lill

Absent: Honorable Meg Snead

**II. INTRODUCTIONS**

Jon Rubin announced that the Honorable Meg Snead would be absent from the meeting and that she designated him as acting chair for today's meeting. Mr. Rubin asked the Task Force members to introduce themselves, including Michael Lynch who was appointed on April 4, 2022.

**III. PRESENTATIONS**

The bulk of the agenda and most of the meeting was dedicated to three presentations about the commonwealth's systems' structure for handling substance use disorders and pre-natal, neonatal, and infant care.

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

Dr. Kelley presented information about the PQC program in Pennsylvania.<sup>1</sup> The state's PQC began in 2019 after several years of work in the area of reporting neonatal abstinence syndrome (NAS) that originally began at Pennsylvania Health Care Cost Containment Council (PHC<sup>4</sup>). There is continued support from DDAP, DHS, DOH, and other stakeholders. The PQC is administered by the Jewish Healthcare Foundation and WHAMglobal. More information can be found at the PQC's website <https://www.whamglobal.org/papqc>.

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).

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 PA are born in hospitals that participate in PQC.** It is important to have 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.

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 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 the area of standardized care. At the start of the PQC, there were 33 percent of systems that 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 more than double the percentage of providers when PQC was first initiated.

---

<sup>1</sup> U.S. Centers for Disease Control and Prevention, "Perinatal quality collaboratives (PQCs) are state or multistate networks of teams working to improve the quality of care for mothers and babies."  
<https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pqc.htm>

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.

In summary, 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.

## **Discussion**

### *Data and participation*

Discussion following Dr. Kelley's presentation compared West Virginia's PQC data collection to Pennsylvania's PQC data collection, whether there are data about use of screening tools and their success, and Plans of Safe Care. Each state's initiative's responsibility is data collection and PA PQC is currently going through a survey about which hospitals use Plans of Safe Care. There are a lot of data being collected that are not yet ready for publication.

Task Force members asked about what is preventing 100 percent participation in PQC, and what would prevent an institution from participation. Because of COVID, there were staffing challenges for many providers. There is an effort to bring more on board and there will be opportunities to do so when COVID is having less of an impact. COVID presented a huge fiscal and fiscal economic impact on hospitals. It takes time, energy, and money to participate. Participation is based on hospital goodwill because hospitals are not robustly funded to participate. Some rural communities have challenges because they do not offer NICU services, for example. Plans of Safe Care have been a focus all along and is currently undergoing resurvey with hopes that it will reach 100 percent.

The data are difficult to collect because of variations in the definition of NAS. Some physicians look at the definitions differently from one another, and their approach to treating NAS is different. PQC is working to get doctors, nurses, and other staff to work from the same definition of NAS so as 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. It also has to do with how the observations are coded and which computer systems used.

For example, hospitals are required to do Plans of Safe Care, but it is difficult to do correctly. PQC is constructing a flow chart to provide to hospitals. PQC is very resource intensive, which is why not all hospitals joined. Hospital must pay staff to attend all-day meetings, and there are hospitals in PA that do not have the resources to participate at the level they need to. They need to identify the need and then identify someone to “run with it.” The hospitals have to provide coverage while participates are at meetings, for example. Participation a struggle for small hospitals.

Hospitals face ongoing staffing problems, especially with nursing. PQC is looking at ways to help hospitals participate. Data collection is labor intensive, and there has to be a system in place to collect the data. There have to be champions within the systems, doctors, nurses, patient advocates.

The question arose over if PQC is a peer support model where hospitals help each other. The answer is yes, there are sharing opportunities for best practices. The AIM are innovations in maternal care, there is a lot involved, including protocols that mothers are discharged safely to help reduce maternal mortality.

### *Stigma*

Task Force members asked if there are checks and balances in the PQC to combat stigma. There is continued need to educate and retain healthcare professionals, families, and the stigma about treating with MOUD. There is a lot of misinformation about MOUD and pre-natal health. SUD is a disease that needs proper treatment. Some organizations have anti-stigma training for staff, but training is not universal.

