TRANSCRIPT

Amani Echols >> Hello everyone. Welcome to today's webinar.

I will give approximately 30 seconds before we dive into the program today. Thank you all for joining.

All right. Welcome everyone and thank you for joining us.

My name is Amani Echols, and I'm the policy and government affairs manager with the Association of Maternal and Child Health Association AMCHP.

Welcome to today's webinar, this was in a recent journal article and is bounded by ASTHO. The special issue includes 21 open access articles highlighting the latest research, program and policy initiatives to set of four perinatal people with substance use disorder and their family. Now is a critical time to be discussing this topic as that opioid crisis has worsened throughout the COVID-19 pandemic and pregnant and postpartum people are not immune from this reality.

I will defer to my colleague to provide a more comprehensive overview of perinatal substance use throughout our time together today.

I would also like to acknowledge the financial support we received from the health resources and Maternal and Child Health journal for this special issue. Without their support, this issue would not be possible.

I also extend much of gratitude to Dr. Timothy Dye, the editor-in-chief of the maternal child health journals who provided tremendous guidance and support, hands on support throughout this process. We very much appreciate your support, Dr. Dai.

Before we officially get started, there is some additional housekeeping items that I want to cover.

Each participant today will remain for the duration of the webinar. Since the agenda is tight, we invite you to email us your questions at prism at astho.org, you don't have to memorize that we will put the email in the chat box.

Closed captioning is available. You can open and access a full transcript via the streamtext link we will share in the chat. If you prefer to see captions in a separate window, you can also enable captions in the zoom toolbar below.

If you're interested in learning more about the special issue, the speakers in the event today, please locate the handout folder that we will also put into the chat, so you can readily access that information throughout our time today.

Finally, this is being recorded. If you have to hop off early, or have a colleague who cannot make it, anyone who is registered can access the event recording and it will be posted on our website shortly after.

Now, I will pass the microphone over to Terrance Moore, the CEO of AMCHP for welcoming remarks. Following Terrence we will hear from Dr. Michael Fraser, the CEO at ASTHO, and Dr. Shirley Payne, the director of the division of state and community health within our state maternal health Bureau. Welcome, Terrence.

Terrance E. Moore >> Thank you, I want to give thanks to the teams across the organizations that have worked relentlessly to make this moment happen.

Good afternoon, everyone.

I am with the AMCHP.

This is a state program, and the mission is to advance the health of women, children, youth and families and community by strengthening governmental public health and deepening community partnerships through health equity lands.

We are so proud to be here today to release a special issue of the Maternal and Child Health journal.

I'm so grateful and for this topic which is an emerging threat to postpartum women and their infants. I also want to recognize and thank our close partners at the Association of State and territorial health issues who are instrumental in helping us bring this project to fruition, ASTHO.

We have a Maternal and Child Health crisis in this country, and we've seen an alarming increase in infant mortality in recent years. For some time now we have known that substance use has played a part in driving these numbers up.

Suicide and overdose are now the leading causes of pregnancy related deaths. Stigmatization, workforce shortages, systemic inequities and fragmentation of behavioral and physical health care affect all perinatal women with substance use disorders.

However, we know that pregnant and postpartum women of color are disproportionately impacted by the punitive policies and racial discrimination in our healthcare system.

We know that this creates great barriers for women of color to receive behavioral health services that they desperately need.

Featured in our journal are 21 cutting at articles written by experts and perinatal health and substance use disorders experts.

You will hear from some of the authors today this is leading evidence-based approaches which I hope you incorporate into your work, states and communities. Some state MCH programs care deeply about the populations and the natural partners as you develop your projects.

We hope and we are already seeing that you are able to garner the support around your localities, we encourage you to reach out to state health department in this effort. Thank you again for joining us today.

It's now my pleasure to pass the baton to my colleague, Mike Fraser, the CEO of ASTHO.

Mike Fraser >> Great to see you. I was telling the team that this would be a bad day to have a national webinar because of the holidays, but I see we have over 500 people joining us. That is wonderful, they prove me wrong yet again. I'm Mike Frazier, and I'm the chief executive officer of the associated state and territorial issues or ASTHO and I like to welcome you to this public health approach to perinatal substance use.

Let me extend my thanks to the team who help produce this webinar and to AMCHP for partnership and HRSA for their collaboration. As many of you know, our mission is to support and equip an advocate for state and territorial health officials in their work of advancing the public's health and well-being.

Earlier this year we conducted an environmental scan of current and emerging public health priorities. We look through state health improvement plans, and we interviewed state health officers, we use other data to put together top current and emerging priorities across public health programs all over the country.

Maternal and Child Health along with behavioral health and substance use emerged as the top two programmatic priorities for health officials in the 2023 environmental scan. That's the first time Maternal and Child Health rose to the number one priority among all state health officials.

This is timely work and its important work and relevant to so many and I think that's why we have so many folks engaged even today on the call.

And as you know health officers and leadership teams play a critical role in improving care through programmatic and policy change, rooted in health equity, improving access and reducing barriers for families affected by substance use. It's a complex issue and it takes a multifaceted approach across agencies, groups and communities.

As you will hear from the authors this afternoon, the state health departments are key partners in this effort and play a vital role in increasing access to screening and treatment, leveraging coverage, bolstering the workforce and creating patient center policies focus on the mother baby dyad.

We look forward to continuing to support you for this rewarding work. With that I sincerely thank you for taking time out of your day to a participant in the event today and the continued dedication to improving health and well-being in your communities. The successes and lessons in this journal will no doubt inform public clinical health practice in the future and help state health agencies meet goals and priorities, and above all will help America become a much healthier country.

Thank you offer being with us today. It's my pleasure to turn this over to Dr. Shirley Payne, the director of state and community health at HRSA.

Shirley Payne >> Thank you so much, Michael, I appreciate that.

Good afternoon, everyone. I'm the director of the Division of State and Community Health at the maternal Child health Bureau.

Thank you for having me and I'm looking forward to the great presentations that will happen in the discussion on this very important topic. MCHB is proud to be a sponsor of this journal and its special issue addressing perinatal substance use.

This is the underlying cause of and our investment in this journal is very timely.

This aligns with their mission to improve the health of America's mothers, children and families and also supports the principle that there is no help without mental health.

