PERINATAL SUBSTANCE EXPOSURE TASK FORCE

Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment and Recovery

Task Force Chair: Monica Edgar and Tricia Tilley

January 25, 2017 - 2:00PM – 4:00PM

Minutes

Attendees:

In-Person: Gary Kaufman, Susan Latham, Monica Edgar, Tricia Tilley, Courtney Gray, Rekha Sreedhara, Addie Murray, Rebecca Ewing, Ann Collins, Vicki Flanagan, Felicity Bernard

Via Phone: Michelle Merritt, Julie Bosak, David Laflamme, Eileen Mullen-Kennedy, Peg Clifford, Annette Escalante, Terry Alord, Linda Parker

I. Approval of September Minutes

- Susan Latham requested a follow up on SB 515.
  - Tricia Tilley provided an overview on the September discussion regarding SB 515.
    - SB 515 was enacted last legislative season, it raised many questions around the impact on families, particularly those in treatment. In September, the Task Force went through what's in the bill that is now law.
    - If a child is found to have withdrawal symptoms, DCYF has ability to open a case, but the family can also present evidence that there was no harm done to the child (i.e., if a mother was in treatment).
    - Susan asked if they will report women who are receiving medication assisted treatment (MAT). She also questioned what women they referring to? Is it pregnant women, all women? Tricia believes it is pregnant women or recently post-partum women but will get clarity from DCYF.
    - This bill is leading DCYF to do some investigation where they previously couldn't and in hoping that all children can have a safe plan of care.
- The September minutes were accepted.

II. Update on Developing Safe Plans of Care

- Safe Plans of Care are a requirement for all infants born with drug withdrawal symptoms.
- A team is working on crafting a cover letter which uses language from the laws and summarizes what's happening which will be shared with all perinatal providers along with a safe plan of care template which is also in development. Rebecca Ewing will share the draft letter with task force members to obtain substantive comments. The cover letter states:

- For all born affected by substance abuse symptoms, withdrawal symptoms, or FAS symptoms.
- Ensure that infants affected by prenatal substance exposure and their families receive adequate services and determine (DCYF) if the child is at risk or increased risk.
- Determination of level and risk and services needed.
- Completed during hospital stay and will be reported to point of contact at DCYF at discharge. The patient must sign consent to share this information between entire healthcare team that care for the patient directly. Patient may request list of providers who will have access to information.
- A proposed HIPPA and 42 CFR Part 2 form will be included
- The process hopes to provide consistency and receive feedback thus far.

- Vicki asked how the team sees the letter being distributed.
  - The team has been working hard on what the cover letter will include and what the plan looks like and will focus on the dissemination/communication and care coordination plan next.
  - It was suggested that materials be posted on the web to easily access and print out each of the components.
- Vicki asked if it was possible to have some data on patients that get the safe plan of care at 6 months, 1 year, 2 years? How many were investigated? How many were not?
  - The point of the plan of care was ultimately to help DCYF get a better handle on the current situation. DCYF is responsible to report out.
  - The Task Force agreed they did not want to lose sight of this idea moving forward.
- Within the next three months things should really be moving forward, hopefully soon they will be able to test.

III. Governor's Commission Planning Process

- The Task Force will be meeting monthly to plan and work through the state plan template which will be due April 25th to the Center for Excellence.
- Rekha provided an update of the planning process:
  - The current state plan will expire at the end of the year. In preparation, a new state plan will be developed for the next 3 years. The new plan will be focuses on all substances (including alcohol and other drugs).
  - Planning will include all 8 Task Forces, commission members and their agencies and an ad hoc group which will include safety and law enforcement that will be headed by James Vara.
  - The template is organized by steps, and will be data driven.
    - **Step 1:** Identify and review guidance relative to the specific areas of focus of the task force as well as state resources
    - **Step 2:** Based on data reviewed in the previous step, record observations of the data as they relate to the specific areas of focus of the task force.