There is peer support. Community health centers have teams, and most of the time, if not all the time, there are team members who are involved who have lived experience. Some teams have community health workers who are out in the community. It is essential in making this as effective as possible.

### *Screening tools*

One of the statistics cited is that 100 percent of the PQC participants are using a screening tool. Members discussed how can this experience be used to help the Task Force and what practices would be helpful to the Task Force. There are probably a host of tools that are helpful. All the health systems probably have tools in place but whether it is happening with every mother is unknown. There are questions such as, “What are you doing with the results? What are the barriers

around screening? What is done with results? Are people comfortable with being assessed and are they getting appropriate care?"

There are objections to universal screening because of the stigma associated with SUD. There can be "vast unintended consequences" if biased screeners who do not have trauma-informed training and who do not have stigma training fill out the form. That form could look vastly different from one filled out by someone who does have the training. The outcomes are not always healthy for the children, either. Child separation still has consequences without having someone in place who is trauma informed making the diagnosis. That being understood, there is risk that a mother might, without universal screening, go undiagnosed and would not get the treatment she deserves. The consequences of mothers not being treated is a grave concern and is particularly dangerous for the outcome for the infants. It is a balancing act and is challenging.

Robert Ferguson, MPH, Chief Policy Officer of the Jewish Healthcare Foundation, which administers the PA PQC, was noted as a possible contact for data.

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. Prenatal prevention efforts were targeted based on data findings from the study. The most common substance was THC and the second was opioids. It helped target prevention efforts. Task Force members wondered if it would be possible and what would it cost for PA to conduct a similar study.

Dr. Michele Walsh, Ph.D., LSW, Executive Assistant OCYF (DHS Office of Children, Youth, and Families)

Dr. Walsh presented materials about MDWISE, Plans of Safe Care, and use of federal CAPTA funding. There was a quick review of legislation.

Plans of Safe Care: The Child Abuse Prevention and Treatment Act (CAPTA) has been around since 1974 as the primary source of funding for child welfare services. It has been amended several times, including 2016's Comprehensive Addiction and Recovery Act (CARA) which had a big impact on how plans of safe care are developed. CARA amended CAPTA to include all substances (as compared to illegal substances) and now includes Fetal Alcohol Spectrum Syndrome Disorder (FASD) and now includes family members as well. Act 54 of 2018 is the Pennsylvania response to align with CARA changes to Plans of Safe Care and includes FASD, family members, and expanded from DHS to include DDAP and DOH.

Multidisciplinary Workgroup on Infants with Substance Exposure (MDWISE): MDWISE was formed in 2017 to minimize prenatal exposure to substances and improve infant, child, and family outcomes and to bring Pennsylvania into compliance with CAPTA/CARA.

MDWISE's goals are in two phases focused on compliance because of funding pieces. The accomplishments of the first phase were to closely define "affected by," in terms of substance use exposure, as a detectable physical, developmental, cognitive, or emotional delay or harm associated with maternal substance use. There is a lot of room for interpretation in all of those

pieces. Part of the compliance with CAPTA was to look at how the county teams fully understand the term and who the population is. MDWISE developed the Plans of Safe Care guidance document and rolled it out in a series of Governor's Institutes in 2019. All 67 county teams participated. There were follow-ups for technical assistance. MDWISE involves DHS, DDAP, DOH, and counties were supposed to develop county teams to address physical, psychological, substance use, and anything they felt was needed for their populations. The counties participated and drew in new stakeholders. Phase 2 goals are to carry out the work done in Phase 1. Three subcommittees were formed: Education, Policy & Practice, Technical Assistance.

*Education's* purpose is to develop and disseminate specific resources to support implementation and delivery of Plans of Safe Care.