Our investment aim to improve identification of mental health conditions, promote access to mental and behavioral healthcare and enhance the capacity of the MCH workforce to meet families mental and behavioral needs.

I like to take a moment to highlight some of our investments.

The screening and treatment of maternal mental health and substance use disorder program supports new or expanding state telehealth access programs, offering real-time psychiatric consultation, care and support and training to healthcare providers to screen, assess, treat and refer pregnant and postpartum women for maternal behavioral health conditions.

This is in specified regions including rural and underserved areas.

Our national maternal health hotline or mental health hotline, 1-833-DLC-MAMA, is available 24/7, 365 days per year and provides free, confidential and emotional support, resources and referrals to any pregnant and postpartum mothers facing mental health challenges and love ones.

Our maternal and infant home visit program supports voluntary evidence based on visiting services for pregnant people, parents and caregivers with young children up to kindergarten, living at risk communities. Home visitors educate people about the efforts of substance use during pregnancy and screen caregivers help pregnant people and caregivers with substance use disorder and access treatment and support babies exposed to substances.

This works to improve infant health and to reduce the rate of infant death and adverse maternal health projects. They tailored to the needs of communities by conducting activities such as healthcare services including screening for depression, substance use and interpersonal violence, case management, care coordination and health education.

Finally, our title V maternal child health services is a federal state partnership that awards grants to 59 states and jurisdictions to help with the needs of mothers and infants including children with special needs.

They try to find strategies and this includes screening and referral for mental health among pregnant women, training providers with maternal needs and continuing to address opioid another substance abuse and the impact on women, infants and families. As we collectively include our work and we must acknowledge the need for quality research. Research provides the opportunity for practitioners in all fields to take the latest evidence and data and apply it in new and innovative ways to address challenges we have historically continued to have.

These innovative approaches include care recovery tool is, harm reduction programs, substance use screenings and nonpunitive approaches to addressing the needs of mothers and babies prenatally exposed opioids and other substances.

This is an emphasis on integrative care and the understanding that our program person's health is both physical and mental health and well-being.

We understand that no approach will successfully or be successful in this health equity is centered in all the work on behalf of pregnant and postpartum people and families. The articles in this journal demonstrate this commitment.

Our thanks for the development of this resource that truly advances the MCH field. Thank you.

Amani Echols >> Thank you, Shirley, Mike and Terrence, for being here and supporting this effort and setting the stage for the conversation today.

In our remaining time we will feature several authors of the special issues, they will share key findings and provide insight into how we can collectively support perinatal people with substance abuse disorder and their families.

We will begin with a brief keynote talk and then have a roundtable with authors of papers that connect to state health departments.

This will discuss how to integrate perinatal and behavioral healthcare, then we will end with a fireside call and an authorship team of one of our most viewed papers, to discuss how to translate our research into practice, particularly into policy change.

The content findings and conclusions are those of the speakers and do not necessarily reflect the official position or endorsement by ASTHO, AMCHP or HRSA.

Now, our keynote speaker Kimá Joy Taylor, Dr. Taylor is the founder of a healthcare consulting firm and a nonresident author for the urban Institute.

She is an expert in parents of substance abuse disorder and prevention and early detection of mental and behavioral health problems among adolescents and young adults.

Dr. Taylor has a background in policy and is a pediatrician, I could go on and on but I will now pass the mic over to Dr. Taylor herself. Thank you for being here with us today.

Kimá Joy Taylor >> Thank you so much for inviting me.

I'm putting on my timer. I'm humbled and honored. It's important to note that I'm a pediatrician , I work in the healthcare system as a public health practitioner in Baltimore city, among other things.

I admit and I'm part of the work that needs to be done.

I'm opening this talk partly because I love this quote, but because it stands up in the substance use realm well. To quote from the book Transcended Kingdom, priming progress in the sense of the natural way in which learning something new requires getting rid of something old.

Like discovering the world is round means that you can no longer hang on to the idea you could one-day fall off the edge of the earth. Now that you've learned something you thought was true was ever true at all, it for every idea you hold firm comes into question.

This is really true for histories work on substance use. I ask you to enter this work with this quote in mind. Questioning our past attitudes, responses and clinical practices towards pregnant people who use drugs. Be willing to admit that we can all learn and may have to identify deep courage to identify new vision . For a desired future and a willingness to put in the hard work to achieve this vision.

When I say vision, I mean vision where society uses framework . Our wellness framework requires equitable access with positive outcomes from a full continuum of physical health care, mental health and substance use services integrated as used previously.

These have to include harm reduction in treatment and should include social services that seek to preserve and support families.

And this recognizes the love from the parent and infant and provide services that are welcoming and geographically accessible, community-based, evidence informed and nonpunitive. When I say services in the future, to decrease the amount of words I use, I mean all of this . I don't use cultural competence because I know having worked in a diverse practice setting, I can't be confident I have to learn every day and listen hard and effectively work together to improve outcomes.

This type of care is rare for all pregnant people as we know from the child health mortality rate. It's even less successful for pregnant people who use drugs and even less from those who have been systematically excluded.

Wellness is not a new vision for parents who are raising their children and centering love and well-being to the best of their ability. Despite societal and structural racism, stigma and punitive responses that have included disproportionate family separation. Despite health and healthcare systems that have pushed against them. These parents just need health and healthcare system and public practitioners to get on board, centering love and wellness and reduce the past hostile ways of thinking.

The past, know it, learn and read it. I don't have time to do it now but it's important to know and important to understand willful ignorance is not okay, pretending the past didn't happen is not okay and will affect achievable outcomes.

Presently are we are in the midst of maternal health crisis with poor outcomes for those who give birth and for historically and systematically excluded and particularly her for pregnant people who use drugs.

In many areas the work to improve maternal health outcomes vilifies people who use drugs that prevents them from accessing welcoming prenatal care services that we know can improve gestational diabetes e-services, they can improve outcomes but they fear accessing the resources.

And substance use, like many other endeavors in healthcare, the devil is in the details. It's in the weeds.

So many people want to gloss over and pretend are not important or don't exist. These keys implementations are policies that ensure family preservation outcomes for parenting and pregnant people who use drugs.

But first I want to think about equity, and I want us to pause and remember that this conversation is about equitable outcomes.

