NATIONAL HEALTH CARE for the HOMELESS COUNCIL

NATIONAL HARM REDUCTION COALITION

Supporting Reproductive Health for People Who Use Drugs

May 15th, 2023
Harm Reduction Pre-Conference Institute

Session Speakers:

Dr. Mishka Terplan, MD, MPH: Medical Director, Friends Research Institute

Joelle Purcio, BSN, RN: Co-Founder of the Academy of Perinatal Harm Reduction

Dr. Nayeli Spahr, MD, MPH: Director of Reproductive and Child Health, Project HOME, Philadelphia, PA

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Divya Katti, BS: National Health Corps Child and Family Advocate, Project HOME Stephen Klein Wellness Center

Victoria Keiser, MD: Thomas Jefferson University Hospital

Luna Uhl, Subject Matter Expert, Philadelphia, PA

Reproductive Health for PWUD: Punitive Policies, Health Professional Complicity, and Harm Reduction

Mishka Terplan MD MPH
Medical Director, Friends Research Institute
Substance Use Warmline Clinician, UCSF

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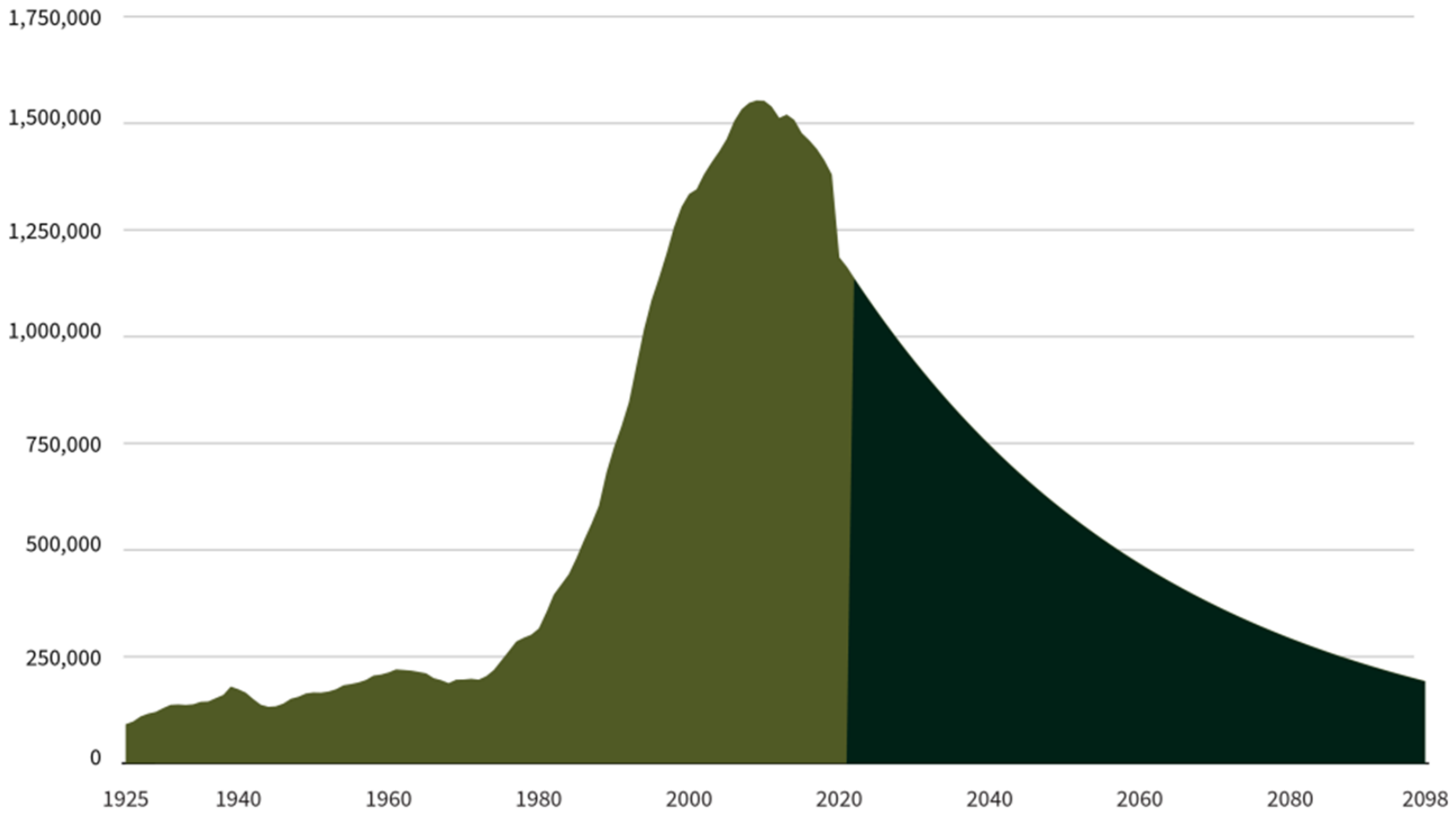
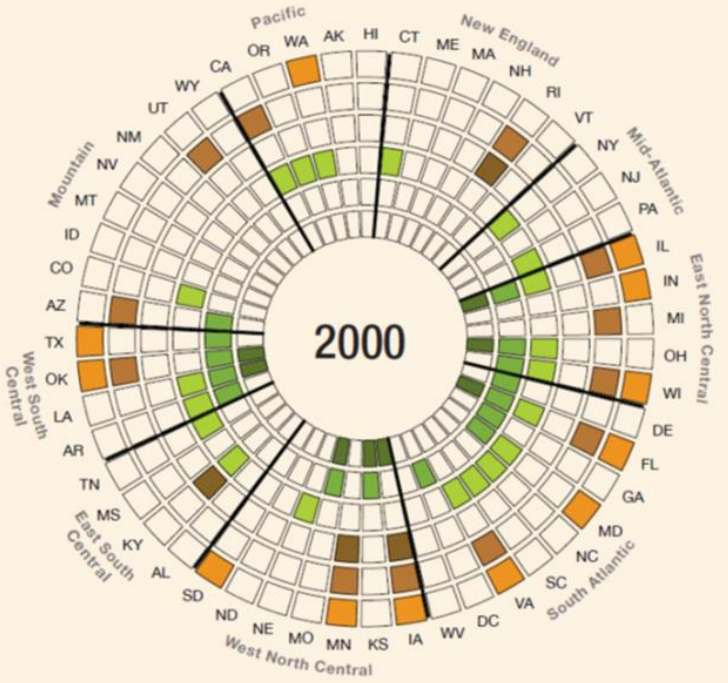
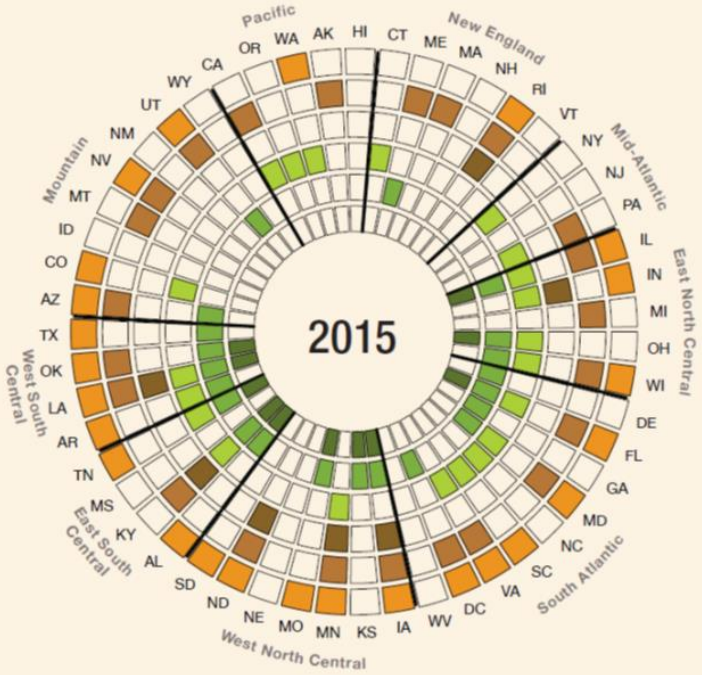
Advancing research to promote health and well-being

Drug Policy and (Gradual) Decarceration



https://www.sentencingproject.org/policy-brief/ending-50-years-of-mass-incarceration-urgent-reform-needed-to-protect-future-generations/

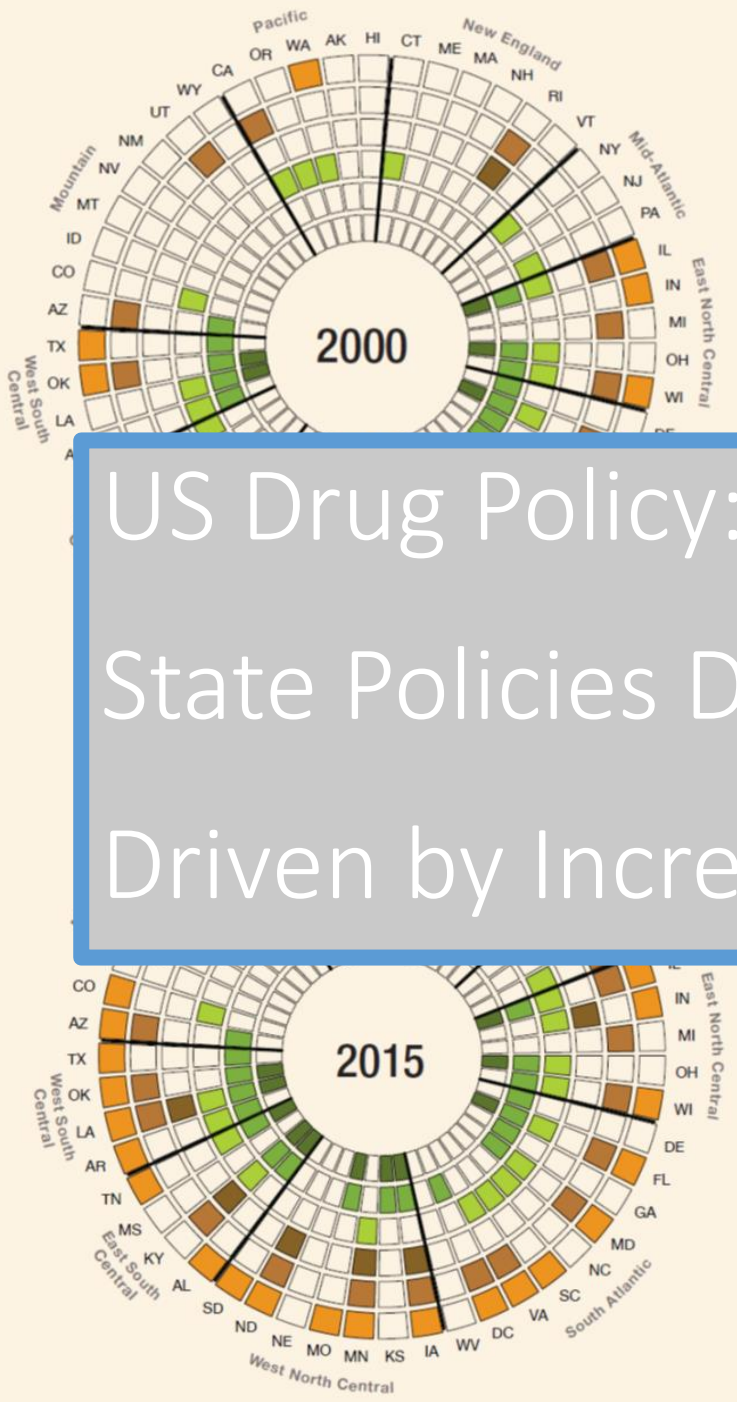




Punitive Policies Related to Substance Use in Pregnancy Proliferated

Punitive Policies Associated with:
Increased Odds of Neonatal Abstinence Syndrome
Increased Odds of Low Birth Weight
Increased Odds of Preterm Delivery
Decreased Odds of any Prenatal Care and APGAR 7+

1. Faherty, et al., *Association between punitive policies and neonatal abstinence syndrome among Medicaid-insured infants in complex policy environments.* Addiction, 2022
2. Thomas, et al., *Drug use during pregnancy policies in the United States from 1970 to 2016.* Contemporary Drug Problems, 2018
3. Carroll, *The harms of punishing substance use during pregnancy.* IJDP, 2021
4. https://www.rand.org/pubs/infographics/IG148.html



Punitive Policies Related to Substance Use in Pregnancy Proliferated

US Drug Policy: Less Punitive

State Policies Drugs + Pregnancy: More Punitive

Driven by Increasing Restrictive Reproductive Policies

1. Roberts, et al., *Forty years of state alcohol and pregnancy policies in the USA: best practices for public Health or efforts to restrict Women's reproductive rights?* Alcohol and Alcoholism, 2017
2. Paltrow, *The war on drugs and the war on abortion: Some initial thoughts on the connections, intersections and effects.* Reproductive Health Matters, 2002

BILL OF HEALTH
EXAMINING THE INTERSECTION OF HEALTH LAW, BIOTECHNOLOGY, AND BIOETHICS

ABOUT BILL OF H

How the Dobbs Ruling Will Affect People with Substance Use Disorder

August 16, 2022 The Petrie-Flom Center Staff Abortion, Bioethics, Criminal Law, Human Rights, Judicial Opinions, Medical Quality, Medical Safety, Pregnancy, Public Health, Race, Supreme Court

By Hayfa Ayoubi and Karishma Trivedi

The Network for Public Health Law

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The Persistent Criminalization of Pregnant People Who Use Drugs

September 16, 2022

(Slip Opinion) OCTOBER TERM, 2021 1

Syllabus

NOTE: Where it is feasible, a syllabus (headnote) will be released, as is being done in connection with this case, at the time the opinion is issued. The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See *United States* v. *Detroit Timber & Lumber Co.*, 200 U. S. 321, 337.

SUPREME COURT OF THE UNITED STATES

Syllabus

DOBBS, STATE HEALTH OFFICER OF THE MISSISSIPPI DEPARTMENT OF HEALTH, ET AL. *v.* JACKSON WOMEN'S HEALTH ORGANIZATION ET AL.

CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

No. 19–1392. Argued December 1, 2021—Decided June 24, 2022

Mississippi's Gestational Age Act provides that "[e]xcept in a medical emergency or in the case of a severe fetal abnormality, a person shall not intentionally or knowingly perform . . . or induce an abortion of an unborn human being if the probable gestational age of the unborn human being has been determined to be greater than fifteen (15) weeks." Miss. Code Ann. §41–41–191. Respondents—Jackson Women's Health Organization, an abortion clinic, and one of its doctors—challenged the Act in Federal District Court, alleging that it violated this Court's precedents establishing a constitutional right to abortion, in particular *Roe* v. *Wade*, 410 U. S. 113, and *Planned Parenthood of Southeastern Pa.* v. *Casey*, 505 U. S. 833. The District Court granted summary judgment in favor of respondents and permanently enjoined enforcement of the Act, reasoning that Mississippi's 15-week restriction on abortion violates this Court's cases forbidding States to ban abortion pre-viability. The Fifth Circuit affirmed. Before this Court, petitioners defend the Act on the grounds that *Roe* and *Casey* were wrongly decided and that the Act is constitutional because it satisfies rational-basis review.

Held: The Constitution does not confer a right to abortion; *Roe* and *Casey* are overruled; and the authority to regulate abortion is returned to the people and their elected representatives. Pp. 8–79.