*Policy & Practice's* purpose is to maintain, update, and revise Plan of Safe Care policy documents.

*Technical Assistance's* purpose is to support county Plan of Safe Care teams with the delivery of monthly virtual informational and roundtable discussions.

The education subcommittee is looking at statewide presentation, including the roles that Centers of Excellence (COE) can play with Plans of Safe Care.

The Roadmap to Plans of Safe Care was developed for the Governor's Institutes to show the relationship of relevant entities, which include the federal HHS, Pennsylvania DOH, DDAP, DHS (including representation from OMHSAS, OCYF, OCDEL, and OMAP). The Governor's Institutes rolled it out to educate, engage, and get feedback from counties.

As outlined in the legislation, Plans of Safe Care are for infants up to one year of age who are affected by substance use or withdrawal symptoms from prenatal drug exposure, or a FASD, and their families and caregivers. The federal legislation does not require particular forms of screening or assessment. It does not outline steps for a provider to use to determine if an infant is affected. Those directives are left to the states. Pennsylvania, having a county administered system, leaves the decisions to the counties.

In Pennsylvania, the plan is a document that lists and directs services and supports to provide the safety of wellbeing of an infant affected by substance abuse, withdrawal, or FASD, including services for the infant and family and caregivers. Each plan is to be created by a multidisciplinary team. Plans are voluntary; families choose to participate.

ChildLine: Physical health providers are required to provide information to Child Line when they are involved with the delivery or care of a substance affected infant. Other requirements are that a multidisciplinary team become involved and the family is offered a plan of safe care. The law states that the notification submitted is not a report of child abuse. The distinction leads to confusion and has been a major point of contention.

Dr. Walsh showed a slide of the steps included in a Plan of Safe Care workflow from a clinical physical health perspective. The general steps to developing a Plan of Safe Care include identification of the mother and infant, notification to ChildLine, convening of a multidisciplinary team, development and implementation of the Plan of Safe Care, and supports for the infant, mother, caregivers, and family. The notification process, (outlined in statute), goes to ChildLine as Notification Only, provided that the mother is appropriately using legally prescribed medications or is a patient in MAT for SUD. In contrast, reports to General Protective Services are made for alcohol, illegal substances, misuse/abuse of legal medication, and unknown substances.

Notifications: The full year of substance affected infants (SAI) notifications for 2021 included 710 GPS reports that were SAI reports. There were 304 Information Only notifications. There were 587 Plans of Safe Care developed for the GPS referrals. The data for the number of Plans of Safe Care developed includes only families that are involved in the child welfare system. The data system does not include families that are reported through the Information Only system. The database does not track Notification Only families after their information is entered and therefore no further data are available for this group. Plans of Safe Care are voluntary whether a family is reported through GPS or through the information only system. Participation in the child welfare system, however, is not voluntary for families who are reported through GPS.

In 2021, SAI notifications included 535 for MAT, 378 for illegal substances, 156 for appropriate use of prescribed medications, 100 for misuse/abuse of prescription medications. Fewer than 20 were of unknown substances and fewer than 20 were of alcohol. A referral may have more than one type of substance per notification.

Funding: Plans of Safe Care Support Grants were authorized to help counties provide what might otherwise have been unfunded mandates. The funding came from existing Commonwealth money that had not been allocated to counties. All 67 counties have MDT teams and participate in the Plans of Safe Care program. Forty-one of the counties are participating in the Plans of Safe Care grant program. The initial grants covered 35 counties beginning on July 1, 2021. To encourage more counties to participate, a second round of funding was made available to six more participants beginning January 1, 2022. The grants are for two-year terms (SFY 2021-22 and 2022-23) and \$3,230,000 has been encumbered. The money is provided as reimbursements to the county child welfare agencies. According to DHS, funding is available for all 67 counties. Counties that did not participate in the grant program cited staff shortages and extra work associated with reporting and invoicing requirements. Technical assistance sessions were available for all counties.