I want to share how I equity today.

Take a moment to think about someone you love the most, someone for whom you want great things, even when that person faces adversity, you will support them and find others to help support them or they can overcome adversity, thrive and love and be loved.

Now that person you're thinking of has the capacity to become pregnant and is also using drugs and gives birth to a child.

A child they love more than breath and more than life itself. Because you love them you love the child also.

You want to be there for them.

Hold that person and feeling in your head. When I talk about equitable outcomes think about the all the people on this call, within their head.

Immigration status, every other intersectional identity that people hold in their head and love, all of those folks should have the same possibility to achieve the highest level of health, social and emotional and physical well-being as a family. That's equity to me and it's hard to achieve because of our past, particularly in the perinatal substance use space.

How do we get to equitable wellness?

Change basic policy to create conditions for change. Policymakers Canon have created policies that asks for increased access to nonpunitive evidence informed systems for pregnant and parenting people who use drugs.

This is so important but also so inadequate.

If we truly seek equitable outcomes.

What is the efficacy of a policy that does not recognize and rectify past policies and actions?

That promote harm such as criminalization, removal, family surveillance, barriers to accessing services including medication and harm reduction.

Coming in for new access if it means my child will be taken away and I still may be reported and face criminal charges and non-able to find substance use providers and services that are equitable?

If prenatal care is not open, when it is open it opens me up to surveillance that may ultimately lead to the removal of my child opening up to the idea that a non-consented urine drug test which is not clinically a test for substance use disorder, parenting or child abuse, but could be the reason that the child my is taken away. Am I coming in?

Maybe not. May be more needs to happen with the access.

Individual and public healthcare systems never learned or chose not to learn how to provide a full continuum of welcome services for parents, families and communities at center equitable outcomes for wellness and family preservation.

It's not enough to craft a policy to tell insurers and providers they have to do something they don't know how to do; we have to implemented in a way that truly supports equitable well-being outcomes.

To start, one way to probably get closer to better equitable outcomes, is ask for help.

To help with partnerships for folks of childbearing age and pregnant and childbearing people who use or abuse drugs. See what services do they deem effective?

Where can you find those services are what makes those services compatible with being a welcoming and nonjudgmental?

Also, talking and listening to the solutions at of already been created in the new ones that people have envisioned.

Community has solutions they've been forced to create while the rest of the world is punishing them.

Listen for those. Also, our society has solutions.

Take a look at alcohol.

Alcohol is a harm reduction frame, complete with early intervention for fetal alcohol sequelae, conversations about how to still breast-feed and get rid of the milk so you can continue breast-feeding should you drink alcohol. Babysitting, free UBER, so parents don't have to drive, all of these in an expectation of family preservation unless there are other factors of concern.

We can ask about and learn from past solutions in the existence of punitive policies. It will take time to build trust and support to make space for diverse voices of parenting and pregnant people who use drugs and their families, to talk to policymakers. It will take time for policymakers and system actors to truly understand how to listen for what some of the barriers and facilitators are in some of the solutions.

Not just listen for the solutions but listen to the solutions that will help achieve equitable outcomes for all diverse people that we are holding in our head that we love dearly.

Such work requires time, dedicated infrastructure must be financially supported and sustained.

The second pieces of health is from substance use providers. This is an odd mix of folks. We can't pretend it's just social workers, peers and nurses and doctors and other healthcare professionals.

There are others that have great say and how and where healthcare is provided. It's regulators that determine benefit packages and can decide what services they will or will not authorize and medications that are covered.

Public health actors that decide when they provide harm reduction, and a successful manner for people who are currently or have used drugs but even researchers were doing research to understand where and how to provide cost-effective services. The majority of these providers have lax institutional diversity for years. They've ignored people who use drugs and of often produce their own social and employment inequities based on race, ethnicity, language, immigration status and other identities.

Giving a policy that says now you have access also requires for them to reassess who they are and reassess and have an understanding of how the passes influence the structures for a way that has not allowed for equitable outcomes to be achieved.

It's having them assess, do even know what full containment from prevention and harm reduction services are?

What are the services?

It may reveal they've push back against some of these services number whether it's accessing Medicaid for pregnant people or harm reduction services.

But outcomes require us to demand this transformation.

I am part of the systems; this is from all of us.

Where and how can this transformation start?

I offer a few ideas, but first landscaping.

Where are these that exist in this requires talking to pregnant and parenting people who are and currently use drugs. Where does it exist?

The resources that provide culturally and linguistic services in the full capacity of them?

The landscaping must include feedback from people not only ask what exists but where do you truly want to go?

What do you truly want to use?

Some of the work can be done using community Hospital benefit money.

When landscaping, I promise landscaping will reveal that there's not enough of the culturally linguistic services. I promise you there's not enough.

This is a barrier to the policy becoming reality.

We have to stop saying we're having expansion policies that act as if effective providers will miraculously appear tomorrow.

We have to start thinking about how to develop and evaluate for efficacy, programs practices and policies that will diversify and grow the field of dividers in all areas of substance use services.

We can grow this first by borrowing from current health and other diversification expansion efforts. Also work with students to develop new pathways and programs that make them want to enter into these workforces.

Finally, we have to hold current providers to account ensuring they're trying to diversify and provide care for pregnant and parenting people who use drugs. Creating a workforce that ultimately from frontline to leadership, reflect the diversity of the clients that we see, then requires that they are educated and how to provide, regardless of demographic, how to provide culturally humble patient-centered services that lead to equitable outcomes.

Once we diversify and grow the workforce, we need to create practices and policies to help to make sure that we can support and sustain the workforce. How can we expand and develop new reimbursement strategies that, for the time it takes in order to create the relationships, to create the patient-based relationship?

Reimbursement is about money but also about time. We keep acting as if it doesn't take time to create these relationships and sometimes we say the provider doesn't have time so will have the social worker create the relationship, then we give the social worker at 30 to 1 client a person ratio, alleviating the ability for them to have the time. So, then we add peers to create the relationship and then we get peers words are 100 to 1 relationship so they can't create the time.

We can't re-create the core things we've already done. Reimbursing in ways that allows the time necessary for people to create trusting relationships that lead to better engagement and partner care that can lead to more equitable and more family preservation and well-being outcomes.