(a) The critical question is whether the Constitution, properly understood, confers a right to obtain an abortion. *Casey*'s controlling opinion skipped over that question and reaffirmed *Roe* solely on the basis of *stare decisis*. A proper application of *stare decisis*, however, requires an assessment of the strength of the grounds on which *Roe*

No Disclosures

Objectives:

Explore the intersections of drug and reproductive health policy with specific attention to child welfare

Critically examine assessment of substance use (drug testing vs screening)

Highlight the historical and ongoing complicity of health care practice and policies with policing and family surveillance in particular

Assumptions

- Addiction is a chronic condition, treatment works, and recovery happens all the time
- Child abuse (physical, sexual, emotional) is real, rare, and within health professional responsibility to assess and respond
- Substance exposure is not in-and-of-itself child abuse

What is a Drug Test?

Presumptive

Point-of-care

Elisa

Rapid and Cheap

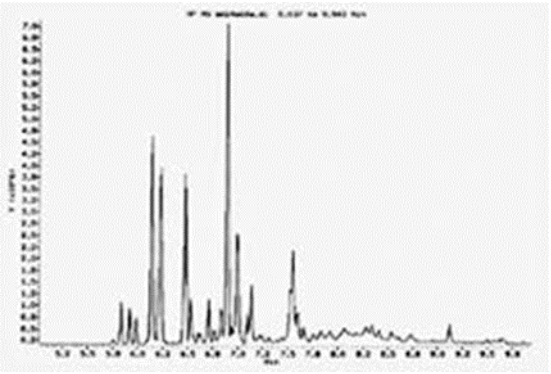
Results Binary

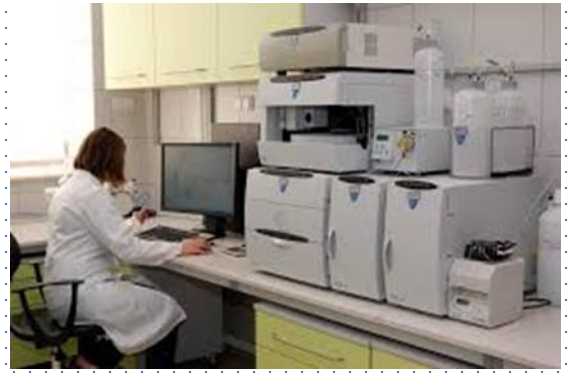
Definitive

Gas Chromatography / Mass Spectrometry

Costly and Timely

Results specific and quantified





Presumptive Drug Tests: Poor Quality Information

TABLE 3. **Summary of Agents Contributing to Positive Results by Immunoassay[a]**

Substance tested via immunoassay	Potential agents causing false-positive result	Substance tested via immunoassay	Potential agents causing false-positive result
Alcohol[20]	Short-chain alcohols (eg, isopropyl alcohol)	Cannabinoids[1,8,43-48]	Dronabinol
			Efavirenz
Amphetamines[21-40]	Amantadine		Hemp-containing foods
	Benzphetamine		NSAIDs
	Bupropion		Proton pump inhibitors
	Chlorpromazine		Tolmetin
	Clobenzorex[b]	Cocaine[49-51]	Coca leaf tea
	l-Deprenyl[c]		Topical anesthetics containing cocaine
	Desipramine	Opioids, opiates, and heroin[8,52,52-63]	Dextromethorphan
	Dextroamphetamine		Diphenhydramine[e]
	Ephedrine		Heroin
	Fenproporex[b]		Opiates (codeine, hydromorphone, hydrocodone, morphine)
	Isometheptene		Poppy seeds
	Isoxsuprine		Quinine
	Labetalol		Quinolones
	MDMA		Rifampin
	Methamphetamine		Verapamil and metabolites[e]
	l-Methamphetamine (Vick's inhaler)[d]	Phencyclidine[8,52,64-70]	Dextromethorphan
	Methylphenidate		Diphenhydramine[e]
	Phentermine		Doxylamine
	Phenylephrine		Ibuprofen
	Phenylpropanolamine		Imipramine
	Promethazine		Ketamine
	Pseudoephedrine		Meperidine
	Ranitidine		Mesoridazine
	Ritodrine		Thioridazine
	Selegiline		Tramadol
	Thioridazine		Venlafaxine, O-desmethylvenlafaxine
	Trazodone	Tricyclic antidepressants[71-81]	Carbamazepine[f]
	Trimethobenzamide		Cyclobenzaprine
	Trimipramine		Cyproheptadine[f]
Benzodiazepines[16,41,42]	Oxaprozin		Diphenhydramine[f]
	Sertraline		Hydroxyzine[f]
			Quetiapine

Moeller KE, Mayo Clinic Proc, 2008

TABLE 2. **Length of Time Drugs of Abuse Can Be Detected in Urine**

Drug	Time
Alcohol	7-12 h
Amphetamine	48 h
Methamphetamine	48 h
Barbiturate	
Short-acting (eg, pentobarbital)	24 h
Long-acting (eg, phenobarbital)	3 wk
Benzodiazepine	
Short-acting (eg, lorazepam)	3 d
Long-acting (eg, diazepam)	30 d
Cocaine metabolites	2-4 d
Marijuana	
Single use	3 d
Moderate use (4 times/wk)	5-7 d
Daily use	10-15 d
Long-term heavy smoker	>30 d
Opioids	
Codeine	48 h
Heroin (morphine)	48 h
Hydromorphone	2-4 d
Methadone	3 d
Morphine	48-72 h
Oxycodone	2-4 d
Propoxyphene	6-48 h
Phencyclidine	8 d

Data from references 7 through 12.

False Positive, True Positive, and the Potential for Misinterpretation

BREASTFEEDING MEDICINE
Volume 11, Number 1, 2016
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DOI: 10.1089/bfm.2015.0173

Correspondence

Maternal Epidural Fentanyl Administered for Labor Analgesia Is Found in Neonatal Urine 24 Hours After Birth

Albert Moore, Aly el-Bahrawy, Roupen Hatzakorzian, and William Li-Pi-Shan

Dear Editor:

FENTANYL IS AN OPIOID MEDICATION that is given epidurally for labor analgesia. Although fentanyl is commonly used, there are reports of it interfering with breastfeeding success.[1] We could find no information on whether fentanyl would be found in a neonate more than 24 hours after delivery and so decided to present this case.

The patient gave consent, and the research ethics board gave approval for this study. A 34-year-old, 39-week gravida 1 para 0 woman presented in spontaneous labor. She was 162 cm tall, weighed 75 kg, was healthy, took no medication other than prenatal vitamins, and had enjoyed an uneventful pregnancy. She requested and received an epidural at 4:45 h the day of her admission. The epidural catheter placement was uncomplicated, and adequate analgesia was provided using a pump that infused 0.06% bupivacaine with 2 μg/mL fentanyl at 10 mL/hour with a patient-controlled 5-mL demand bolus and a lockout time of 10 minutes. Throughout her labor the patient received six extra boluses of this solution.

A 3,780-g baby boy was born at 14:08 h, with Apgar scores of 9 and 9 at 1 and 5 minutes, respectively, and an umbilical artery pH of 7.19. The epidural pump was stopped soon after birth, with the patient receiving 140 mL of the epidural solution (280 μg of fentanyl over 11 hours = 25 μg/hour). The patient recovered and was discharged to the postpartum ward where she was assessed by us the next day. At that time she had used no medications for pain.

The baby-dependent items on the LATCH score were assessed, and the latching ability and audible swallowing were rated at 2 (normal). Urine samples were collected from the mother at 14:00 h. At the same time, a clean sponge was placed in a new diaper, which provided a neonatal urine sample that was collected at 17:00 h. The samples were sent to a toxicology laboratory, where it was determined that the maternal urinary fentanyl level was 2.0 ng/mL, whereas the neonatal level was 2.4 ng/mL.

Although it is known that epidurally administered fentanyl crosses the placenta, it is thought that this leads to clinically unimportant levels in the neonate.[2] The measured half-life of fentanyl administered intravenously to infants 1 day or less of age is highly variable and ranges from 75 to 441 minutes,[3] making the duration it would remain in the neonate unclear. Our case demonstrates that fentanyl can persist in the neonate for at least 24 hours after delivery, at amounts that may have clinical effects. The minimum effective analgesic level of fentanyl in plasma for adults is 0.63 ng/mL.[4] Although the corresponding level is unknown in neonates, a level of 1.1 ng/mL has necessitated prolonged intubation in neonates.[3] The urinary concentration seems to have some correlation with fentanyl dosage and levels.[5]

Although fentanyl is transferred in breastmilk, it is virtually undetectable in colostrum 10 hours after it has been given maternally.[6] In addition, fentanyl's limited oral bioavailability makes us believe the majority of neonatal fentanyl was from placental transfer and not through breastmilk. Although our LATCH score was reported as normal, more subtle markers of breastfeeding difficulty may have been found if we had assessed the Widstrom stages of neonatal breastfeeding,[7] or more severe problems may have occurred if the patient had required higher fentanyl doses. Adequate initiation is essential for the continued success of breastfeeding, and it is possible that the presence of neonatal fentanyl could interfere in the important first days of life.

In conclusion, we provide evidence that fentanyl administered through an epidural for less than 12 hours will remain in the mother and neonate, even 24 hours after cessation of the epidural infusion. The clinical implications of this should be further investigated.

References

1. Beilin Y, Bodian CA, Weiser J, et al. Effect of labor epidural analgesia with and without fentanyl on infant breast-feeding: A prospective, randomized, double-blind study. *Anesthesiology* 2005;103:1211–1217.
2. Gambling DR, Huber CJ, Berkowitz J, et al. Patient-controlled epidural analgesia in labour: Varying bolus dose and lockout interval. *Can J Anaesth* 1993;40:211–217.
3. Koehntop DE, Rodman JH, Brundage DM, et al. Pharmacokinetics of fentanyl in neonates. *Anesth Analg* 1986;65:227–232.
4. Gourlay GK, Kowalski SR, Plummer JL, et al. Fentanyl blood concentration-analgesic response relationship in the treatment of postoperative pain. *Anesth Analg* 1988;67:329–337.
5. Van Nimmen NF, Poels KL, Menten JJ, et al. Fentanyl transdermal absorption linked to pharmacokinetic characteristics in

Department of Anesthesia, Royal Victoria Hospital, Montreal, Quebec, Canada.

American Journal of Obstetrics and Gynecology
Available online 23 November 2022
In Press, Corrected Proof ⓘ What's this?

Original Research
Obstetrics

Fentanyl in the labor epidural impacts the results of intrapartum and postpartum maternal and neonatal toxicology tests

Molly R. Siegel MD [a], Grace K. Mahowald MD, PhD [b], Sacha N. Uljon MD, PhD [b], Kaitlyn James PhD [a], Lisa Leffert MD [c], Mackenzie W. Sullivan MD [a], Susan J. Hernandez CNM [a], Jessica R. Gray MD [d], Davida M. Schiff MD [e], Sarah N. Bernstein MD [a]

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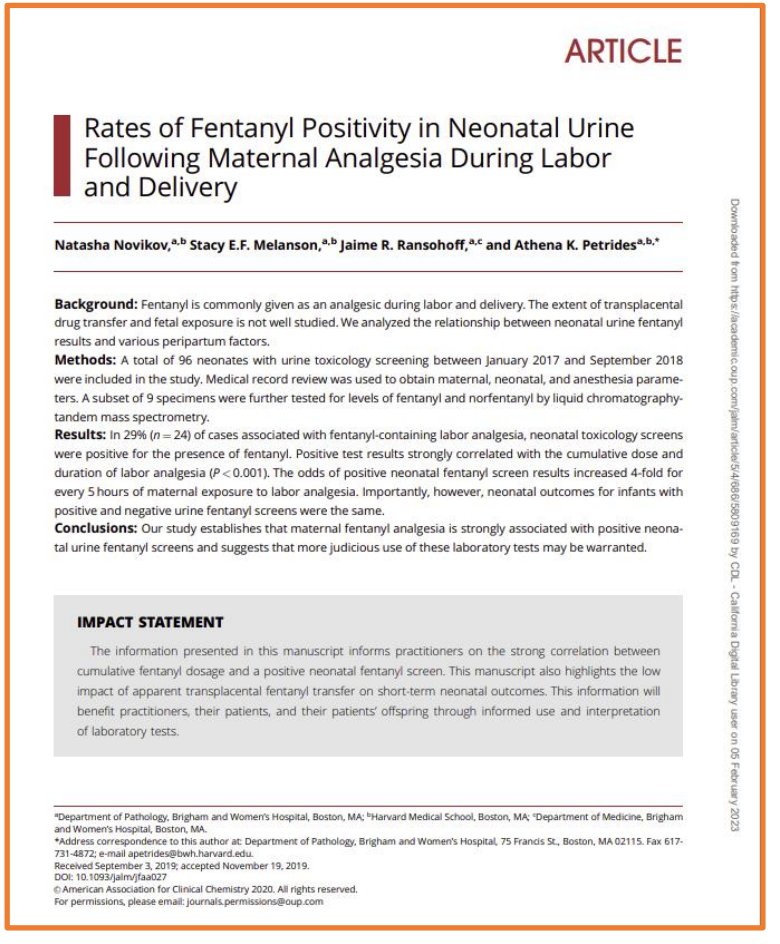
Background

A positive urine fentanyl toxicology test may have considerable consequences for peripartum individuals, yet the extent to which fentanyl administration in a labor epidural may lead to such a positive test is poorly characterized.



ARTICLE

Rates of Fentanyl Positivity in Neonatal Urine Following Maternal Analgesia During Labor and Delivery

Natasha Novikov,[a,b] Stacy E.F. Melanson,[a,b] Jaime R. Ransohoff,[a,c] and Athena K. Petrides[a,b,*]

Background: Fentanyl is commonly given as an analgesic during labor and delivery. The extent of transplacental drug transfer and fetal exposure is not well studied. We analyzed the relationship between neonatal urine fentanyl results and various peripartum factors.
Methods: A total of 96 neonates with urine toxicology screening between January 2017 and September 2018 were included in the study. Medical record review was used to obtain maternal, neonatal, and anesthesia parameters. A subset of 9 specimens were further tested for levels of fentanyl and norfentanyl by liquid chromatography-tandem mass spectrometry.
Results: In 29% ($n = 24$) of cases associated with fentanyl-containing labor analgesia, neonatal toxicology screens were positive for the presence of fentanyl. Positive test results strongly correlated with the cumulative dose and duration of labor analgesia ($P < 0.001$). The odds of positive neonatal fentanyl screen results increased 4-fold for every 5 hours of maternal exposure to labor analgesia. Importantly, however, neonatal outcomes for infants with positive and negative urine fentanyl screens were the same.
Conclusions: Our study establishes that maternal fentanyl analgesia is strongly associated with positive neonatal urine fentanyl screens and suggests that more judicious use of these laboratory tests may be warranted.

IMPACT STATEMENT

The information presented in this manuscript informs practitioners on the strong correlation between cumulative fentanyl dosage and a positive neonatal fentanyl screen. This manuscript also highlights the low impact of apparent transplacental fentanyl transfer on short-term neonatal outcomes. This information will benefit practitioners, their patients, and their patients' offspring through informed use and interpretation of laboratory tests.