There are four categories of grant deliverables in work plans: infrastructure, education to county child welfare offices and families (related to physical health, substance use, etc.), products and services (safe sleep services, new baby baskets, help with childcare costs, help with transportation. Counties were required to provide work plans that included how these categories would be filled.

*Infrastructure.* Fundamental activities needed to support the agency and system partners in the effective delivery of Plans of Safe Care.

*Education.* Training on county-specific policies and procedures for child welfare, physical health, families, and community-based system partners.

*Products.* Items provided to families to: help meet the needs of the infant, support families and caregivers, incentivize participation in programs/services.

*Services.* Services to partner with community agencies, to engage in additional evidence-based programs, certified recovery specialists

Next Steps: CAPTA funding incorporated into the county child welfare agencies' needs-based budget process.

Interdepartmental data analysis to better understand outcomes for substance affected infants and their families

Inclusion of data collection criteria in the child welfare case management system.

### **Discussion**

The Task Force members were appreciative of the work that had been accomplished by DHS Office of Children, Youth, and Families through MDWISE, Plans of Safe Care, and use of federal CAPTA funding, especially given the parameters set by CAPTA's statutory requirements. Nonetheless, there was criticism that the systems being developed are stigmatizing in the way the processes have been incorporated into the child welfare system. Secretary Smith noted that the work done in this space is very admirable, but notification process is stigmatizing because the requirements were incorporated into the child welfare process. This will be a set-back, and the Plans of Safe Care system should not be embedded in the system people are fearful of.

There are a handful of states that do not use the same reporting system for the "Information Only" and have developed an alternate system. However, CAPTA requires that the information goes to the states' departments of human services child welfare systems. Although some states have developed a separate phone number, the information ultimately goes to the same place.

Pennsylvania worked within the parameters of the existing system and statutes because the commonwealth would otherwise have been out of compliance and would consequently risk losing a significant funding source.

There was discussion about whether the Plans of Safe Care are truly voluntary or if families feel coerced to accept the plans or else face consequences of being taken into the child welfare system. The official DHS position is that declining a voluntary Plan of Safe Care does not consequently move a family into the child welfare system provided that the plan was initiated by an Information Only report. A family that is referred through a General Protective Services report is automatically drawn into the child welfare system regardless of their participation in a Plan of Safe Care.

The discussion further delved into the biases of the hotline operators who receive reports. There is a concern that operators' determinations about whether to record reports as Information Only or GPS will be unduly influenced by their biases regardless of the reporter's (a doctor, e.g.) intent. A protocol of checks and balances at the point of reporting could control for individuals' biases in recording reports from healthcare workers and other reporters. This discussion points to the purpose of the Task Force, that is, to review the existing system and make recommendations for improvements. One such recommendation could be to implement Plans of Safe Care as community-based services rather than as from DHS.

*MDT.* There was a brief discussion about MDTs (multidisciplinary teams) and which stakeholders are required to be represented on county MDTs. Child welfare is the lead on each MDT where General Protective Services is involved. The timeline of MDT implementation varies on individual cases and families.

Dr. Denise Johnson, M.D., Acting Secretary of Health presented materials on Neonatal Abstinence Syndrome and three areas of initiatives: Surveillance, Prevention and Treatment, and the Thriving Families Learning Opportunity.

Surveillance: To standardize reporting, a NAS surveillance case is defined as a newborn with a clinical diagnosis in the neonatal period (birth to 28 days) who has symptoms of withdrawal:

- prenatal exposure to opiate drugs, either via prescription, MAT, or illegal use (IDC-10 codes P06.1 and P04.49 only); and
- who is a resident of Pennsylvania (infants born to mothers who resided in Pennsylvania before the baby's birth); and,
- an infant born on or after 1/10/2018.