In this space the last thing is education, not just education on how to provide medications for people who use opioids. This is important but not sufficient it's about changing and transforming what is taught in schools and clinical practices, requiring mastery of the understanding of what is a full continuum of substance use services for prevention and harm reduction to treatment and recovery.

This education should be throughout and cannot allow providers to cherry pick and offer evidence-based care but not harm reduction.

I want to offer this medication because it goes along with what I believe but not others. It's a partnered relationship with our clients get to dictate their care, just like we do for secondary prevention and all of their chronic health diseases.

Finally, need for regulators and insurers and others to understand and pay for the full continuum of care, including medications and harm reduction, in ways that provide access to at notable outcomes to the services.

To recap, policies can create policies to expand access. Implementation counts for equitable outcomes. Partnering is important. But so is the last piece of accountability. This is a two-step process. It's hard to talk about accountability if you're not sure what you're measuring. We have to create new measures for these outcomes for perinatal substance use.

This requires again working in partnership with the people who've been affected, communities, families, regnant people who use drugs and practitioners and everyone to develop quantitative and qualitative measures.

We have to ask people if what the numbers are saying is actually true.

Do they truly feel welcome?

Are they achieving the services they need to?

Measures that center on love and family preservation and outcomes.

Once defined and retested they need to learn to collect, disaggregate, analyze and use the data to assess where inequities exist.

Once they identify inequities they need to act to eradicate them.

This is not flipping on a switch, they've been born in this disdain and it requires education and will take time and attention.

Once the inequities are identified, society has to use all these actors in the individual health systems and hold them accountable for achieving equitable outcomes. I say positive because I want to be clear, not equity because we put all the white wealthy people in jail and criminalize them and take away their kids, we want all equitable positive outcomes. Accountability may need to create performance plans to how they will move more quickly and working with partners and people on the ground to help them understand how to achieve this.

Where there is lower progress it might mean that folks need to be fined. Defines need to clearly delineate why they are fined and how they can avoid being find in the future. It can be used as a tool to move progress. But if there's egregious lack of progress this may require losing funding, accreditation, contracts and people really deserve access to high-quality culturally and

linguistically an effective community-based services that support equitable well-being and family preservation outcomes.

There are ways to think about these policies and achieve equitable outcomes. We have to include pregnant and parenting people who use drugs and use the actors and be honest about where they stand and where they stood in the past and where we need to go. We have to understand that people have a right for chronic health concerned to have a health and social responses that seek to support their well-being and support their family preservation.

We as a society can ensure equitable access to and positive outcomes from a full continuum of care. We need to admit that's what we want to do and be honest and willing to work in the weeds and in partnership to get there.

Let's roll up our sleeves and get working.

Thank you.

Amani Echols >> Thank you so much, Dr. Taylor, for sharing your insight and your messages so clear and powerful.

Punitive approaches are not helpful and we must diversify and grow the behavioral health workforce and center wellness within our strategies and must create policies and practices that support these goals.

As we work towards them, holding ourselves accountable to these commitments.

Thank you for those reminders.

And thank you for your time.

I will now pass this over to Sanaa Akbarali, the senior director of maternal and infant health at ASTHO.

Sanaa Akbarali >> The following authors exemplify how to partner with your health agency and other critical stakeholders to create meaningful change.

It's not my pleasure to introduce our three panelists for this Roundtable.

First, we have Laura Sternberger, the director of Pregnant and Postpartum Women's programs for health and recovery and the director of the Massachusetts moms do care program.

Next, Dr. Sarah Reese, an assistant professor at the University of Montana school of social work and a licensed clinical social worker herself. And finally we have Jessi Fuchs, Epidemiologist, at the environmental Department of Health in New Mexico.

To help level out our audience, we'll have each panelists provide us with the two-minute overview of your research and main findings.

Laura, we will start with you if that's okay.

Laura Sternberger >> Hi everybody, it is an honor to be here.

First, I just want to thank everyone on the call who have been incredible colleagues and mentors to me over the years and all of these who support this program. I'm here to talk about the Massachusetts program, a multi-pronged approach to creating and sustaining a web of support for pregnant, postpartum and parenting people and their families affected by substance use disorder.

We began in 2015, thanks to a SAMHSA grant, and we have gone from two healthcare systems to 11.

Currently eligible clients are 18 or older and have a history of any time in their life of substance use concerns for any substance and her parenting a child, 36 months or younger. The program works in both clinical direct service and system level domains. The direct service objective is to build integrated, specialized multidisciplinary teams adept at best practices to serve this population. The site teams differ from site to site but usually include a repertoire primary obstetrical, pediatric nursing and behavioral health and addiction providers.

Most importantly peer recovery coaches. All staff involved in the care of this population are offered training among other things in trauma informed and recovery oriented approaches, to science into each other, with the understanding that the approaches that support clients also support the providers.

Because the work is performed by the best practices in caring for the population as well as the universally applicable principles of recovery, our coaches hold a central role on each team.

Perinatal peer recovery coaches act as engagement specialists, care coordinators, wellness and recovery coaches and data gatherers, they also act as leaders when considering program implementation, system change in policy development .

In the system level domain, moms who care helps to create and maintain these integrated and regional continuums of clinical care, by building and enhancing the relationships and collaborations among all of the providers to support this population, pregnancy through early childhood.

This is not limited to the departments throughout the healthcare system, the community-based primary obstetrical pediatric addiction behavioral health organizations and our local child welfare offices.

The trainings and TA or in trauma informed recovery oriented practices often serve as a catalyst for building and sustaining these relationships among the providers.

Moms Do Care, have expertise and leadership that is central to all of these initiatives, because they not only represent a critical family voice in these collaborations but also provide a model for what long-term recovery and well-being looks like the this is impactful for both best client care practices and our provider sustainability.

Later I will touch on some lessons learned and strategies for recruitment, hiring, supervision support and advancement of the perinatal workforce and the moms do care sustainability work will continue to involve healthcare leaders in managed-care organizations to both budget for and finance this wraparound, multidisciplinary model . This is to help create a culture that helps to sustain the highly trained and specialized workforce.

Sanaa Akbarali >> Thank you so much. Now over to you, Dr. Reese.