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DOI: 10.1093/jalm/jfaa027

Drug Tests: Poor Quality Information that is Misinterpreted

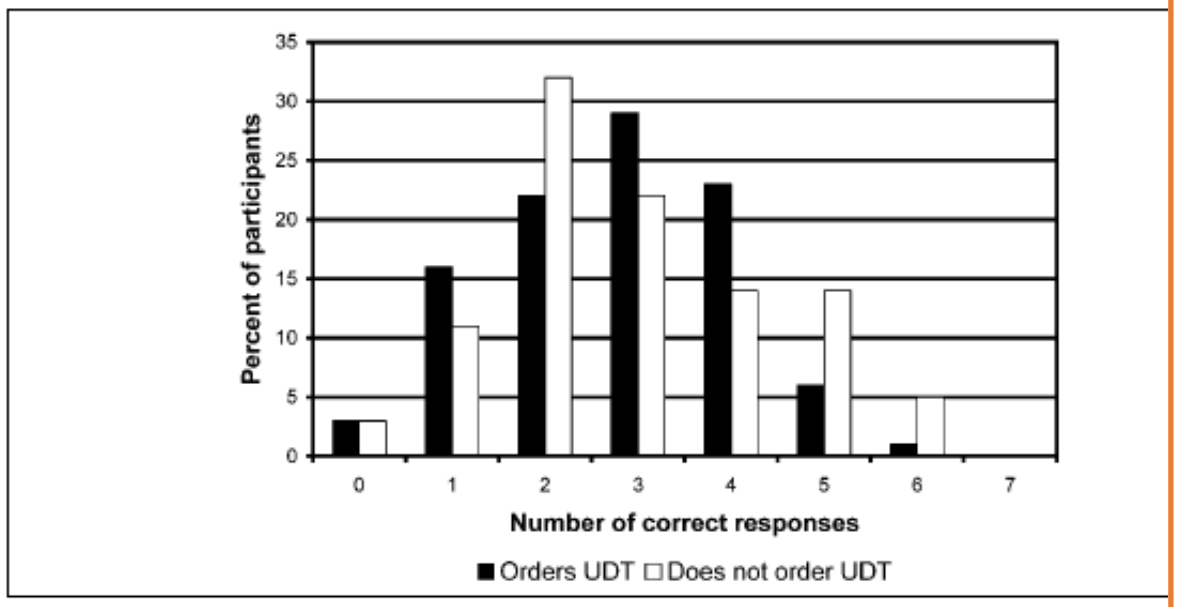


Figure 2.

APPENDIX. URINE DRUG TESTING (UDT) QUESTIONNAIRE: KNOWLEDGE QUESTIONS*

1. In a patient prescribed Tylenol #3 (codeine and acetaminophen), one would reasonably expect which of the following to be detected in the urine:
   a. codeine
   b. dihydrocodeine
   c. morphine
   d. all of the above
   e. a and c only

2. In a patient prescribed MS Contin (morphine), one would reasonably expect which of the following to be detected in the urine:
   a. codeine
   b. dihydrocodeine
   c. morphine
   d. all of the above
   e. a and c only

3. In a patient using heroin, one would be likely to detect which of the following in the urine:
   a. heroin
   b. hydromorphone
   c. morphine
   d. all of the above
   e. a and c only

4. A patient on OxyContin (oxycodone) therapy is administered a random urine drug test. He notifies you that he ate a large lemon poppy seed muffin for breakfast. What substances might reasonably be detected in the urine?
   a. oxycodone
   b. codeine
   c. morphine
   d. all of the above
   e. a and c only

5. A patient on chronic opioid therapy tests positive for cannabis on a random urine drug screen. She explains that her husband sometimes smokes pot in their bedroom. Is this a plausible explanation for the test findings?
   a. yes
   b. no

6. Which of the following are plausible explanations for a negative urine opiate drug screen in a patient on chronic opioid therapy:
   a. Patient ran out of opioid early and has not used any in a few days.
   b. Patient is a "fast metabolizer."
   c. Drug screen does not detect that particular opioid.
   d. a, b, and c
   e. a and c only

7. A patient on chronic Dilaudid (hydromorphone) therapy tests negative for opioids on a urine drug screen. The patient claims to be using the medicine as prescribed. The most appropriate next step would be to:
   a. subject this urine to a different type of test
   b. readminister a urine drug screen at the next visit
   c. taper and discontinue opioid therapy
   d. refer the patient to a detoxification/rehabilitation program
   e. notify law enforcement

* Correct responses are bolded.

Screening vs. Testing Professional Society Recommendations

Universal Screening:

Recommended (ACOG, ASAM, SMFM, AAP, SAMHSA, CDC)

- Voluntary (ACOG, SAMHSA, CDC)

Testing:

Not Recommended - Not an appropriate measurement of addiction (ACOG, ASAM, SAMHSA)

AAP: positive test = exposure, NOT indication of health or ill-health, not injury or harm, not mentioned in discharge criteria

ASAM: Definitive testing required “when the results of inform decisions with major clinical or non-clinical implications for the patient”

- Consent required (ACOG, ASAM, SMFM, SAMHSA)

Adherence to consent, even under “optimal” conditions is inadequate

American Journal of Obstetrics & Gynecology MFM
Volume 4, Issue 4, July 2022, 100621

Original Research

Informed consent is poorly documented when obtaining toxicology testing at delivery in a Massachusetts cohort

Kathleen J. Koenigs MD [a], Joseph H. Chou MD, PhD [b], Samuel Cohen MD [b], Moira Nolan BA [c], Gina Liu MSc [d], Mishka Terplan MD, MPH [e], Brian M. Cummings MD [b], Timothy Nielsen MPH [f], Nicole A. Smith MD, MPH [g], Joseph Distefano BS [h], Sarah N. Bernstein MD [i], Davida M. Schiff MD, MSc [b]

https://doi.org/10.1016/j.ajogmf.2022.100621

BACKGROUND

Positive toxicology testing at delivery can have enormous consequences for birthing persons and their families, including charges of child abuse or neglect and potential loss of custody for the birthing parent. Therefore state and national guidelines stipulate that, clinicians must obtain consent before toxicology testing at delivery.

What is the Clinical Utility of Routine Drug Testing during the Birthing Hospitalization?

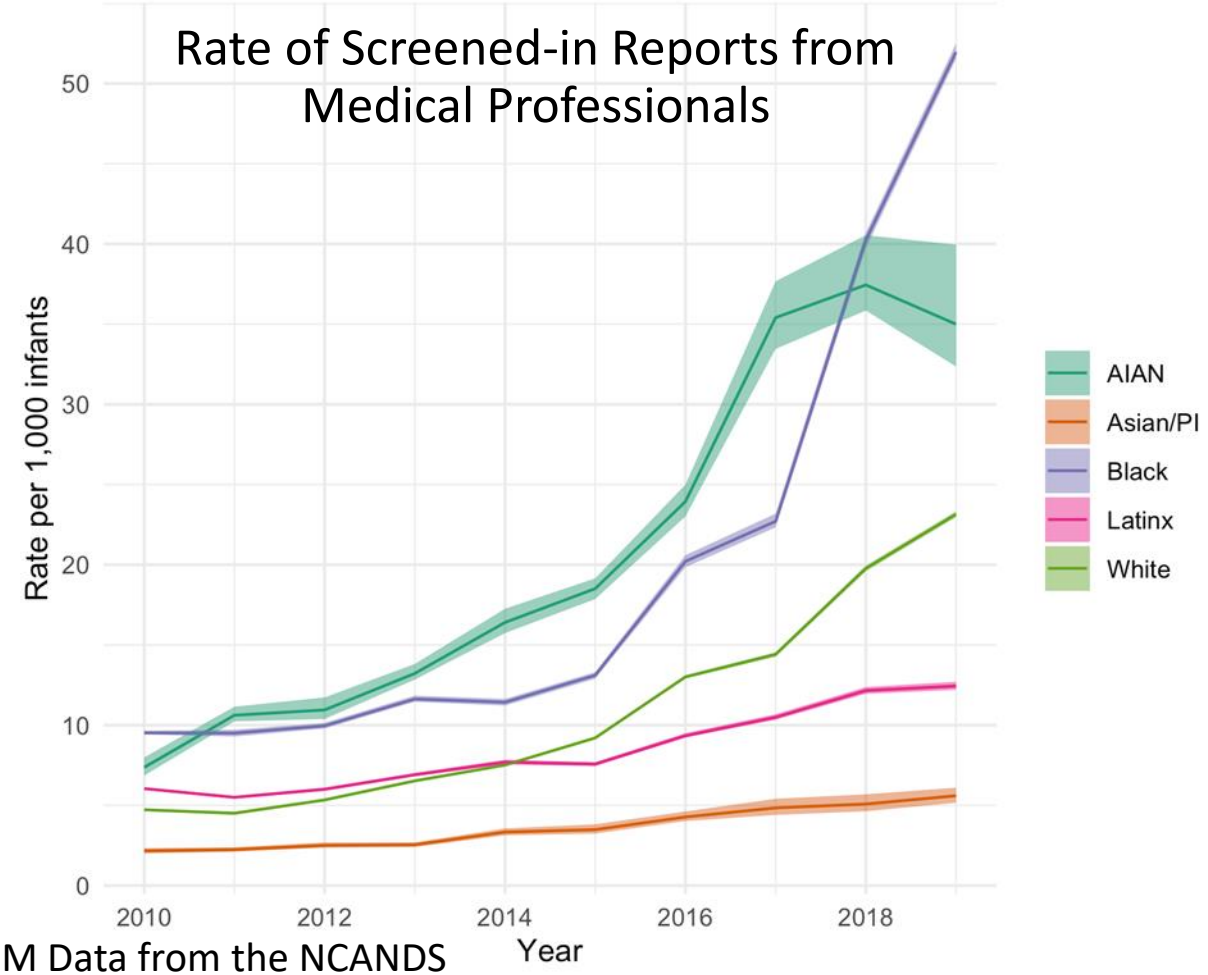
Do health professionals properly interpret drug test results?

Is Drug testing required by CAPTA?

Does universal testing reduce inequities?

“Test and Report” -- Provider Culpability

- Most child welfare reports (<1yr) are from medical professionals during birthing hospitalization
- Health Professional Reporting increased 400% in past decade
- Driven by (misuse of) urine drug testing
- Compounds racial inequities



Manuscript in preparation by Edwards F, Terplan M, Roberts S, Raz M Data from the NCANDS

HHS 2020 https://www.childwelfare.gov/pubs/factsheets/cpswork/

AAP 2015 https://pediatrics.aappublications.org/content/135/5/948

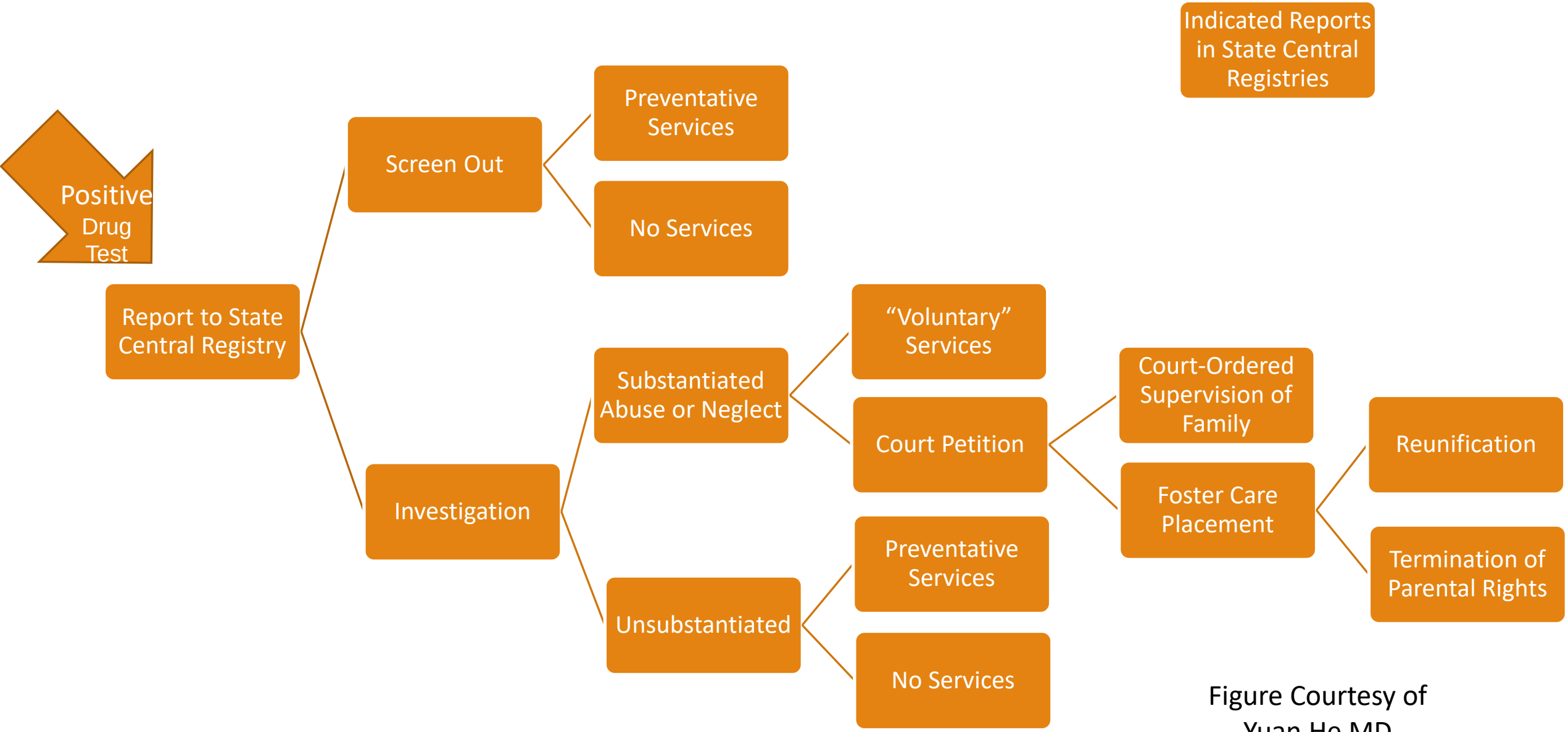
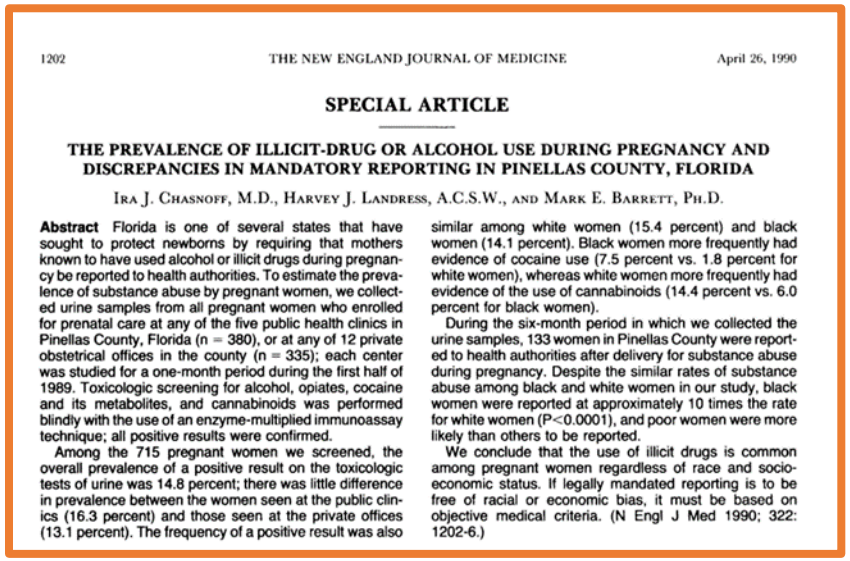


Figure Courtesy of Yuan He MD

Racial Inequities in Drug Testing and Selection Bias in Child Welfare Reporting



1202 THE NEW ENGLAND JOURNAL OF MEDICINE April 26, 1990

SPECIAL ARTICLE

THE PREVALENCE OF ILLICIT-DRUG OR ALCOHOL USE DURING PREGNANCY AND DISCREPANCIES IN MANDATORY REPORTING IN PINELLAS COUNTY, FLORIDA

IRA J. CHASNOFF, M.D., HARVEY J. LANDRESS, A.C.S.W., AND MARK E. BARRETT, PH.D.