NAS surveillance data were gathered beginning in 2018. There were 2,140 NAS cases reported in 2018 and 1,608 reported in 2019. For 2019, many cases were more likely to have their births covered by medical assistance, to be born prematurely, with low birthweight, and more likely to have a mother who did not have prenatal care.

Looking at births by facility, densely populated counties with a lot of birthing facilities showed higher numbers of cases, whereas some counties showed zero cases. Some counties have no birthing hospitals, however. In terms of case counts by maternal residency, some counties showed zero. Philadelphia had the highest case count at 221. The highest incidence rate was in Fayette County, which had 61.1 cases per 1,000 live births. There is a wide range in incidence rates. In terms of treatment type for NAS infants by race, non-pharmacologic treatments were the most common treatment provided to infants of Black Non-Hispanic mothers. Morphine was the most common treatment for infants born to Hispanic, Other/Unknown Non-Hispanic, and White Non-Hispanic mothers.

Maternal Mortality: The Maternal Mortality Review Committee (MMRC) looked at 2018 data for women who died during and up to one year after childbirth. Of 85 deaths recorded, most were categorized as accidental poisonings, which accounted for 51 percent of deaths. Most were presumed to be overdoses. MMRC recommendations were to address mental health, substance use, comprehensive medical care, and intimate partner violence.

Substance use recommendations from policy makers were to:

1. Safeguard continuous Medicaid eligibility for individuals during pregnancy and up to one year postpartum. (began April 1, 2022)
2. Address the privacy laws around 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 stigmatizing pregnant and postpartum individuals.

Data showed that many maternal deaths occurred after 60 days but within one year, which prompted the expanded length of eligibility for medical assistance. MMRC also discussed the stigma surrounding SUD, particularly if mental health problems are also involved, and recognized that protecting privacy can sometimes hamper treatment and present barriers to comprehensive care and potentially lead to maternal deaths. Patient autonomy must be balanced with adequate care. The third item, decriminalization of substance use during pregnancy and promotion of mental health and SUD treatment, is important because a lot of pregnant women are not exposing themselves to treatment because of stigma, because they do not have assurances that they will be respected and protected so that they will disclose and be able to access services. Fourth, there needs to be ongoing education for both the public and providers about decreasing the stigma associated with SUD so as to further help pregnant and postpartum women in need of services.

The MMRC made recommendations for healthcare providers and hospital systems' staff at all levels, as well. These included a recommendation to refer pregnant and postpartum patients with SUD to behavioral health and SUD treatment. The committee also recommended that standards of care for SUD include:

1. Providing ongoing training and education for providers;
2. Implementation of a validated universal screening tool for SUD;
3. Development of guidelines around frequency and timing of screening;
4. Development of plans for care coordination and communication for all pregnant and postpartum patients; and
5. Increased work force of treatment providers to support potential increase in pregnant and postpartum patient referrals resulting from universal screening.

It is important to note that universal screening needs to be accompanied by assurances that patients will get the help and support they need and not be further traumatized or criminalized. Providers and patients both need to understand what treatment is available, and that biases not be introduced in terms of how patients are screened, referred, treated, and supported. The MMRC also recommended standardized hospital discharge plans for pregnant and postpartum patients with SUD or a prescription for and opioid to include distribution of prescription for naloxone.

Prescription Drug Monitoring Program (PDMP): When first initiated, the PDMP was seen as burdensome on prescribers. However, it has since provided a look at how, from where, and the quantity of drugs patients are being prescribed. MMRC reviewed the dispensation of opioids by OB/GYN/Midwives. Over the time of the PDMP, opioid dispensation has decreased both in terms of total number of dispensations and in the proportion of controlled substance dispensations.

Prevention Initiatives: Prevention initiatives from DOH include funding for county and municipal health departments (CMHDS) to provide a program for home visiting based on national models such as Partners for a Healthy Baby, Healthy Families America, Bright Futures, Parents as Teachers, and Nurse Family Partnership. The Centering Pregnancy Program includes group prenatal care and is designed to support vulnerable groups. A Neonatal Abstinence Syndrome Family Guide was written as part of the Safe Plans of Care program to provide parents with robust information. The guide was included in a basket of baby items and safety items provided to new families in Crawford County. The baskets were delivered by Children & Youth workers to destigmatize Children & Youth and start a positive interaction.