Sarah Reese >> Thank you for inviting me. I'm here to represent a HRSA funded innovation grant from the University of Montana, this is between Montana Health and Human Services, inclusive communities, and Billings clinic.

Dr. Andy Glover is the principal and lead investigator of the grant, and I serve as the primary investigator on one initiative, implementing screening, intervention and treatment for perinatal

substance use. Our study assessed the barriers and facilitators of implementing in an outpatient clinic.

This serves a larger area with maternity care shortages. We assess efforts by analyzing the frequency of universal screening and referral to treatment as well as implementation, team meeting notes, a semi structured focus group and interviews with staff.

In the first year of implementation, we found that 48.5% of patients receiving care in the clinic completed a standardized screen, or at least once during the perinatal period. Screening appeared in a fourth of visits and identified several barriers to implementation, a perceived lack of time and competing priorities during office visits and delays in integrating into the electronic health record.

We also identified facilitators and that we were able to get about half of people to complete a screener.

Those facilitators included things like engagement and supportive clinic leadership. Based on these findings we are currently implementing a structured quality improvement process guided by the Institute for Quality Healthcare Improvement Model, to build a more resilient system into the day-to-day workings of the clinic. We brought in more people to the table and provided more comprehensive and ongoing training and education and support to clinic staff and we integrate this process into the electronic medical record for SBIRT, we hope others can learn with the challenges we faced an address those in their efforts.

Sanaa Akbarali >> Thank you.

Jessi, you get to round us out.

Jessi Fuchs >> Thank you for having me. I'm here with some material from the MMRC, a group of people who are clinicians or providers or people with medical expertise and experience with mortality who come together to review debts that were pregnancy associated any death that occurred during pregnancy or within one year of a pregnancy.

They reviewed these cases and have information like birth and death certificates and medical reports, so we have is whole of the picture as possible about the circumstances surrounding the death.

And so, they made some determinations about these situations and direct recommendations to present these in the future.

And the contributing factors, preventability as well as information about the cases themselves. We completed an analysis of all pregnancy associated death in New Mexico. We determined which ones were substance use disorder related, deaths were substance use disorder was the cause of death or a contributing factor to the death and we completed this to assess the risk factors and also, we looked at patterns of substance use.

We found that half of all deaths from 2015-2019 were substance use disorder related and half of these deaths said evidence of documented substance use in the prenatal record. Missing a lot of evidence there.

We also found that they were more likely to die in the late postpartum, six weeks to one year postpartum, more likely to have a primary cause of death of mental health conditions, overdose, and more likely to experience one or more social stressors. We found that over 60% of people with a substance use disorder death engaged in poly use of substances meaning using more than one substance.

I'll stop there.

Sanaa Akbarali >> Thank you so much. Thank you for the overview. We'd like to dig deeper in the research, Laura we will start with you. How are recovery coaches integrated into the moms due care program and why are they so valuable?

Laura Sternberger >> As I mentioned earlier, we found the expertise and experience as a - to coaches to be central in every aspect of the work. Optimally the perinatal peer recovery coach input is integrated into the clinical practice decisions about each client, as well as the development of policies and system change initiatives.

As providers to engage in partner with clients through a shared experience and people who have by necessity, hone the principles of recovery and well-being, our perinatal colleagues have a lot to teach all of us.

Yet, it can be as expected, as you can imagine we have faced challenges in creating a pathway for the recruitment, support and advancements of our workforce.

We have worked with HR departments to shift policies around mandatory education levels, criminal justice system involvement, negative driving history and livable wages.

The moms do care employees to full-time perinatal recovery coaches who offer training and TA to all of the 11 sites. The moms do care training and TA team endeavors include perinatal recovery coaches support calls for all recovery coaches across the state, separate calls for supervisors as well as training and trauma informed supervision.

A leadership team designed to influence statewide policy and a perinatal recovery coach mentorship program.

We also offers site-based TA to help build nonhierarchical and team cultures to integrate the voices of all staff into policy and practice decisions. Important conversations that as we learned earlier address stigma, racism, provider fatigue and secondary trauma. We continue to work with leaders in healthcare organizations devaluing budget for these endeavors.

Sanaa Akbarali >> Fantastic, thank you so much.

So, providers may feel hesitant to provide screening with few resources to refer patients, how do you address potential concerns from providers around universal screening and generate buy-in?

Sarah Reese >> One thing we were able to do is embed a person into this. From the beginning of the project we engaged providers from the clinic as champions of SBIRT, you didn't ask about this, but I read that to ensure that patients were connected our goal is to connect them within 24 hours to one level of care. We made a partnership with a large substance use provider in the state that guaranteed a connection to at least one level of care within 24 hours.

Since publishing the article, we also formed a partnership with the local federal healthcare centers for a dual let in the clinic to provide peer support and services to patients.

Sanaa Akbarali >> Thank you so much, Jessi over to you, how can your research support pregnant people and families impacted by substance use. There's also a question in the chat about data collection and if you could explain a little bit more about how you were able to collect the data on substance use.

Jessi Fuchs >> Yes, the first question about policy and programs.

There are a lot of policies and programs we can pick about with this work.

One I will also add in addition to the findings I brought up earlier, 95% of substance use disorder related deaths were people on Medicaid or had as a primary payer, Medicaid can be a helpful way to improve access to care. In April 2022, New Mexico extended Medicaid from 60 days postpartum to one year postpartum. We don't yet have evidence of what impact that might have, but we've seen in other states that when you extend this care to one year, there's an uptick in people getting mental health and behavioral health services.

I think that if you are in a state where it's only 60 days postpartum, I really encourage people to work to extend this to one year. We are seeing the increased likelihood of death in the later postpartum period, even if you're eight months it doesn't mean you don't need the healthcare anymore.

That was one big thing.

Also, universal screening is something that's really important and helpful to assess who is using substances during pregnancy and I stress nonpunitive measures doing this as people have been speaking about really beautifully today.

We really need to be meeting people where they are at and not bringing in measures of threatening to take a child away or have a situation where people can be honest with their providers, so providers can provide them with the education and services that they need also, improving the quality of substance use treatment.