- **Step 3:** Use observations of the data (Step 2) to identify at a minimum two priority areas and corresponding strategies to address identified areas of focus and specifically indicate the role your Task Force will play.
- **Step 4:** Include recommendations identified for other task forces that would be important to monitor over the next three years.
- **Step 5:** Identify additional measures and datasets, not mentioned above, that would be important to monitor over the next three years.
- **Step 6:** Please list additional stakeholders who were engaged with this process outside of task force members (e.g. focus groups).
- **Step 7:** Submit completed template to NH Center for Excellence staff by April 25, 2017 and present recommendations at the Governor's Commission Retreat on May 5, 2017.

- It was asked if there was an overarching goal for the three years? Rekha shared that specially there is not because they wanted to see what the Task Forces recommend for priorities and strategies and they want the Task Forces to direct the work towards the goals.
- It was suggested that methadone dosing data for the perinatal population would be very important to have access to.
  - Methadone doses in pregnant women are high and the team wants to get an idea of the dosing that is being used in the state, even if it is a threshold.
  - It was discussed that they do have access to fee for service claims, but those are not as detailed for those part of a managed care organization (MCO). They don't have that data but could look for it.
  - It was suggested that this data be gathered from the hospital for time of delivery. But, it was identified that this data would need to be obtained from each hospital individually.
  - Buprenorphine data, also could access fee for service but not MCO, could check with Emily who works with the encounter data. This data is definitely easier to get to, but probably less interesting.
  - Tricia Tilley reminded everyone that we did look at a sample of data a couple years ago.
- Courtney shared a SAMSHA report, A Collaborative Approach to Treatment of Pregnant Women with Opioid Use Disorders (https://ncsacw.samhsa.gov/files/Collaborative_Approach_508.pdf)
- Step 2 is the rationale for the work, such as how much maternal mortality is related to overdose, overdose deaths in women of childbearing age.
  - The White Paper: Opioid Use, Misuse and Overdose in Women was reviewed for observations (see planning template for observations). (https://www.womenshealth.gov/files/documents/white-paper-opioid-508.pdf)
  - Rekha suggested to assign 2-3 people to a document and share 3-4 observations at the next meeting.
- There was a discussion around the NH Statewide Addiction Crisis Line:

- If someone called the Crisis Line and they are pregnant, they become priority and it is the crisis workers job to find them treatment. Keystone will pick them up and take them to the residential anywhere in the state.
    - Anything that's more than a woman with 2 kids is difficult to find placement for.
    - They can enter treatment when they're 4-6 months pregnant, stay the entirety of the pregnancy, give birth, and up to 6 months after.
    - A possible data point is how many beds are there and how many can't get access?
    - What is the number of anticipated pregnancies that will be NAS? (10% or 1200 kids)

- It was asked if there was a dataset of percentage of mothers with opioid use disorders who need residential care. At what level do they present? Outpatient, intensive outpatient, inpatient? Is there modeling on this? It was suggested that the Task Force reach out to Jaime Powers at Bureau of Drug and Alcohol Services (BDAS).
- Possible data sources to review were discussed:
    - Surgeon General's Report – Chapter on special populations
    - PRAMS data
    - NICU Cost
    - Medicaid cost for NAS
    - 2015 discharges (will be released in February)
    - Data on pregnant women smoking cigarettes (PRAMS # is most accurate)
- It may be helpful to get baseline data and then put at the end what more sophisticated analysis should be done, such as recommendations to improve data.
- It was shared that for things such as discharges, situational surveillance, and claims, there can be linking of datasets using the birth as the anchor and then seeing if you can find them in other datasets. That could be the most comprehensive.
- Data sources to be reviewed by Task Force members for next meeting:
    - *PRAMS - Becky Ewing, Linda Parker, David Laflamme, Julie Bosak, Rekha Sreedhara*
    - *Surgeon General's Report - Courtney Gray*
    - *Young Adult Assessment - Vicki Flanagan, Peg Clifford, Felicity Bernard*
    - *Maternal Mortality Report - Tricia Tilley, Gary Kaufman, David Laflamme*
    - *NSDUH - Ann Collins, Susan Latham, Monica Edgar*
    - *YRBS - Vicki Flanagan, Ann Collins, Tricia Tilley*

Next Meeting:

Wednesday, February 22, 2016 – 2:00PM-4:00PM
Community Health Institute, 501 South Street, Bow, NH 03304

Call-In: 1-866-210-1669
Passcode: 9060313