Abstract Florida is one of several states that have sought to protect newborns by requiring that mothers known to have used alcohol or illicit drugs during pregnancy be reported to health authorities. To estimate the prevalence of substance abuse by pregnant women, we collected urine samples from all pregnant women who enrolled for prenatal care at any of the five public health clinics in Pinellas County, Florida (n = 380), or at any of 12 private obstetrical offices in the county (n = 335); each center was studied for a one-month period during the first half of 1989. Toxicologic screening for alcohol, opiates, cocaine and its metabolites, and cannabinoids was performed blindly with the use of an enzyme-multiplied immunoassay technique; all positive results were confirmed.

Among the 715 pregnant women we screened, the overall prevalence of a positive result on the toxicologic tests of urine was 14.8 percent; there was little difference in prevalence between the women seen at the public clinics (16.3 percent) and those seen at the private offices (13.1 percent). The frequency of a positive result was also similar among white women (15.4 percent) and black women (14.1 percent). Black women more frequently had evidence of cocaine use (7.5 percent vs. 1.8 percent for white women), whereas white women more frequently had evidence of the use of cannabinoids (14.4 percent vs. 6.0 percent for black women).

During the six-month period in which we collected the urine samples, 133 women in Pinellas County were reported to health authorities after delivery for substance abuse during pregnancy. Despite the similar rates of substance abuse among black and white women in our study, black women were reported at approximately 10 times the rate for white women ($P<0.0001$), and poor women were more likely than others to be reported.

We conclude that the use of illicit drugs is common among pregnant women regardless of race and socioeconomic status. If legally mandated reporting is to be free of racial or economic bias, it must be based on objective medical criteria. (N Engl J Med 1990; 322: 1202-6.)

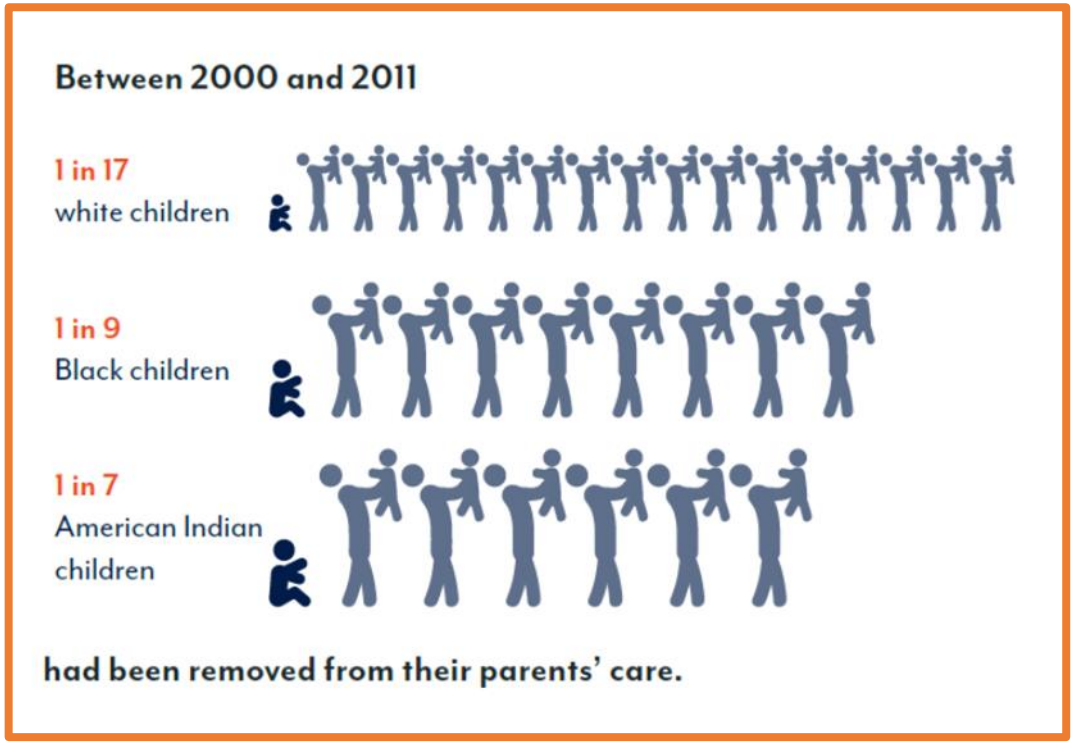
Journal of Behavioral Health Services & Research, 2011. © 2011 National Council for Community Behavioral Healthcare. DOI 10.1007/s11414-011-9247-x

Universal Screening for Alcohol and Drug Use and Racial Disparities in Child Protective Services Reporting

Sarah C. M. Roberts, DrPH
Amani Nuru-Jeter, PhD, MPH

	Chasnoff (1990)	Roberts (2011)
Positive Urine Drug Test		
Black Women	14.1%	14%
White Women	15.4%	14%
Child Welfare Report		
Black Women	10.7%	13.5%
White Women	1.1%	7.6%

Racial Inequities in Family Separation



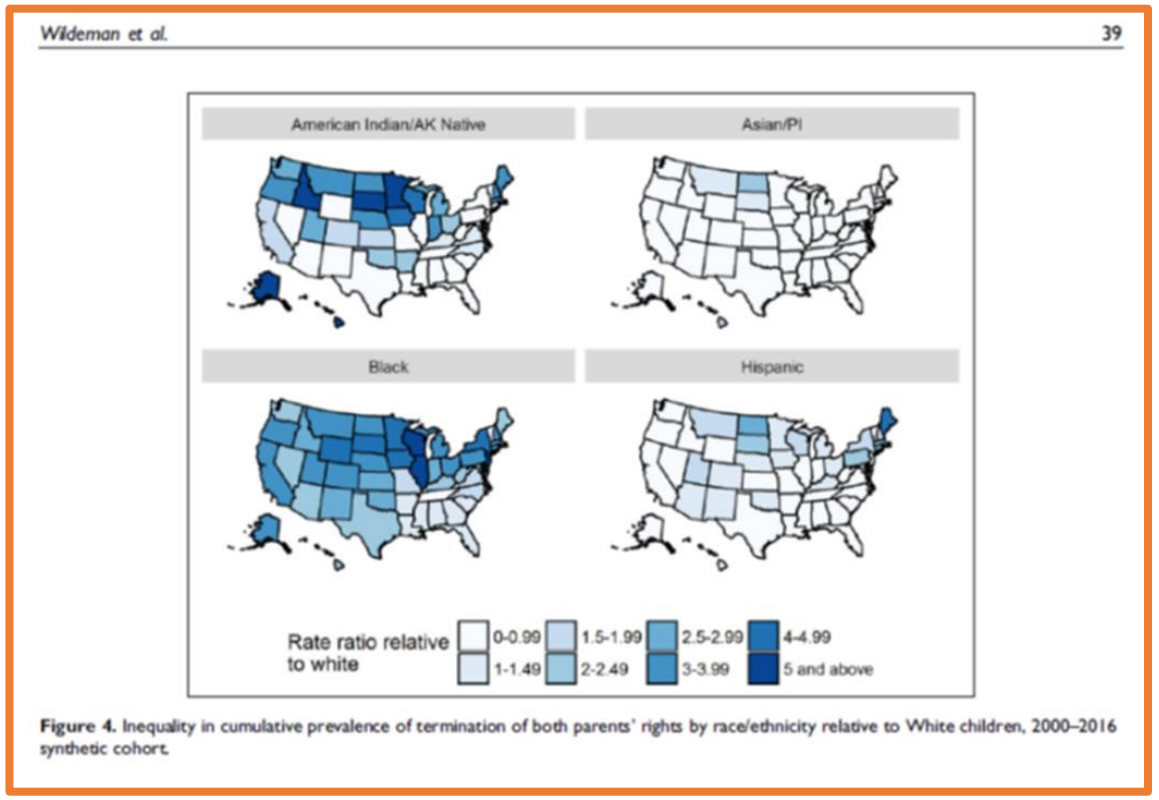


Figure 4. Inequality in cumulative prevalence of termination of both parents' rights by race/ethnicity relative to White children, 2000–2016 synthetic cohort.

MFP 2020

Wildeman C, 2020 *Child Maltreatment*

“Better Safe Than Sorry”? Child Welfare Report and Consequence for Drug Exposure

20% children experience abuse or neglect in out-of-home placement

Mental health and somatic conditions greater among children in foster care compared to general population

Toxic stress: The physiologic result of physical of dangerous, recurrent, or prolonged experience of trauma caused by the initiation of the stress response without the protective existence of a compassionate adult

Non-death Loss and Grief in Foster Care

Dorsey S, *Journal of Child & Family Studies*, 2012; Jonkowski MK, *Child Maltreatment*, 2019
Forkey HC, *J of Child & Family Studies*, 2016; Mitchell MB, *Child Adolesc Soc Work J*, 2018

Child Fatalities due to Maltreatment are Tragic and Rare

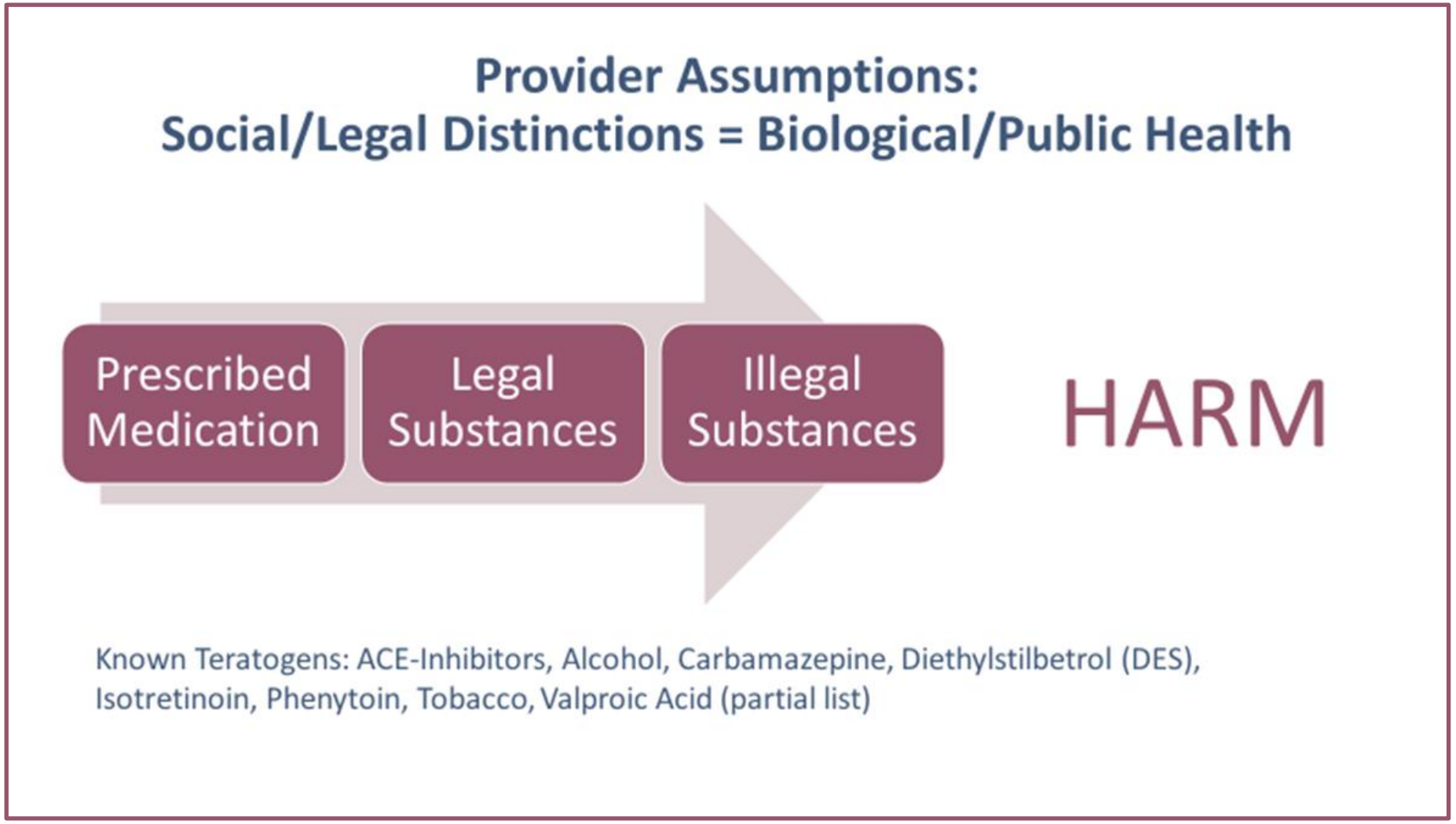
1713 fatalities in 2020 (rate 2/100,000)

Each Death is Preventable

But there is no evidence that removing children for substance exposure protects them from fatality due to maltreatment

Ideology and Misinformation

The fetus does not know if the exposure is prescribed, used as directed or misused, legal or illegal, natural or synthetic



Logical Tautologies

The Statutory Association between Substance Use in Pregnancy and Subsequent Maltreatment

Logical Tautology
True (or false) by definition
Defined in reference to itself
“Formally undecidable”
Not falsifiable
Therefore, not scientific

A = B

Substance Use in Pregnancy and Subsequent Child Maltreatment: Where is the Evidence?

- Substance-exposed infants have increased likelihood of child welfare involvement
- No strong evidence of substantiated maltreatment
- Overall literature is of poor methodological quality

Review Article

Child Maltreatment
1-26

DOI: 10.1177/1077559521990116
journals.sagepub.com/home/cmx
SAGE

Prenatal Substance Exposure and Child Maltreatment: A Systematic Review

Anna E. Austin[1,2], Caitlin Gest[1], Alexandra Atkeson[1], Molly C. Berkoff[3], Henry T. Puls[4], and Meghan E. Shanahan[1,2]

Abstract

State and federal policies regarding substance use in pregnancy, specifically whether a notification to child protective services is required, continue to evolve. To inform practice, policy, and future research, we sought to synthesize and critically evaluate the existing literature regarding the association of prenatal substance exposure with child maltreatment. We conducted a comprehensive electronic search of PubMed, Web of Science, PsycInfo, CHINAL, Social Work Abstracts, Sociological Abstracts, and Social Services Abstracts. We identified 30 studies that examined the association of exposure to any/multiple substances, cocaine, alcohol, opioids, marijuana, and amphetamine/methamphetamine with child maltreatment. Overall, results indicated that substance exposed infants have an increased likelihood of child protective services involvement, maternal self-reported risk of maltreatment behaviors, hospitalizations and clinic visits for suspected maltreatment, and adolescent retrospective self-report of maltreatment compared to unexposed infants. While study results suggest an association of prenatal substance exposure with child maltreatment, there are several methodological considerations that have implications for results and interpretation, including definitions of prenatal substance exposure and maltreatment, study populations used, and potential unmeasured confounding. As each may bias study results, careful interpretation and further research are warranted to appropriately inform programs and policy.

Keywords

child maltreatment, infants, substance abuse

Table III. Foundational principles for the clinical definition of opioid withdrawal in the neonate

1. Substance use disorder is a disease requiring compassionate, ethical, equitable, and evidence-based care.
2. The maternal–neonate dyad is the appropriate subject of care; this definition is intended to identify clinical and supportive care needs of the dyad; shared interests should be prioritized.
3. A diagnosis of NAS or NOWS does not imply harm, nor should it be used to assess child social welfare risk or status. It should not be used to prosecute or punish the mother or as evidence to remove a neonate from parental custody.
4. Environmental factors, family influences, and social structures strongly influence neonatal outcome and should be recognized.