Syringe Service Programs (SPPs) Legislation: SSPs are public health programs that serve the community by addressing the health needs and risks of people who use drugs. The objective is to keep people alive and healthy and supported long enough for them to get into treatment and recovery. Individuals can take used syringes to programs and receive clean syringes in exchange. SSPs lower the risk of overdose deaths and are associated with 50 percent decline in HIV transmission. Users are five times more likely to enter treatment. Results benefit law enforcement by reducing the risk of needlesticks and there is no increase in crime. There are fewer improperly discarded syringes and SSPs are the only programs dedicated to taking back and disposing of used syringes. Pennsylvania is one of ten states that do not allow SPPs and is therefore ineligible for federal funding. Senate Bill 926 would permit SSPs to operate in the commonwealth.

Fentanyl Test Strip Legislation: Another piece of legislation aimed at harm reduction would provide fentanyl test strips, which cost about \$1 for home use. Increasingly, illegal drugs are contaminated with fentanyl. Individuals who have been surveyed said that, had they known their drugs were contaminated with fentanyl they might not use it, or use less, or use it in the presence of another person and be much less likely to overdose and have another chance to enter treatment. The Department of Health supports these harm reduction initiatives.

Thriving Families Learning Opportunity: The program was convened by the Association of State and Territorial Health Officials (ASTHO) and the American Public Human Service Association (APHSA). Pennsylvania is one of ten states that participated. The goal was to create a prevention focused child welfare system. States were directed to create a work plan and set goals. Pennsylvania's focus was the impact of SUD on children prebirth to five years old.

### **III. Public Comment**

The floor was turned over to public comment or questions.

Maryann McEvoy, Acting Executive Director of the Office of Advocacy & Reform and Child Advocate for the Commonwealth of Pennsylvania, spoke to the Task Force's support for mothers in ways to better protect children. She advocated the need to have a very intentional direction that conversations are centered on the impact on children and on child fatalities, and to determine where opportunities for improvements exist. She emphasized that everyone wants children to stay with their mothers and with their families. The efforts must ensure families are healthy with the central focus being the safety and well-being of the children.

There was a comment from a public attendee who has been raising her great nephew because his parents had been caught up in the opioid epidemic. She wanted to make sure the Task Force does not lose sight of the children involved and advocated for more support for the families that step up to take care of children and keep them from entering the foster care system.

Cathleen Palm, Center for Children's Justice, offered clarification about the changes made 2018 related to Plans of Safe Care. Federal law was always intended to cover illegal drugs or withdrawal or FAS disorder. People who were prescribed MAT were always eligible for Plans of Safe Care; states' misinterpretation of the statute may have led to wrong conclusions about the intent of federal law regarding MAT and Plans of Safe Care.

### **IV. Next Steps**

The Task Force turned back to the agenda and areas to look at for the next meeting. Suggestions included:

1. A presentation from someone working in the child welfare system; hearing from family members and foster parents
2. Information on the impact on children in the system because of opioids, including the number of child fatalities and near-fatalities from opioids;
3. Data in the context of what is available and what is needed; and
4. The reporting structure and the response structure, including available research and what Penn State's Children's Hospital is doing

### **V. ADJOURNMENT**

The meeting adjourned at 3:00pm. The next meeting is scheduled for 1:00pm Monday, May 23, 2022 at the CoPAHUB, Hilltop Conference Room 115, located at 2525 N 7th St. in Harrisburg. Contact [ra-pw@2TaskForce.pa.gov](mailto:ra-pw@2TaskForce.pa.gov) for virtual connection.

Updated: 5/5/22 at 3:30pm