A lot of people have mental health conditions or social stressors or others issues going on. In New Mexico there's limited access to care for people who need treatment, inpatient treatment for someone with a young child. So, extending care for people who have much more going on, not just looking at a single substance use, polysubstance use it may be involved in other mental health conditions might be involved and other stressors that may be in a person's life at that time. I think I'm overtime, so I'll respond in the chat how we collect the data

Sanaa Akbarali >> Thank you so much. The final question is for all panelists. How are these efforts critical to improving maternal morbidity and mortality in this country?

I know it's a big question but certainly your research is helping to make progress in this area. Laura?

Laura Sternberger >> Supporting pregnant postpartum and parenting people and their families impacted by substance use disorders is intensive work that requires high levels of commitment, care coordination and collaboration.

Our clients face multiple and persistent challenges related to addiction, recovery, parenting, poverty, housing, stigma, historical community and personal trauma, racism and fragmented systems of care that frequently have conflicting, punitive and historically harmful practices and policies. Provider champions bear witness to and walk with clients through the challenges on a daily basis.

When thinking about best care practices to support the well-being of our clients, we also need to address the best practices for the well-being of the provider spirit our perinatal peer recovery coach colleagues have the unique potential to influence both.

This enhances the health of pregnant, postpartum people and their families and broadening and deepening the perspectives of the providers.

Sanaa Akbarali >> Thank you, Laura.

Really well said, Dr. Reese over to you.

Sarah Reese >> What we know, many clinics experienced challenges with SBIRT and we are addressing those challenges in healthcare settings. I hope people take away the idea that this type of system change is not easy, but it is worth it, and it can save lives.

Sanaa Akbarali >> Thank you so much.

Jessi, over to you.

Jessi Fuchs >> I will say some of the findings in this paper for our new findings, and it's not new that we know that we need a higher quality of care for people using substances.

80% of pregnancy related deaths in New Mexico are determined to be preventable by the MMRC, so this is not something that should be happening.

I would just encourage people to really remember that and think about that, we know what the issues are and complicated cases where social determinants are linked in, that's how it goes. We need to be improving the quality of care that people are accessing . I know I'm saying things people have already said but that just emphasizes even more so how much we know and how much more work there is to do in relation to that.

Thank you so much

Sanaa Akbarali >> Thank you so much to all of our panelists. Please check out their manuscripts and learn more about the research in this supplement with that it's not my pleasure to turn it over to Stacy Collins, the associate director for AMCHP for our next session .

Stacy Collins >> Thank you so much. I'm hoping my authors pop on to our call.

I see Dr. Schiff, two others, Erin and Nikki, Okay we are all set.

The last panel was really informative in this I think will flow well from our last discussion. I am delighted to be with the authors of prescribed and penalize, the detrimental impact of mandated reporting for prenatal medication of opioid use disorder.

This, like our other 20 articles, it's very impactful and very cutting-edge and I'm delighted to be here to talk to our authors for this conversation.

One quick administrative point I want to make for we start. You might wonder why were using some acronym soup, it's really important that we have two that I want to make sure you can distinguish, one is MOUD medication for substance use disorder and the other is FOUD.

Now I will introduce the fabulous authors here with us today.

Erin Work, is a student in the dual Masters program in public health and social welfare, at the University of California Los Angeles. She previously worked as a clinical research coordinator at Mass General Hospital in the prison research group.

Her research and practice interest include reproductive justice and harm reduction.

Next we have Nikki Bell-Pena, the founder of living in freedom together known as a LIFT. Based in Massachusetts this is a survivor led nonprofit working to end prostitution and provide pathways out of the sex trade.

Under Nikki's leadership, LIFT opened Jana's place, a recovery home for women exiting prostitution with substance use and mental health disorders.

This is the first of its kind in the nation.

Then we have Dr. Schiff a pediatrician, Director of Perinatal and Family-Based SUDs and addiction medicine physician and health focus researcher focused on families impacted by these issues.

She has a master in her hospital she founded I hope clinic, a multidisciplined place for pregnant and parenting people and their families with SUD. Welcome to our authors today.

I will be directing questions and we will get everyone's opinions on the topic related to the subject . Erin, I'm talking to you, what drew you to explore mandated reporting for pregnant women?

Erin Work >> In Massachusetts we have statutory language that specifies that a filing of Abuse and neglect has to be made in cases of physical dependence on an addictive substance at birth, which is a little bit vague . In Massachusetts our child protective services agency and the Department of children and families has provided for the direction that this should include exposure to opioids including prescribed MOUD or medications for opioid use disorder such as methadone. Most hospitals in the state take this is direction for automatic filing to DCF at the time of delivery.

Working at the hope clinic, we saw that this was in clinical experience, really impacting patients who are pregnant or postpartum with substance use disorders.

Then, in trying to do some advocating with folks with lived experience and folks who were trying to make changes to the policy, we were getting feedback from legislators that it would be helpful to have some sort of published data on these harms.

That was a contributing factor . This is a secondary analysis of some original research, looking at barriers and facilitators to medications with opioid use disorder, this came up in every single interview that was done for the project.

It felt like it was really important to specifically focus on that in the secondary analysis.

Stacy Collins >> Excellent.

Now, Nikki the next question, what were the most significant findings of your research and how do they contribute to our understanding of the challenges associated with mandated reporting in this context?

Nikki Bell-Peña >> Thank you.

I think the biggest finding was that punitive approaches like this theme throughout the webinar, punitive approaches are not helpful.

I also think about all of the themes that came up in the article.

I myself am a person in recovery.

The reporting for being on Suboxone still impacts how I parent today.

So, the fear, the loss of children, people wanting to come off medication because they are afraid they are going to lose their children.

And looking at how harmful the punitive approaches was really important.

Stacy Collins >> Here's a follow-up question if you don't mind, where there any unintended consequences of this reporting among pregnant women with prescribed MOUD that you are not expecting?

Nikki Bell-Peña >> For me, the things that came up in the article were not really unexpected.

And I think for people with lived experience, we know what's going to happen but DCF was called and often we have our children removed or we have surveillance afterwards.

And I don't think there were really unintended consequences that came up.

I don't know if Davida or Erin want to add to that.

Davida Schiff >> There were two places that the article highlighted, gender discrimination, a point that Nikki has made constantly, mothers are treated differently than fathers or partners, when it comes to reporting. The second was also really how much ones medical decision-making was impacted either mandated reporting experience . So it's the decisions that people are making about continuing medications in the vulnerable postpartum period were impacted by the mandated reporting.