THE JOURNAL OF PEDIATRICS • www.jpeds.com ORIGINAL ARTICLES

Standardizing the Clinical Definition of Opioid Withdrawal in the Neonate

Shahla M. Jilani, MD[1,*], Hendrée E. Jones, PhD[2,3,*], Matthew Grossman, MD[4], Lauren M. Jansson, MD[5], Mishka Terplan, MD, MPH[6], Laura J. Faherty, MD, MPH, MSHP[7,8], Dmitry Khodyakov, PhD, MA[7], Stephen W. Patrick, MD, MPH, MS[9], and Jonathan M. Davis, MD[10]

Objective To standardize the clinical definition of opioid withdrawal in neonates to address challenges in clinical care, quality improvement, research, and public policy for this patient population.
Study design Between October and December 2020, we conducted 2 modified-Delphi panels using ExpertLens, a virtual platform for performing iterative expert engagement panels. Twenty clinical experts specializing in care for the substance-exposed mother–neonate dyad explored the necessity of key evidence-based clinical elements in defining opioid withdrawal in the neonate leading to a diagnosis of neonatal abstinence syndrome (NAS)/neonatal opioid withdrawal syndrome (NOWS). Expert consensus was assessed using descriptive statistics, the RAND/UCLA Appropriateness Method, and thematic analysis of participants' comments.
Results Expert panels concluded the following were required for diagnosis: in utero exposure (known by history, not necessarily by toxicology testing) to opioids with or without the presence of other psychotropic substances, and the presence of at least two of the most common clinical signs characteristic of withdrawal (excessive crying, fragmented sleep, tremors, increased muscle tone, gastrointestinal dysfunction).
Conclusions Results indicate that both a known history of in utero opioid exposure and a distinct set of withdrawal signs are necessary to standardize a definition of neonatal withdrawal. Implementation of a standardized

Healthcare is not Safe, Especially for Pregnant People who use Drugs; Discrimination is a Patient Safety Issue

Top 5 Do No Harm Checklist

1) Check your systems in which individuals navigate getting care. Change adversarial systems into supportive spaces
2) Check the entire care team. From the front desk to physicians, everyone who interacts with patients should have an understanding of what harm is, why understanding it is important, and how to prevent it.
3) Check your biases. Understand that everyone is biased, including you. Understanding and addressing your own biases is a life-long journey.
4) Check each other. Sometimes the person causing the harm does not realize s/he is doing it.
5) Check your listening skills. Believe what people are telling you and know that listening is key to understanding and providing respectful care.

Developed through DC Equity Action Lab at DC Primary Care Association. Based on the Top 5 Do No Harm list created by Ebony Marcelle, CNM, MS, FACNM, Director of Midwifery at Community of Hope and Family Health and Birth Center. Contact the DC Primary Care Association for the full Do No Harm Guide.

Original research

OPEN ACCESS

First do no harm: practitioners' ability to 'diagnose' system weaknesses and improve safety is a critical initial step in improving care quality

Mike English ,[1,2] Muthoni Ogola,[2,3] Jalemba Aluvaala ,[2,3] Edith Gicheha,[2,4] Grace Irimu,[2,3,4] Jacob McKnight,[1] Charles A Vincent[5]

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[5]Experimental Psychology, University of Oxford, Oxford, UK

ABSTRACT
Healthcare systems across the world and especially those in low-resource settings (LRS) are under pressure and one of the first priorities must be to prevent any harm done while trying to deliver care. Health care workers, especially department leaders, need the diagnostic abilities to identify local safety concerns and design actions that benefit their patients. We draw on concepts from the safety sciences that are less well-known than mainstream quality improvement techniques in LRS. We use these to illustrate how to analyse the complex interactions between resources and tools, the organisation of tasks and the norms that

What is already known on this topic?

- Harm resulting from unsafe care is common and results in significant adverse health and economic consequences in high-income countries.
- Efforts to prevent or reduce harms often focus on identifying errors so that their specific causes can be addressed.
- More recently, attention has been turned to considering how harms arise as a product of complex interactions in systems.

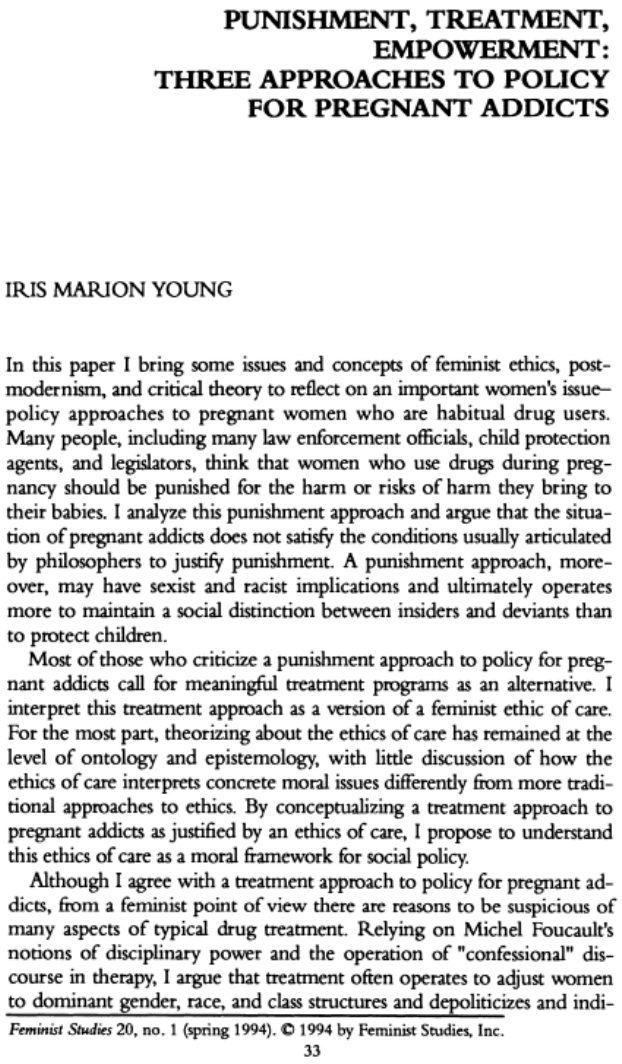
The Body Politic and Healthcare-Induced Violence: Information Sharing Contributes to the (Further) Criminalization of the Female Body

"Equating a positive toxicology test with child abuse or neglect is scientifically inaccurate and inappropriate, and can lead to an unnecessarily punitive approach, which harms clinician-patient trust and persons' engagement with healthcare services."

ASAM Public Policy Statement on Substance Use and Substance Use Disorder Among Pregnant and Postpartum People, 10, 2022

"The laws, regulations, and policies that require health care practitioners and human service workers to respond to substance use and substance use disorder in a primarily punitive way, require health care providers to function as agents of law enforcement."

ACOG, *Opposition to Criminalization of Individuals During Pregnancy and the Postpartum Period: Statement of Policy, 11, 2020*



PUNISHMENT, TREATMENT, EMPOWERMENT: THREE APPROACHES TO POLICY FOR PREGNANT ADDICTS

IRIS MARION YOUNG

In this paper I bring some issues and concepts of feminist ethics, postmodernism, and critical theory to reflect on an important women's issue–policy approaches to pregnant women who are habitual drug users. Many people, including many law enforcement officials, child protection agents, and legislators, think that women who use drugs during pregnancy should be punished for the harm or risks of harm they bring to their babies. I analyze this punishment approach and argue that the situation of pregnant addicts does not satisfy the conditions usually articulated by philosophers to justify punishment. A punishment approach, moreover, may have sexist and racist implications and ultimately operates more to maintain a social distinction between insiders and deviants than to protect children.

Most of those who criticize a punishment approach to policy for pregnant addicts call for meaningful treatment programs as an alternative. I interpret this treatment approach as a version of a feminist ethic of care. For the most part, theorizing about the ethics of care has remained at the level of ontology and epistemology, with little discussion of how the ethics of care interprets concrete moral issues differently from more traditional approaches to ethics. By conceptualizing a treatment approach to pregnant addicts as justified by an ethics of care, I propose to understand this ethics of care as a moral framework for social policy.

Although I agree with a treatment approach to policy for pregnant addicts, from a feminist point of view there are reasons to be suspicious of many aspects of typical drug treatment. Relying on Michel Foucault's notions of disciplinary power and the operation of "confessional" discourse in therapy, I argue that treatment often operates to adjust women to dominant gender, race, and class structures and depoliticizes and indi-

Feminist Studies 20, no. 1 (spring 1994). © 1994 by Feminist Studies, Inc.

Begin by Decriminalizing Healthcare

- Institutions concerned with the promotion of public health possess a duty of justice
  - Hence – Decriminalize Health Care

- Drug Tests and Informed Consent – Tools not Solutions
  - Both embedded in structures of oppression

- Recognize and Resist False Dichotomies

Pregnancy and Addiction: Mutual Mistrust

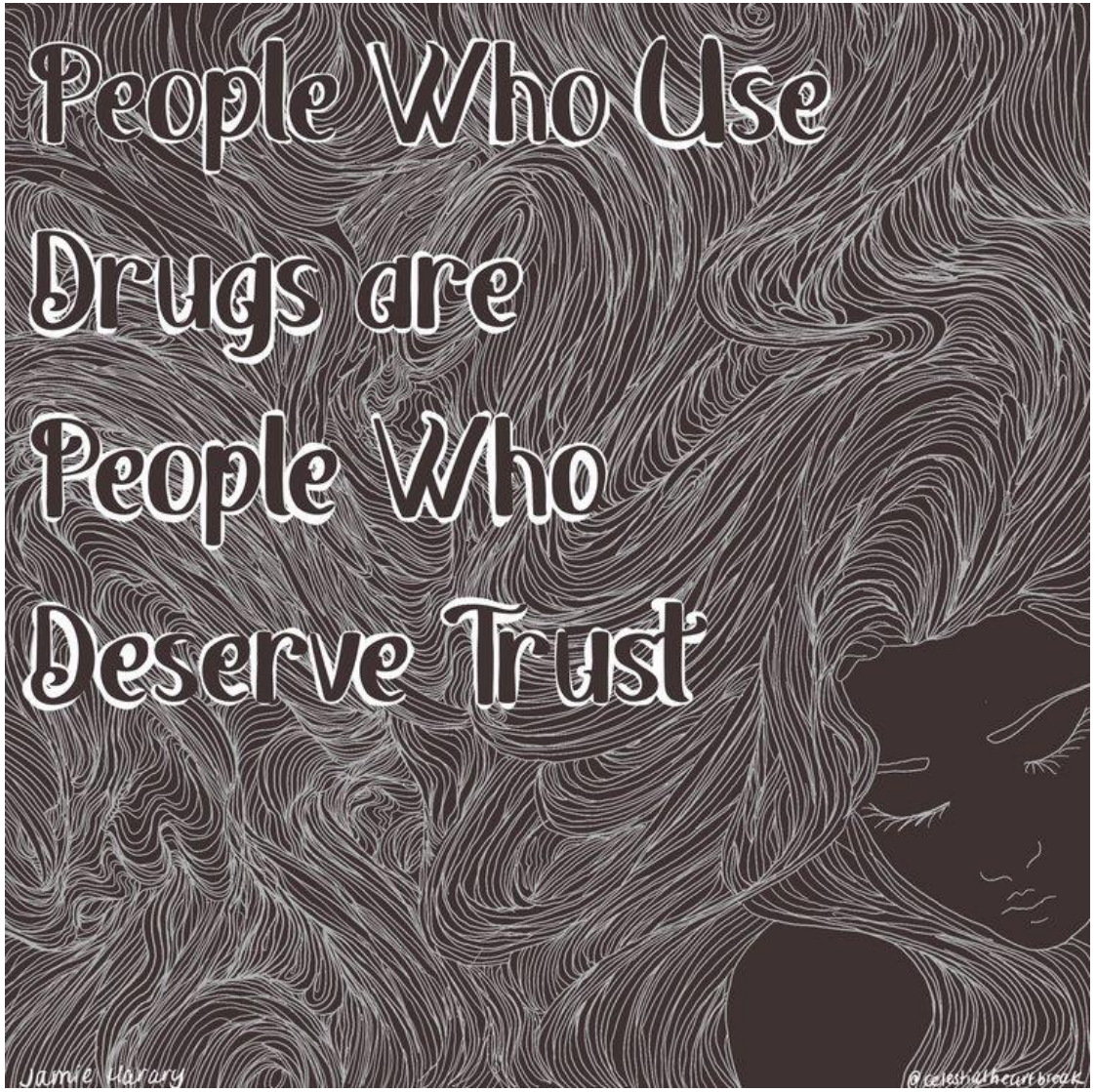
Provider

- Mistrust (often) misplaced
- Rooted in discrimination and prejudice
- Consequences of misplaced trust are minor

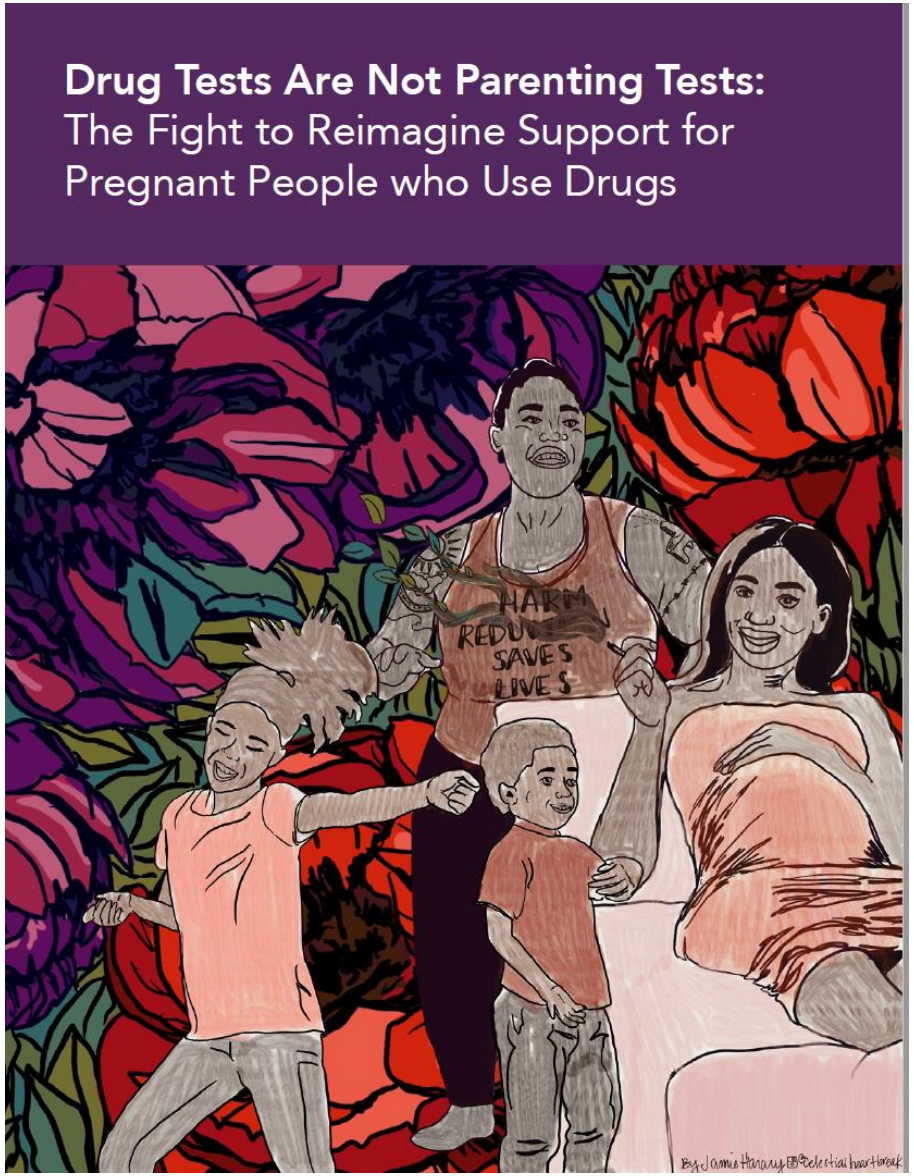
Patient

- Mistrust warranted by people who experience oppression
- Legitimate: historic memory and everyday discrimination
- Consequences of misplaced trust are severe

Power Differential
Risk/Vulnerability Different
Responsibility for Overcoming Mistrust Rests with Providers



https://www.movementforfamilypower.org/



Shared Values

People who use drugs should be treated with dignity and respect when they seek health care.

