DEPARTMENT OF HEALTH

Task Force on Pregnancy Health and Substance Use Disorder Meeting Minutes

Date: April 11, 2024
Minutes prepared by: Mary Ottman, Alison Moore

- Go to the task force webpage to find the formal meeting agenda, presentation slides, and any other relevant documents from the meeting.

Attendance

Task force members present	Task force members absent
- Alexandra Kraak - Amal Ali - Brittany Wright - Dr. Chris Derauf - Dr Fran Prekker - Dr. Kari Gloppen - Dr. Kurt Devine - Dr. Shanna Vidor - Kristen Brewley - Lisa Edmundson - Meagan Thompson - Rebecca Wilcox	- Caroline Hood - Dr Chris Derauf - Dr Cresta Jones - Hannaan Shire - Heidi Holmes - Margarita Ortega - Tamara Dejaurlais - Tanisha Brown

Decisions made

- No voting was conducted at this meeting.

Meeting notes

I. Welcome and introductions, Mary Ottman and Kurt Devine
    - Mary Ottman - Review of staff and their roles from Minnesota Department of Health and Management Analysis and Development
    - Reviewed deliverables and purpose of the Task Force – MN Statue 360E
    - Reviewed agenda – deepen understanding of inequities and learning from another state.
    - Kurt reviewed the timeline for the Task Force from its inception with focus on creating a shared foundation, identifying options, develop and refining draft protocols, and submitting a written report on Task Force's activities
    - Stephanie – reviewed that work groups started meeting in March

II. Agenda **overview**, including review of Mural – Stephanie Heim

- Stephanie shared overview of the agenda and purpose for meeting
- Both work groups met once and both groups meet again the following week
- Encouraged members to visit Mural page and SharePoint to stay connected with the work happening on the Task Force

III. Grounding in **group agreements**

- Read aloud by Task Force members.

IV. **Revisit introductions** for members who were not with us in December and February

- Welcome to new Task Force members and space to share in Mural about themselves.

V. **Presentation** from Connecticut about their state's approach to testing and reporting, with emphasis on their protocols, guidelines, and best practices - Kris Robles-DCF, CT; Lisa Daymonde, Careline Director CT; and Shelly Nolan

- Panel introduced themselves to the Task Force
- Connecticut uses a collaborative approach with a variety of partners involved with supporting populations in state
- CAPTA & CARA State impact – requirements to support infants with prenatal exposure to substance use and pregnant person and family
- Shifted language to notifying of newborn exposure per CAPTA notification portal to determine whether it meets threshold for mandated report
- Want to ensure that Family Care Plan addresses need of infant and family/caregiver
- Have used the Department of Child and Families (DCF) Bulletin – Child Abuse Prevention and Treatment Act (CAPTA) Notification Process with updates on guidelines that went to all providers
- Beginning March 2019, birthing hospitals required to enter information into newborn portal when an infant with prenatal substance exposure is born or presents with suspicions of abuse or neglect through an online portal.
- Explained difference between DCF report and CAPTA notification – notification does not contain identifying information about the mother/birthing person or baby if no abuse or neglect is found
- Walked through a workflow of the notification process if a newborn has been exposed in utero to substances – Testing infants is not necessary
- Showed resources for a Family Care Plan – online and the template – to use example and then encourage hospitals or health care providers to design their own
- Use notification process to gain information about prenatal substance exposure and better understand needs of the population
- Training and technical assistance prioritizing behavioral health, hospital providers, SUD providers, and clinic OBGYN providers - started training early
- Intention of the work is to collaborate and coordinate on CAPTA ensuring that information is collected to support programs and to empower birthing people - Hired a Plan of Safe Care Coordinator
- No one agency could accomplish this work alone

- Shared process of developing a family care plan and how to ensure that family care plan follows the birthing person and newborn into the community
- Addressed stigma and reducing stigma for people with SUD important to support health and wellbeing of pregnant/birthing person and infants exposed to substances – reframing language used
- Highlighted resources and supports put in place in CT and long-term vision