Stacy Collins >> The next question is a good segue for that and directed to Davida and Nikki.

Can you elaborate on the source of methodology used in your study to assess the impact of mandated reporting, particularly as it relates to a person's lived experience?

We know that people will with lived experience were interviewed but was anyone with lived experience part of the research design early in the process?

Davida Schiff >> I can start.

There's now numerous studies that have quantified an association between punitive approaches for premade roles substance abuse and poor obstetrical outcomes across the country. What we wanted to do was give a voice to women's experience in our state to describe in their own words how they've been negatively impacted by reporting. With respect to including individuals with lived experience, the here recovery coach in the clinic at the time provided the feedback and Nikki help to provide critical manuscript feedback. We also learned a lot. We learned how we needed to do better and more in future projects.

So, how can you actually include individuals with lived experience at the early stages including one submitting grant proposals and study design and content. We've recently began using peers with lived experience to complete interviews of that has provided much deeper content.

Nikki Bell-Peña >> As Davida said, as we do this we're learning how we can do better.

I think about how many studies we do for people with lived experience. We are asking them really traumatizing questions.

And academia, this probably won't go over so well but I'll say it anyways, and academia we asked people to participate in research studies and then we pay them with a $25 gift card for sitting through really tough stuff, right?

They talk about the challenges they've had.

I do think that we need to do better.

Just to be fair, I wouldn't work for $25 an hour anywhere.

So, how can we really show people that we value them monetarily as well, I think it's important.

One of the things I do appreciate about the group is even being able to provide manuscript feedback. It's a bigger accomplishment for anyone to have a journal article published, so why wouldn't we include the people with lived experience that participated in the research project?

But that doesn't often happen so kudos for that.

Stacy Collins >> Excellent I appreciate your thoughts on that.

So now, based on your findings, what policy recommendations at both the state level and hospital level would you propose to address the detrimental impacts of mandated reporting in this area?

Davida Schiff >> The women we interviewed were quite clear about the need to decouple medical decisions for reporting for child abuse and neglect. Were hopeful we will see a new approach in Massachusetts soon that uses a dual track system. One that notifies the federal government have a substance exposed delivery and the other to me the requirements of kept Akira and the other to report concerns of child abuse and neglect choose services. We start to see hospitals make changes already with several leading hospital systems no longer reporting at time of delivery without additional safety concerns. We hope more hospitals will follow. States like Rhode Island, New Mexico, have Utah have had this practice in place for years, and we're learning more about their effectiveness and opportunities that are ongoing for improvement.

As we begin to see less reflexive mandated reporting, it will wire are public health and addiction systems to share the risk in assessing for child safety and well-being at every treatment and counter.

I will ask this incredible group that have shown up today, are we ready and what do we really need to do to be ready to envision the alternate system that Dr. Taylor showcased as possible.

Stacy Collins >> Thank you, I will take your question one step further.

As you guessed, of the 500 people we have on the call, we have lots of state and local health departments, give recommendations or how they can play a role in efforts to uncouple treatment decisions from mandated child protective services reporting. What do you suggest?

Anybody can take a crack at that.

Erin Work >> I'm happy to jump in.

One thing is just thinking about policy, advocating for policies that will be supportive rather than promoting punishment and surveillance among these families. Thank you to teach in the chat for bringing up sharing the responsibility of being mandated reporters and screening, that is a very sideload for child protective services right now and thinking about ways, like safety assessment, that were can be taken on by multiple stakeholders like Davida mentioned.

Stacy Collins >> Now I will ask a couple questions about future research directions.

Nikki and Erin, directed to you two, what areas do believe warrant further research in this field and how can future studies built upon your findings to contribute to improved outcomes for pregnant individuals with opioid use disorder?

Nikki Bell-Peña >> I think this really talked about the immediate harm that happens and we have punitive approaches to substance use disorder.

I think looking at the long-term harm and how this impacts people parenting throughout their lifetime of their children.

So many programs are focused on the first 36 months which is important, I'm not disparaging that, but I will share a personal experience I had.

My daughter was three years old, and she fell down the stairs. She was with a babysitter, I was not present, but I had to take her to the emergency room. You don't know the debate that went on in my head, do I bring her, do I not bring her, can I monitor her at home, right?

I'm walking into the emergency room with my daughter and no clothes, because she threw up on herself in the car, thinking they're going to report me and take my child. It took everything to get through that door. We think about the immediate impacts of people coming off

medication, but we don't think about the trauma that this mandated reporting causes for people.

I think with the new policy change in Massachusetts, I am super excited about it, but I'd like to see some rigid guidelines on what are the additional risks that we are going to file for.

I can tell you, when I had my daughter, I was seven years and recovery and the social worker told me they are definitely going to screen this out, there's no reason.

But they screened it in.

So, I'm sitting in the NICU with my premature daughter, leaving her to go outside and be interviewed DCF.

I think we are changing the policy but what are the additional risks?

How do we quantify that, so it's not left to individual judgment?

I think building on this research study when thinking about harm.

Erin Work >> I'd like to add on to that.

Being that this was a secondary analysis, and we didn't get to ask a lot of pointed questions about this topic, one of the weaknesses is that it is very detrimental, and harm focused. That's obviously something we felt the need to highlight. But we also didn't get to explore a lot of strengths and solution-based approaches.

I think that is definitely somewhere that would be a helpful place to go from here. I would point to things like rise magazine, the action report that was done by and for families that have been impacted by the CPS system in New York. This really pointed to some community centered supports.

Not just eliminating harm so policies but thinking about solutions. Another is that there's a long history and currently racism plays a big part in both substance use services and treatment and with child welfare.

I think further attention to that is really necessary.

Stacy Collins >> Thank you so much for sharing. Thank you for your sharing your personal story, Nikki, that was impactful for the audience.

The next question I open to the whole group. Reproductive bodily autonomy has been a contentious topic, lots going on politically in that space.

How does your research fit into broader conversations we are having about the need to sip for perinatal people with SUD and their families, relative to the broader systemic harm that is present in our society?

In other words, providing care that is not punitive or paternalistic or generally harmful to families, what do you think about that?