Parenting is hard, and we support non-punitive approaches that empower the parent, infant, dyad, and family to thrive together.

Thank you

Understanding THE EVIDENCE

Joelle Puccio, BSN, RN

Joelle@perinatalharmreduction.org

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Natalie Proctor – Tribal Chairwoman, Cedarville Band of Piscataway Indians

- Quit accepting invitations to events due to feeling of tokenism and lack of sincere desire for change on the part of organizers
- Piscataway Indian Museum and Cultural Center was forced to close due to lack of attendance
- Living the American Indian Experience is a program aimed at raising awareness
    - Certain aspects of history avoided due to non-indigenous people's intolerance for discomfort
- Perceived as invisible unless wearing traditional garb, and not seen as whole people, with modern interests and talents
- Natalie hopes to bring their story to other colonized and war-torn peoples around the world
- **Make a donation via PayPal at:**

PiscatawayIndians@gmail.com

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- Experience in NICU/Postpartum since 2004 at 14 hospitals in 8 states, and counting...
- 11 years in direct service and as a member of Board of Directors at syringe services program
- Presenter at NHRC, DPA, CDC, ONDCP, ACOG, ANN... and more
- Co-Founder of the Academy of Perinatal Harm Reduction

Joelle@perinatalharmreduction.org

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Our mission is to improve the lives of pregnant and parenting people who use substances.

We strive to create communities where all families are safe, intact, and informed regardless of what they put into their bodies.

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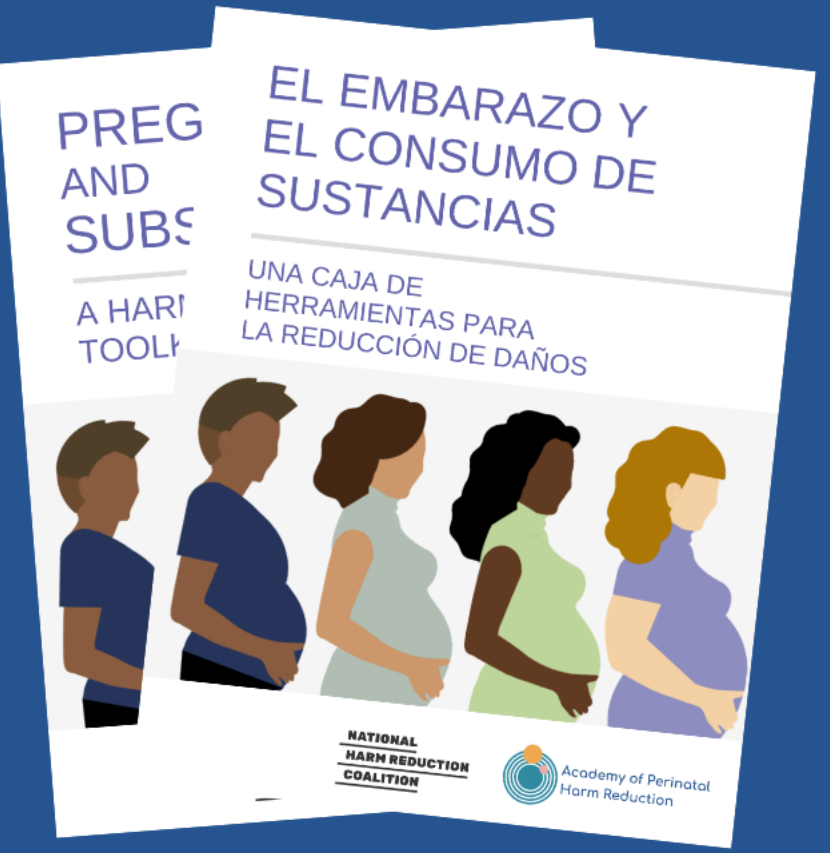
I have no relevant financial relationships with any commercial interests to disclose.

PERINATALSUBSTANCE USE:
A Harm Reduction Toolkit

- Quality Perinatal Care is Your Right
- 6 Classes of Substances
- Navigating Systems
- Prenatal Care
- Labor and Birth
- Postpartum Care



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WHAT DO WE NEED TO KNOW?

- Does exposure affect parent health?
- Does substance cross the placenta?
- Does exposure affect lactation?
- Does substance pass into human milk?
- Do infants absorb it in the GI tract?
- Does pre- or postnatal exposure affect infant health and development?
- Law, policy, and social norms*

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WHAT WE DON'T NEED TO KNOW

Urine tests:

- Are not recommended
- Lead to cascade of harm
- Are rarely medically indicated
- Are performed without patient knowledge or informed consent
- Do not provide useful information

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Study samples are not representative of the general poplation, but based on

who gets caught

- Black, Indigenous, People of Color
- Young
- Disabled
- Neurodiverse
- Rural
- Families that do not conform to western ideals
- Poor
- LGBTQIA+
- Unmarried
- Former foster children

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Major funders and medical associations do not have an interest in funding, conducting, or publishing research that does not find negative effects and outcomes.

- National Institutes of Drug Abuse (~90% of substance use research funding)
- American Society of Addiction Medicine (ASAM)
  - *Journal of Addiction Medicine*
- Society for the Study of Addiction (SSA)
  - *Addiction*

Association vs Causation

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Statistically vs Clinically SIGNIFICANT

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Statistically vs Clinically SIGNIFICANT

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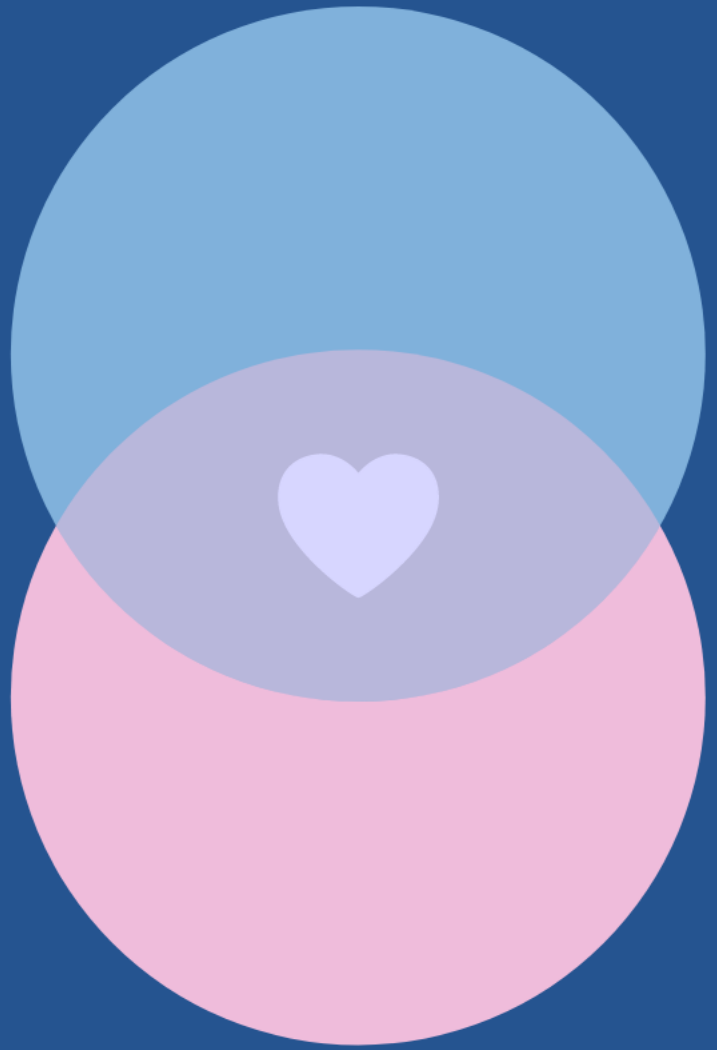
Dyad

“There is no such thing as a baby ..."

“If you set out to describe a baby, you will find you are describing a baby and someone. A baby can not exist alone, but is essentially part of a relationship”

DW Winnicott, 1966



OPIOIDS

- Neonatal Opioid Withdrawal
- Not dose-dependent Cleary 2011
- Long-term outcomes similar to peer group ACOG 2017, SAMHSA 2005

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The EVIDENCE

Overdose in Pregnancy

- Respond the same way you would for any overdose
  - naloxone
  - rescue breathing
  - supplemental oxygen
- Use the LEFT side for recovery position to increase blood to the placenta

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GOLD STANDARD

ACOG 2017, SAMHSA 2016

OAT opioid agonist therapy

MOUD medication for opioid use disorder

- methadone
- buprenorphine

* Buprenorphine is probably slightly better than methadone. ACCESS

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ANOTHER OPTION: Naltrexone

opioid ANTagonist therapy

- Less likely to work (Jones 2013)
- Poor patient satisfaction (Wachman 2019)
- Increased risk of death (Kelty 2017, Wachman 2019, Ward 2018)
- Requires detox first (Jones 2013)

* NO INFANT WITHDRAWAL

(Chan 2004, Hulse 2001, Hulse 2002, Hulse 2004, Jones 2013, Kelty 2017, Kelty2017)

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ANOTHER OPTION: Naltrexone

RECOMMENDATION

- Continue if it's working
- Don't start during pregnancy

* Unless the patient chooses it

Harm Reduction

- Overdose prevention and reversal
- Avoid codeine
- SUID risk and NOW interventions
- Eat, Sleep, Console (ESC)
- Recommend OAT
- Advocate for safe supply
- Method of Administration

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TOBACCO + NICOTINE

- Ectopic pregnancy, intrauterine growth restriction, placenta previa and abruption, premature rupture of membranes, low birth weight, congenital anomalies, infant mortality, altered maternal thyroid function, respiratory, gastrointestinal, and metabolic disease in offspring

ACOG 2017, Einarson 2009, AAP 2012, USDHHS 2004

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The EVIDENCE

Smokeless Nicotine

- Quitting nicotine altogether is the safest choice, both for your future health and for your pregnancy
- Gum, patches, and medications are not FDA approved for pregnancy, but have better data than e-cigarettes (vaping).

Safest	Quitting nicotine altogether
Safer	Quitting with traditional therapies
Safer	Quitting with a vape
Least Safe	Continuing to smoke cigarettes

E-cigarettes and Vaping

- E-cigarettes are safer than smoking for everyone, including pregnant people.
- Health and birth outcomes are improved for people who exclusively vape compared to those who smoke cigarettes

Bowker 2020, CDC 2019, McDonnell 2020, Shittu 2021, Spindel 2016, Wong 2020, Whittington 2018

Safest	Quitting nicotine altogether
Safer	Quitting with traditional therapies
Safer	Quitting with a vape
Least Safe	Continuing to smoke

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TOBACCO + NICOTINE

We do have it, and we recognize that even so, it's no reason to tear apart families and deprive babies of human milk.

Why don't we apply this logic to other classes of drugs?

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EVIDENCE we DON'T HAVE

QUESTIONS and ANSWERS

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Street Corner Deliveries:

A trauma-informed approach to caring for pregnant patients with substance use

Hillary Miller, MSN, BSN

Victoria Keiser, MD

No Financial Disclosures

Objectives

- Discuss the foundation and start of Project HOME Street Medicine in Philadelphia, PA
- Define Project HOME Street Medicine Pregnancy Care Program
- Demonstrate the importance of trauma-informed and culturally competent prenatal and pregnancy care for individuals who use substances
- Discuss the impact of local hospital collaborations and medical residents on street-based pregnancy care
- Discuss different barriers that patients may face when encountering formalized hospital or hospital-like settings
- Analyze the impact of street-side pregnancy care on maternal and child health outcomes
- Formulate ideas on how to incorporate Street Med Pregnancy Care into your current practice and/or hospital settings

PROJECT HOME

The mission of the Project HOME community is **to empower adults, children, and families to break the cycle of homelessness and poverty,** to alleviate the underlying causes of poverty, and to enable all of us to attain our fullest potential as individuals and as members of the broader society.

Project HOME stands for **Housing, Opportunities for Employment, Medical Care, and Education**. Project HOME empowers people to break the cycle of homelessness and poverty.

Coming HOME | The Story of Project HOME
https://www.youtube.com/watch?v=gZkZ22BKcco
Providing Recovery Care: Project HOME in Kensington
https://www.youtube.com/watch?v=E8YF3Lezyu8&t=8s

"The critical flaw in our health-care system… is that it was never designed for the kind of patients who incur the highest costs.