Discussion – Q&A – with Connecticut Staff

- Testing – do not always do toxicology testing of birthing person and infant – how did you get to this point of not always testing? How did you get hospitals to not think they are the police?
    - Medical decision to complete toxicology testing of newborn – not a requirement of child protection
    - Leave it up to medical providers to make determination of toxicology testing of baby – there are inconsistencies in practice with hospitals
    - Universal testing is not best practice; universal screening is best practice
- Are you able to pull data on newborn testing?
    - Hospitals will share data and processes for newborn testing within collaborative practice communities
- Is there bias in interpretation of impacts of substance use on safety and wellbeing of infants (race, ethnicity, socioeconomic status) and how do you evaluate this?
    - The CAPTA evaluation did show disparity about who is reported – Black and Hispanic families more likely to be reported than white families
    - Continue to have large discussions around cannabis – most likely to be reported and secondary is alcohol
- What constitutes concern about parental functioning for suspicions for abuse/neglect? What operational definitions are used? Is it subjective? Are there guidelines around this?
    - There are operational definitions in mandated reporter laws – defining abuse and neglect. There are behaviors and examples in definitions
- What happens if you get multiple reports and there are different impressions of concern and risk?
    - They will look at multiple reports from multiple individuals and it varies whether reports will be accepted for further investigation.
- Receive a lot of marijuana reports through portal – need to do further investigation to determine whether the reports should be accepted.

VI. **Presentation** by **Dr. Cresta Jones** to build a common knowledge around the inequities related to substance use testing in pregnancy. Specifically learning about

- The differences between screening and testing for substance use in pregnancy – How does it help/harm
    - Screening – use written screening tool to identify risk for non-prescribed substance use
        - 15% - 20% of population will need additional discussion based on responses

        - Biological testing – testing biological material, birthing person urine, meconium, etc.
    - Task Force - needs to understand reason for toxicology testing
    - MN state law requires toxicology testing at birth, in certain situations – statue remains vague on when to perform toxicology testing
        - Testing is required if obstetrical complications present indicating substance use
    - Universal screening tool is recommended – toxicology testing is not recommended by any of the major expert health care organizations
    - The data supporting racism and discrimination in the application of perinatal toxicology testing in the US.
        - Rates of SUD are similar across race/ethnicity groups yet Black and Hispanic people 5x's more likely than white birthing patients to undergo toxicology testing (national studies indicated this)
        - Shared MN data showing disparity in urine drug screening (UDS) before admission and at delivery admission – Black birthing parents much more likely to be tested
    - Discussed limitations of urine drug screening specifically
        - High rate of false positives, urine drug testing is not substance use screening tool
    - Shared considerations for biologic testing – medical indications for biologic testing
    - Shared example of a MN health system that changed medical indications for biologic testing

VII. **Make meaning of presentations.** Use the following questions to guide individual reflection, small group and large group discussion:
    - What does this information mean for the **testing** protocols?
        - Depending on what hospital you go to the testing protocols will vary
        - MN Statute uses only language of women – only looking at mothers or people who the statute applies to. Should evaluate statute language to think about another parent.
    - What does this information mean for the **reporting** protocols?
        - If we go down the pathway of not reporting, where does it lead to? How will family get services?
        - CPS seems to be a gatekeeper for resources; we lack enough access to services for people who use substances without CPS involvement.
        - So many disparities for children and families of color, Native American, Hispanic population in terms of reporting.
        - County-based system in MN – differences across counties as to how reports are responded to. CT is a state-based system – how can we enhance and apply what CT learned to MN context?

VIII. Wrap up and next steps.

- **Reminders about work groups, stipends for participation, and ability to still join and participate in work groups**
- Reporting workgroup meets Monday, April 15 from 12:00-1:00 pm
- Testing workgroup meets Tuesday, April 16 from 3:30-4:30 pm
- Co-chairs meet Thursday, April 18 from 3:30-4:30 pm
- Full Task Force meets again on Thursday, June 6th from 12:00-2:00 pm

Other business

No other business was discussed.

Next meeting

Date: Thursday, June 6, 2024

Time: Noon to 2 p.m.

Location: Virtual

Agenda items: Submit proposed agenda items to mary.ottman@state.mn.us.

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