Erin Work >> I can start. I see the research is really fitting in with some of the broader advocacy and activism being done by folks focused on reproductive justice. One we take about bodily autonomy, especially in the last couple years, things have been shifting at a federal level and often that focuses on abortion rates which is obviously very important.

But reproductive justice is the right to have children, not have children and to parent children in a safe and sustainable environment. I think that this really speaks to that third principle that is often not as focused upon. Really thinking about what are the broader impacts of these types of policies that limit autonomy over your body.

We saw in this article that individual medical decisions were not made autonomously, they were really influenced by these kinds of punitive policies.

Stacy Collins >> Thank you, Erin.

Another couple questions I'll throw out all the authors. How are you translating your research into practice and how do you communicate your research results to different stakeholder audiences?

You have a very public health related audience here today, but what about the important conclusions of your research and how to communicate that in a way that resonates with two different audiences?

Davida Schiff >> We thought a lot about that before this article because we need to elevate participants voices to hopefully affect legislative change in Massachusetts. I shared in the chat that we were fortunate enough to receive some funding to be able to develop a beautiful graphic that we worked with the public relations team at the hospital to really promote the message of the participants experience in our state.

I wanted to reflect a little bit thinking about communication on research findings and acknowledge that it can't talk, or it feels like self-promotion. And particularly for women this can feel challenging to do in this space.

The articles I promoted are the only ones that get read, when you think about the question, how do you translate research into practice and I look at the amazingly talented first author list of this really incredible impactful special issue, I can't help but think about how it really needs to be our collective responsibility, all 500+ people on the call today, to think about how we can uplift and extend the reach of each of these articles so that we can more effectively translate the findings into a change of practice.

Stacy Collins >> Thank you.

One last question to wrap up the fireside chat, directed to any and all of you.

What are some final would you like to leave our audience with collectively as we work to support perinatal pedal with SUD and their families?

Nikki Bell-Peña >> For me, when we talk about reporting and sharing of risk, me and Davida had a conversation one day that said, who will assume the risk for these children. I'm like I am, they are mine. I know people get very hesitant when there are substances involved.

But, when we talk about the right to parents our own children, I think that when people start talking about people who are using drugs, or people then get scared we need to look at harm reduction, how we support people in whatever state that they are in so that they can be a part of their family and have their children present.

Harm reduction strategies work. We know that.

How can we ensure that children are staying with their parents who want to be with them, even if they are using drugs?

I think we really need to look at ways to increase the safety for people who are using and want to parent their children.

Stacy Collins >> Well said.

We have a couple minutes left and I wanted to see, we have a lot of people on the call but if there's one or two questions from the audience that we can pose to our panelists, please do so.

Davida Schiff >> While those are coming in, I can make one other comment about really what is the for over surveillance, what does it look like with that word where we invest in public health, and we think about the need of all parents but particularly parents and early recovery?

How do we embolden a community health response to provide respite for exhausted parents who are doing this alone?

How do we think about home visiting services that are really offering parental aid and choice and supports and, how do we really reimagine what support looks like to have healthy families and children?

Stacy Collins >> There's a couple questions coming in, and I'll have to pick a few, because we're running out of time.

I will share Melina Saville's question; I'm already thinking about how we can implement your learnings. We are looking at behavioral and mental health screening practices within our black infant health program. I'd love to learn more from the authors on op this is for equitable referral and service linkages and outcomes.

What screeners do you all endorse?

Davida Schiff >> When we think about equity can we stratify the data by the particular group we are thinking about?

So, we've done work that looks at this when with respect to perinatal opioid use disorder. Over the past 10 years very few studies looked at exposures or outcomes and that feels like it's an important first step.

Once we understand the areas we are trying to target, think about the screening questions and approaches stay for postpartum depression or risk of postpartum overdose are really important. Thank you for that question.

Stacy Collins >> Back to the discussion about harm reduction, Laura Ramsey asks are there harm reduction strategies that work for those in rural communities, really any of you could take a crack at that if you'd like.

Erin Work >> We are all coming from an urban environment, so we have less experience with that.

Nikki, I think you are muted, but please jump in.

Nikki Bell-Peña >> I think when we talk about harm reduction strategies, we want to make sure that people have access to Naloxone and are using alone. There's an overdose prevention hotline, where someone is using alone, they can call the hotline to ensure that they live through using.

I think those are strategies that can be used in rural areas as well as urban ones.

I also think that having people with lived experience doing outreach, from those communities, hiring people from rural communities that know those folks, I think it's really important.

We often times will hire somebody who does not understand the community they are trying to serve. I think it's really important that the folks providing the services are reflective of the communities that we are serving.

Davida Schiff >> So many experts in the chat, the western part of the state, Western Massachusetts, experts and colleagues should connect us.

Erin Work >> I think also expanding the idea of what harm reduction means in this.

One thing that was brought up in the keynote was childcare services, statewide childcare policies that can allow families to access childcare when it is needed, can be thought of as a harm reduction policy.

Maybe even just thinking more broadly about things that keep families safe and healthy beyond some of the more specific harm reduction strategies to protect against the potential harms of substance use.

Stacy Collins >> I'm looking at the chat and we have about 25 questions.

I think what we will do is give everyone some assurance that we will be addressing the questions. We will try our best to talk to the authors and another there were questions directed to some earlier authors as well. If you could join me in the virtual applause for our speakers, our incredible speakers for this article. Then, I am going to pass the baton.

Amani Echols >> Thank you all for sharing about your article. The chat was on fire, there were so many comments and so much great conversation and kudos, thank you all for sharing your experiences, your personal experiences. Thank you, also, for your time.

Thank you to the speakers who came before you, for sharing your knowledge and engaging in such a rich discussion. I do want to end with highlighting the five key strategies that became prominent across all 21 articles. The first is to assess the state of perinatal behavioral health. Build a diverse perinatal health workforce.

Integrate perinatal and behavioral healthcare services together.

Advanced nonpunitive and harm reduction approaches.

And finally, strengthening systems of care and thinking more broadly about how to keep families together and well when it comes to the determinants of health that we just started talking about at the end of the fireside chat.

This brings us to the end of the event. Thank you so much for joining us on this Tuesday, on the heels of the winter rest period. I hope you all have a lot of time with your families and enjoy the holiday season.

With that, AMCHP and ASTHO wish you a great rest of your day.