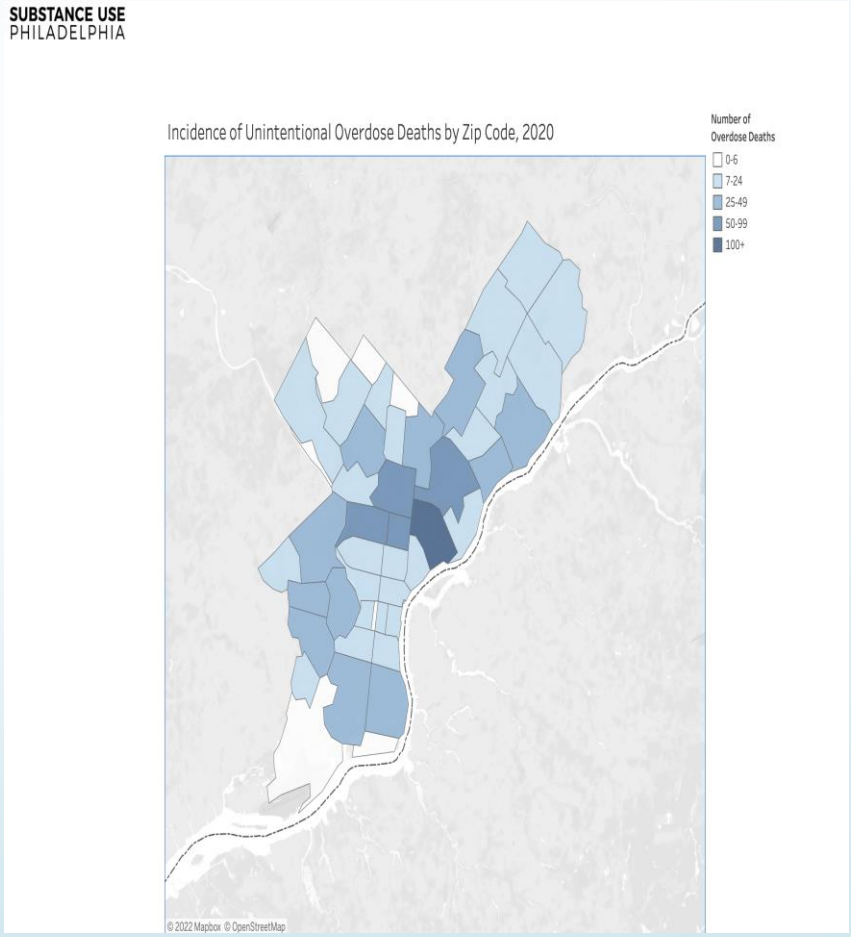
Medicine's primary mechanism of service is the doctor visit and the E.R. visit… For a thirty-year-old with a fever, a twenty-minute visit to the doctor's office may be just the thing. For a pedestrian hit by a minivan, there's nowhere better than an emergency room…

These institutions are *vastly inadequate for people with complex problems:* **the forty-year-old with drug and alcohol addiction**; the eighty-four-year-old with advanced Alzheimer's disease and a pneumonia; the sixty-year-old with **heart failure,** obesity, gout, a bad memory for his eleven medications, and half a dozen specialists recommending different tests and procedures. ***It's like arriving at a major construction project with nothing but a screwdriver and a crane."***

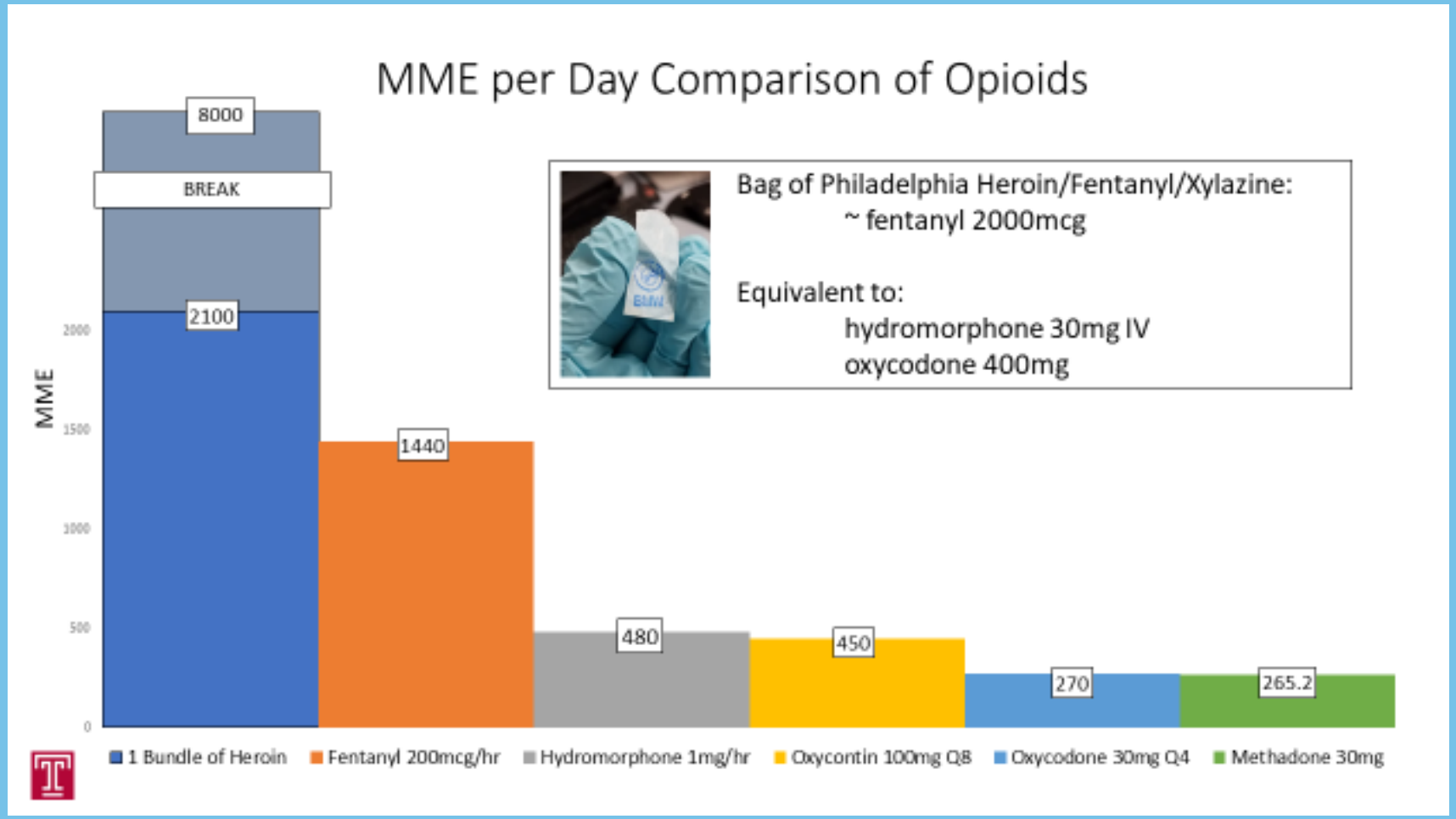
Excerpt from Atul Gawande's (2011) article "The Hotspotters: Can we lower medical costs by giving the neediest patients better care?"
http://www.newyorker.com/magazine

Substance Use in Philadelphia

- In 2020, more than 1,200 people died from drug overdoses in Philadelphia
- 86% of deaths involved an opioid and 60% involved a stimulant
- In 2020 the number of overdoses among non-Hispanic black individuals increased 29% while the number of overdoses among non-Hispanic white individuals decreased by 10%



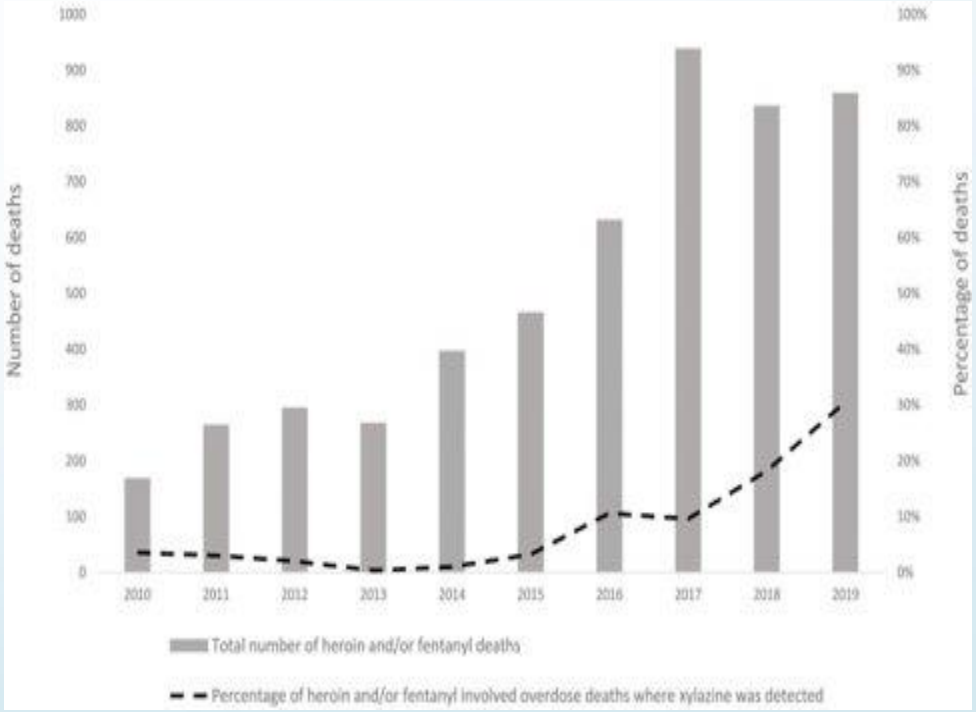
https://www.substanceusephilly.com/unintentional-overdose-deaths



Credit to Dr. D'Orazio-Temple Addiction Medicine

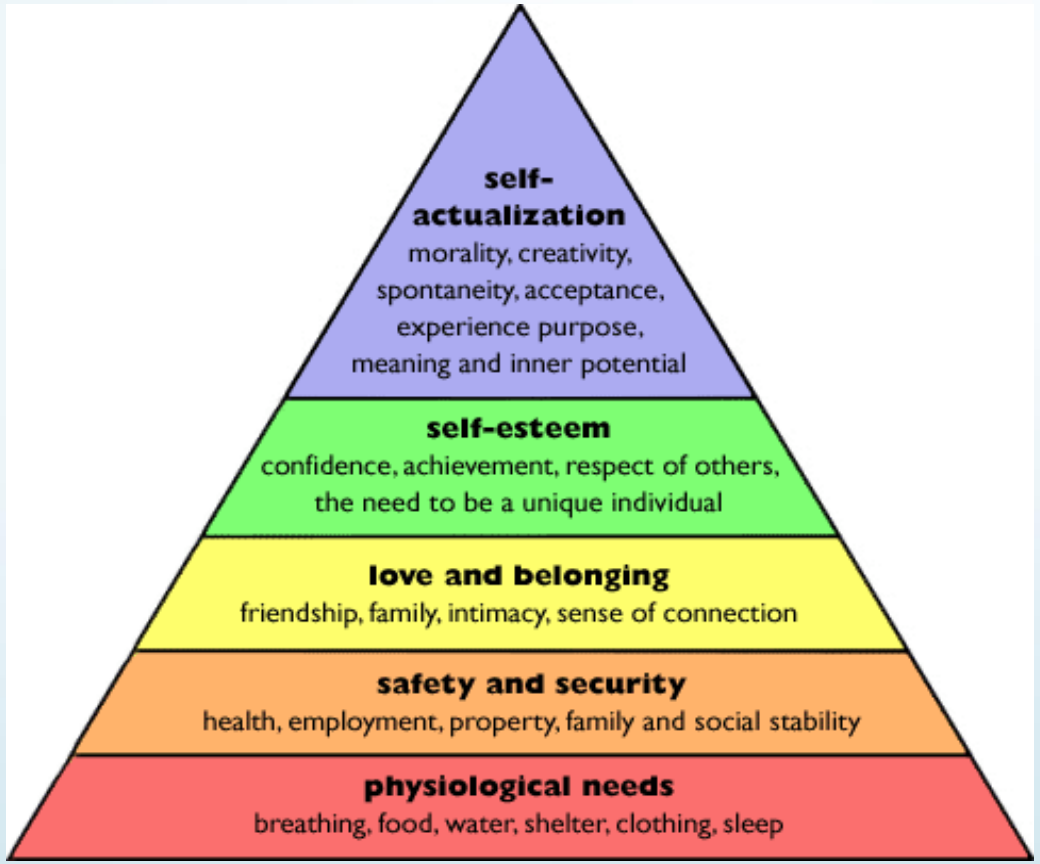
Xylazine "Tranq" in Philadelphia

- First appeared in drug supply prior to 2010, rapidly increased starting in 2016/17
- Xylazine present in 91% of fentanyl/heroin samples in <u>2021</u>
- (slide adapted from Kate Gleason Bachman, RN, 2022)



Maslow's Hierarchy of Needs:

Where do you think people experiencing chronic homelessness spend most of their energies? How does this impact their health?



Retrieved from http://theskooloflife.com/wordpress/self-actualization-in-the-maslow-hierarchy/

Project HOME Street Medicine

Project HOME Street Medicine

- Founded and lead by Kara Cohen, NP our team became a full-time street medicine team in February 2022
  - Prior to the "full time" status Kara was going out 1-2 sessions a week for 5 years prior
- Our team provides PRIMARY CARE AND PREVENTIVE SERVICES
  - Complex wound management (under the guidance of our own wound expert Lydia Williams, CWOCN)
  - Literal point of care services
  - Extremely mobile and able to track, locate patients and coordinate follow-ups
  - Ability for warm hand-offs to be seen in a satellite Project HOME Site (Stephen Klein Wellness Center, Pathways to Housing and HUB of Hope)
- Our team has seen over 500 new unduplicated patients in the first year
- Our team averages about 12-14 patient visits per day
- On average, each patient encounter requires 30-45 minutes of case management work after the visit

Project HOME Outreach and Project HOME Street Medicine

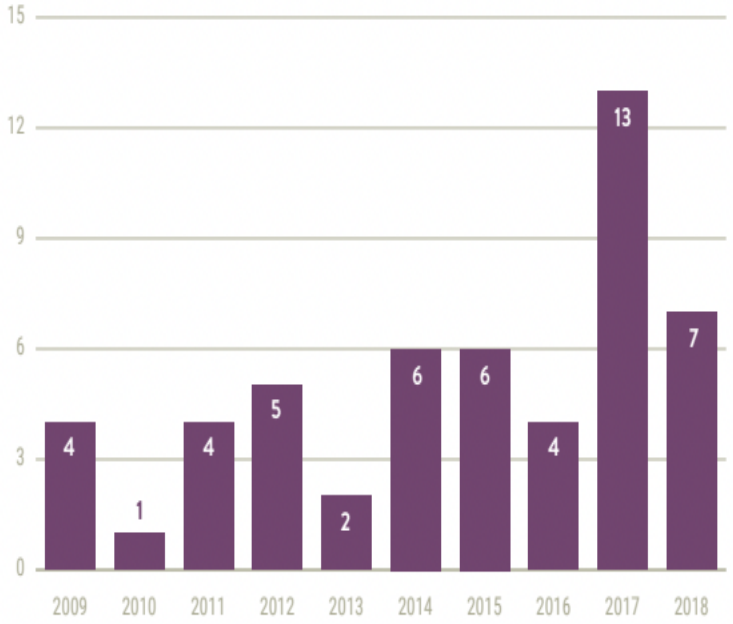
- Close partnerships with Project HOME Outreach
- Trust and rapport building are KEY!
- Identification of the people/patients we work with
  - They know EVERYONE in Philly!
- Improves safety while we provide medical care

Project HOME Pregnancy Care

Maternal Mortality in Philadelphia: Philadelphia Maternal Mortality Review Committee Report- 2021

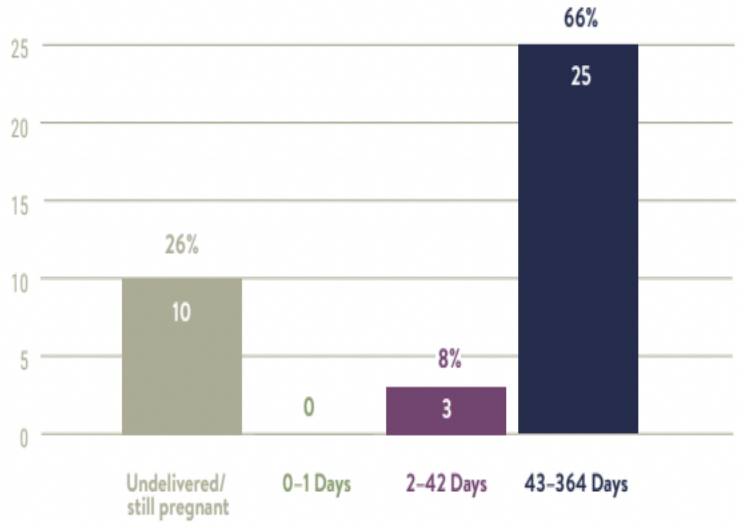
Between 2009 and 2016, accidental drug overdoses accounted for 25% of pregnancy-associated deaths. This increased to 39% between 2017-18. Preliminary data from 2019 and early 2020 suggest that this upward trend is continuing persistently.

Figure 3.1 Drug-Related, Pregnancy-Associated Deaths of Philadelphia Women, 2009–2018



Sixty-six percent of drug-related deaths occurred after the traditional 6 weeks postpartum period.

Figure 3.2 Time from End of Pregnancy Until Death for Drug-Related, Pregnancy-Associated Deaths, 2013-2018 (n=38)



Pregnancy and Substance Use in Philadelphia area

- Increase in fentanyl/xylazine → decrease in ability to access prenatal care
  - Our patients have reported it is getting "harder and harder" to leave Kensington due to the immense cravings and withdrawals effects in the current drug supply
- Increase in violence across all of Philadelphia and especially Kensington area
  - Specifically, an increase in the reports of IPV (to our staff) within the past year

Establishment of Pregnancy Care Program

- After the start of the Street Medicine program in February 2022
  - Our team was notified of multiple street corner deliveries (over 10)
    - Delivery at the corner of Kensington and Allegheny intersection
    - Many additional close calls
- A substantial need for trauma-informed pregnancy care options for patients using substances
  - Right where our patients live!
- Our team started to first work to establish and formalize different connection points throughout the city to help support Street Med patient needs
  - As well as becoming more confident in managing street-based pregnancy care in primary care

Pregnancy Care and Project HOME Street Medicine

- "Pregnancy Care"
  - Term created by Lifelong Street Medicine
  - Providing harm reduction (patient-led/directed) care based on patient's desires and goals
  - Acknowledgement that a standardized prenatal care plan will not always work for patients experiencing homelessness

- **Project HOME Street Medicine Pregnancy Care Goals**
  - Provide regular access to pregnancy testing to allow for earlier identification of pregnancy and options counseling
  - Provide street based comprehensive collaborative pregnancy care with the goal to connect patient to a trusted hospital network for safe (non-street) delivery
    - Currently, all of the Project HOME Street Medicine connected patients have delivered in a hospital setting (not on the street)
  - Provide more regular and consistent access to LARC and all forms of contraceptives
    - Currently a bit difficult due to the confines of our vehicle set up and the lack of a touch down base-coming soon in Spring 2023
  - Continuously work to address systemic barriers and racism in healthcare systems while working to increase access to healthcare
    - Acknowledging the high rates of maternal mortality specifically for black women (nationwide) and in Philadelphia

Nurse-Led Nurse Run Street Medicine Program

- Important role of nursing in the field of Street Medicine
- Importance of awareness for continued learning and progression of the medical fields
  - It is much more difficult for our Street Med team to reach in-patient providers than our MD/DO counterparts
  - Continued advocacy to ensure that our patients can receive the care they deserve and the sign-off that is needed to make that happen can occur

Established Referral Sites

- Stephen Klein Wellness Center-Project HOME
  - Supported their team in the creation of walk-in Wednesday afternoon time slot
- Esperanza Health Center
  - Location is ideal
- Einstein Complex Family Planning
  - Further support miscarriage management and options counseling
- Jefferson Hospital OBGYN (including maternal fetal medicine - MFM)
  - Very important to have a connection to a hospital team, particularly a hospital that offers inpatient medication assisted treatment (MAT/MOUD) to pregnant patients

Academic Hospital Collaboration

OBGYN Elective Rotation Experience

- 2-3 ride-alongs per week with Street Medicine team
- One half-day of "walk-in" clinic per week
  - Open to anyone who was willing to be transported by the Street Medicine van to the Jefferson OBGYN outpatient office
- 1-2 days of research and quality improvement

Jefferson
Thomas Jefferson University
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

Advocacy in the Hospital Setting

- Adapting the inpatient visitor policy to allow Street Med team to visit patients
- Adjusting the intake form for inpatient services when a patient is admitted for medication assisted treatment
- Encouraging colleagues to always utilize trauma informed language
- Acknowledgement that the care for street med patients' needs to be catered to the patient's wishes
  - Multiple postpartum visits are crucial in order to keep patients in the healthcare system and prevent postpartum mortality
  - Cluster care to get as many tasks done in one visit as possible

Barriers to Accessing Pregnancy Care

- Stigma
  - Patients shared that they often felt judged by providers and have a lot of trauma associated with past pregnancies/healthcare encounters
- Transportation issues/Strict late policy
  - Patient makes it to the office 5 minutes past the 15-minute window and is informed that they have to reschedule the appt
- Lack of access to prenatal/pregnancy care
  - Can be difficult to find low-barrier prenatal care in the Kensington area (eg, walk in availability/accommodating for rescheduling or cancelling appointments)
  - Due to supply inconsistences and Fentanyl and xylazine many folks are not able to leave the Kensington area easily due to fear of withdrawal
  - Many patients do not have ID, insurance, transportation

HIPAA permits sharing of PHI under for coordination/continuity of care

- **HIPAA permits health care providers to disclose to other health providers any protected health information (PHI) contained in the medical record about an individual for treatment, case management, and coordination of care and, with few exceptions, treats mental health information the same as other health information. Some examples of the types of mental health information that may be found in the medical record and are subject to the same HIPAA standards as other protected health information include:**
- • medication prescription and monitoring
- • counseling session start and stop times
- • the modalities and frequencies of treatment furnished
- • results of clinical tests
- **• summaries of: diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.**
- **HIPAA generally does not limit disclosures of PHI between health care providers for treatment, case management, and care coordination, except that covered entities must obtain individuals' authorization to disclose separately maintained psychotherapy session notes for such purposes**. Covered entities should determine whether other rules, such as state law or professional practice standards place additional limitations on disclosures of PHI related to mental health.
- For more information see:

  Does HIPAA provide extra protections for mental health information compared with other health information?

  (https://www.hhs.gov/sites/default/files/hipaa-privacy-rule-and-sharing-info-related-to-mental-health.pdf)

Next Steps For Street Medicine Pregnancy Care

- Connection with Philadelphia-Department of Public Health
- Continued advocacy for more inclusive resources for pregnancy care
- Mobile OB van (YAY!)
- Maternal Mortality Review Committee involvement

- Future for our Street Med team:
  - Looking to get Street Med van up and running to allow for more mobile med services
  - Increase clinical partners and hospitals that our team can refer patients to
  - Integration of street side ultrasound into Street Med pregnancy care
  - Eager to learn from all of you and different programs at Healthcare for the Homeless Conference

Additional Resources

- Coming HOME | The Story of Project HOME
- https://www.youtube.com/watch?v=gZkZ22BKcco

- Providing Recovery Care: Project HOME in Kensington https://www.youtube.com/watch?v=E8YF3Lezyu8&t=8s

Recommended Literature

- Stories from the Shadows: Reflections of a Street Medicine Doctor
- Hotspotters Article (entire article)
- NY Times Article: "You have to learn to listen": How a Doctor Cares for Boston's Homeless

Questions?

- Hillary Miller-RN, MSN- Street Med RN
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  - 267-379-7450
- Victoria Keiser
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- Kara Cohen- CRNP- Street Med Director and Founder
  - karacohen@projecthome.org


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PROJECT HOME

OB Walk-In Clinic at Stephen Klein Wellness Center

Nayeli Spahr, MD, MPH
Divya Katti, BS
Luna Uhl, Superstar

May 15, 2023

There are no financial disclosures.

Objectives

- Discuss the integrated colocation of services provided at Project HOME Health Services – Stephen Klein Wellness Center through the Perinatal Recovery Support Program and OB Walk-In Clinic as a model of care
- Describe the population served and outcomes for the Perinatal Recovery Support Program and OB Walk-In Clinic
- Describe results of lived-experience perinatal care survey
- Describe an individual's journey through perinatal care in Philadelphia, PA while experiencing homelessness and how to celebrate and support resilience

PROJECT HOME

Agenda

- Services at Stephen Klein Wellness Center
- Perinatal Recovery Support Program and the OB Walk In Clinic
- Perinatal Care Survey Responses
- Luna and Alanna's Story

PROJECT HOME

Stephen Klein Wellness Center

- Primary care for all ages including:
- Reproductive health services
- Centering Pregnancy and Parenting + Programming
- Integrated Behavioral Health
- Perinatal Mental Health Therapy
- Medication-assisted Treatment
- Psychiatry
- Dentistry
- Pharmacy
- Community Legal Partnership
- Hospitality with showers, laundry services, food pantry, and clothes distribution
- Team of outstanding Nurse Care Managers, Medical Assistants, Community Health Workers, Peer Specialists, Social Work, Providers, and Front Desk staff

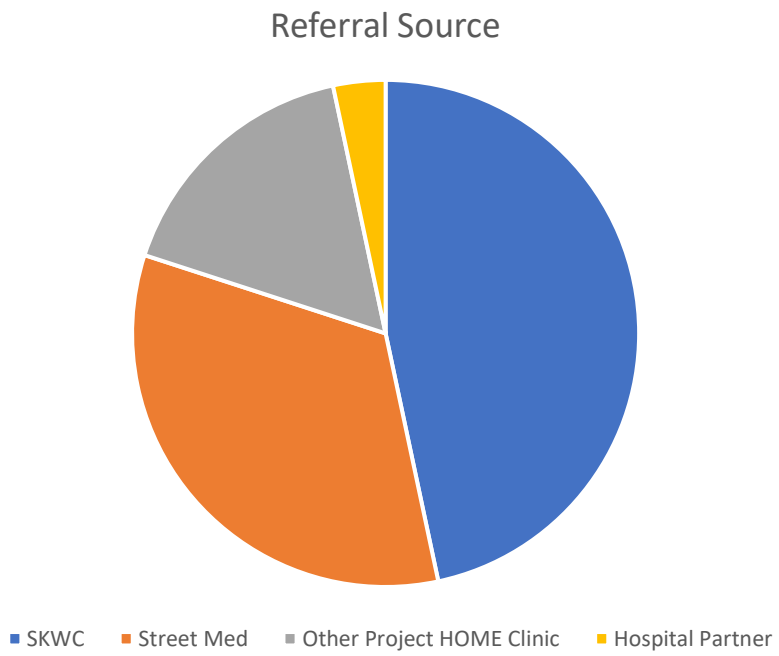
Perinatal Recovery Support (PRS) Program

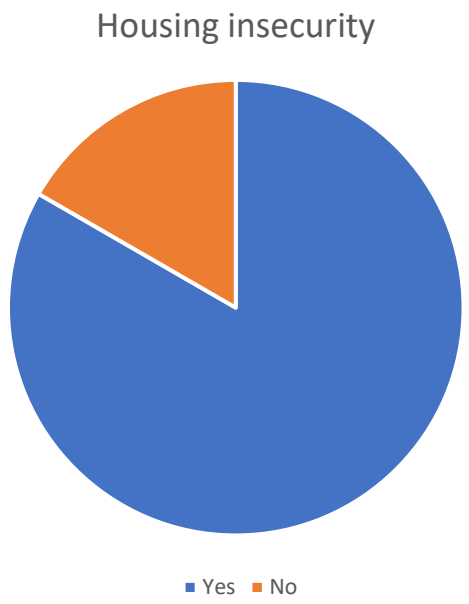
Target population: individuals who are pregnant or post pregnancy up to 1 year postpartum with history of substance use

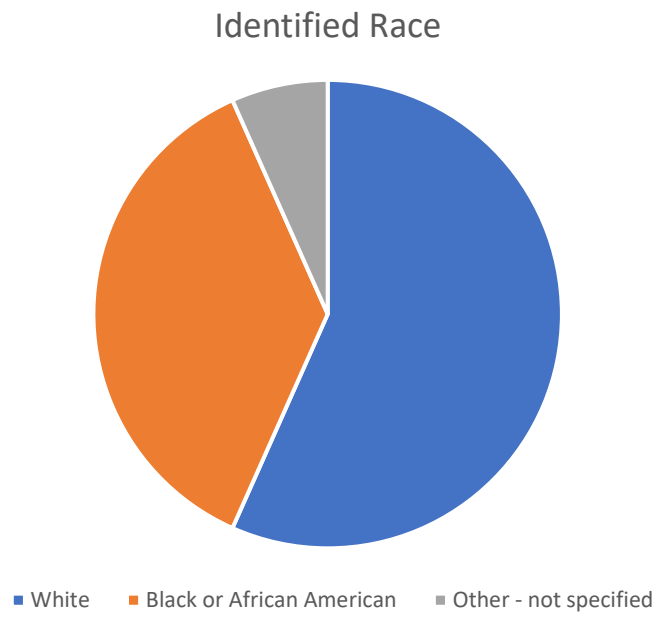
- Patients enrolled and tracked in biweekly care coordination meetings, includes Project HOME – Street Medicine Team members
- Incentives at each perinatal medical appointment, including post-pregnancy follow up
- Assist with social services needs including insurance enrollment and DHS support
- Monthly care coordination meeting with hospital partners

PROJECT HOME

Perinatal Recovery Support Program







OB Walk-in Clinic

Street Medicine and Outreach Warm Handoff

Flexible walk-in hours, every Wednesday 12:30 – 2:30PM

Address food, housing, other barriers

Enrollment into PRS program, hospitality services, MAT, benefits, incentives

Create care plan

Prenatal care, specialty consults (i.e., MFM), ultrasounds

Weekly Follow-up

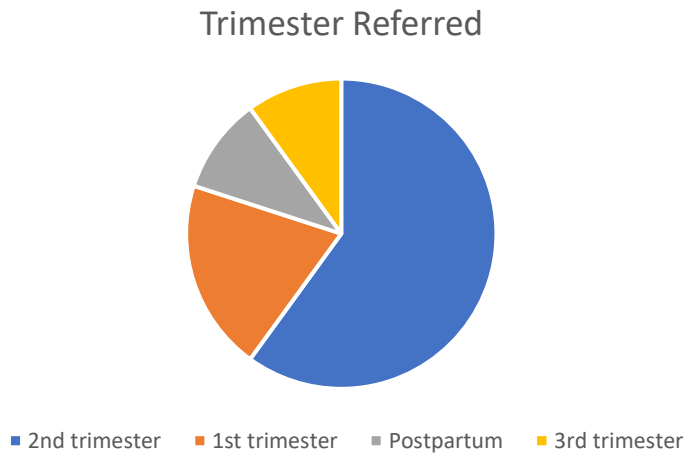
Provide transportation accommodations for next visit, ongoing social and behavioral health support

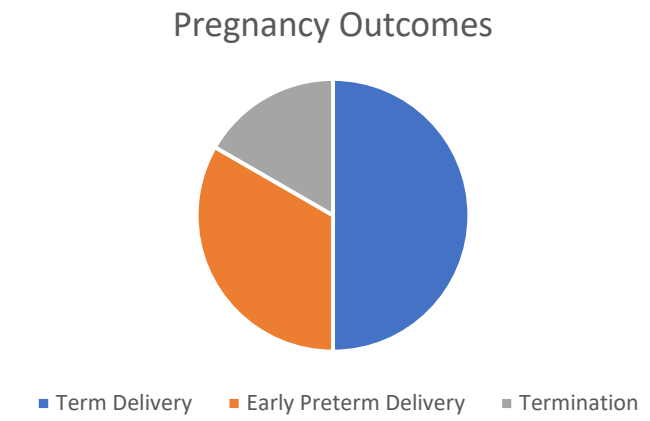
PROJECT HOME

OB Walk In Clinic

80%

Of Street Medicine referrals made it to SKWC





PROJECT HOME

OB Walk-in Clinic

50%

Initiated on MOUD
(100% with OUD)

75%

Received mental health services

100%

Treated for infection

57%

Initiated on birth control

PROJECT HOME

Objectives:
Identify barriers to perinatal care, past experiences of trauma in healthcare settings, and gauge current care experiences at SKWC

Perinatal Care Survey

“They [hospitals] looked at me like ‘she was a junkie so why take her in?’”

“Money for transportation is my biggest barrier.”

“I have PTSD - if I go to a hospital, answering questions and filling out forms brings up those memories.”

“SKWC made me feel like I was important whether I had insurance or not”

Luna and Alanna's Story

Thank you!

PROJECT HOME

NONE OF US ARE HOME UNTIL
ALL OF US ARE HOME®