Virginia Opioid Addiction ECHO* Clinic

March 15, 2019

*ECHO: Extension of Community Healthcare Outcomes
• Rename your Zoom screen, with your name and organization
Helpful Reminders

- You are all on mute please unmute to talk
- If joining by telephone audio only, *6 to mute and unmute
Helpful Reminders

- Please type your full name and organization into the chat box
- Use the chat function to speak with IT or ask questions
VCU Opioid Addiction ECHO Clinics

- Bi-Weekly 1.5 hour tele-ECHO Clinics
- Every tele-ECHO clinic includes a 30 minute didactic presentation followed by case discussions
  - Didactic presentations are developed and delivered by inter-professional experts in substance use disorder
- Website Link: www.vcuhealth.org/echo
# Hub Introductions

<table>
<thead>
<tr>
<th>Role</th>
<th>Team Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Director</td>
<td>Mishka Terplan, MD, MPH, FACOG, FASAM</td>
</tr>
<tr>
<td>Administrative Medical Director ECHO Hub and Principal Investigator</td>
<td>Vimal Mishra, MD, MMCi</td>
</tr>
<tr>
<td>Clinical Expert</td>
<td>Lori Keyser-Marcus, PhD</td>
</tr>
<tr>
<td>Didactic Presentation</td>
<td>Courtney Holmes, PhD</td>
</tr>
<tr>
<td>Program Manager</td>
<td>Valerie L’Herrou, JD, Margaret Rockwell</td>
</tr>
<tr>
<td>Practice Administrator</td>
<td>Bhakti Dave, MPH</td>
</tr>
<tr>
<td>IT Support</td>
<td>David Collins, MHA</td>
</tr>
<tr>
<td></td>
<td>Vladimir Lavrentyev, MBA</td>
</tr>
</tbody>
</table>
Introductions:

• Name
• Organization

Reminder: Mute and Unmute to talk
  *6 for phone audio
  Use chat function for Introduction
What to Expect

I. Didactic Presentation
   I. Virginia Mandatory CPS Reporting: substance-affected infants
   II. Valerie L’Herrou, JD

II. Case presentations
   I. Case 1
      I. Case summary
      II. Clarifying questions
      III. Recommendations
   
   II. Case 2
      I. Case summary
      II. Clarifying questions
      III. Recommendations

III. Closing and questions

Let's get started!
Didactic Presentation
A PRESENTATION BY THE
VIRGINIA POVERTY LAW CENTER

VALERIE L’HERROU
STAFF ATTORNEY, CENTER FOR FAMILY ADVOCACY

VIRGINIA MANDATORY CPS REPORTING:
substance-affected infants
VPLC

The statewide support center for legal aid in Virginia providing support in

**ADVOCACY**  
**TRAINING**  
**LITIGATION**

on the civil justice issues faced by low-income Virginians
State responses to prenatal substance use

- **23 states** and the District of Columbia consider substance use during pregnancy to be child abuse under civil child-welfare statutes.

- **3 states** consider it grounds for civil commitment during pregnancy.

- **25 states** and DC require health care professionals to report suspected prenatal drug use, and 8 states require them to test for prenatal drug exposure if they suspect drug use.

- **19 states** have either created or funded drug treatment programs specifically targeted to pregnant women, and 17 states and the District of Columbia provide pregnant women with priority access to state-funded drug treatment programs.

- **10 states** prohibit publicly funded drug treatment programs from discriminating against pregnant women.

*Source: Guttmacher Institute: https://www.guttmacher.org/state-policy/explore/substance-use-during-pregnancy*
Treating in-utero substance exposure as child abuse

**Twelve states**: positive results from a toxicology test performed on a newborn, or signs of prenatal drug exposure in newborns, is considered evidence of child abuse or neglect.

- In these states, evidence of substance exposure provides grounds for removing the infant from the mother’s custody and qualifies as a factor in determining whether to terminate parental rights.

- **Example**: Under South Carolina law, a newborn is presumed to be neglected and “cannot be protected from further harm without being removed from the custody of the mother” if there is a positive drug test on either the mother or the child at birth.

*Source: Guttmacher Institute: https://www.guttmacher.org/gpr/2000/12/state-responses-substance-abuse-among-pregnant-women*
Treating in-utero substance exposure as child abuse

Virginia:

- While the CPS response to infants born affected by maternal substance use is to treat it as a red flag for risk of neonatal neglect and abuse, and thus local CPS workers are to assign a reported case to the assessment track, police and prosecutors sometimes treat such a case as criminal, even though prenatal substance exposure is not part of the criminal code; they argue that §63.2-1509(B) (civil child abuse) is evidence to prove § 18.2-371.1 (criminal child abuse).

- Women may come to the attention of law enforcement if they are arrested for possession of an illicit substance while pregnant, for example.

- It is not known how many women may have been prosecuted for criminal child abuse for prenatal substance use, as many may have pled guilty to lesser charges. While some cases have been prosecuted as felonies, these have been dismissed based on the fact that Virginia law does not classify fetuses as children.

Federal law re: substance-affected infants

- **Federal laws regarding states’ response:**
  - CARA (Comprehensive Addiction & Recovery Act)
  - PHSA (Public Health Service Act)
  - CAPTA (Child Abuse Prevention and Treatment Act)

  - **2016: CARA amended CAPTA and PHSA**
    - Addresses state responses to substance use by pregnant women
  - **PHSA:**
    - Federal funds for prenatal *family-based* treatment
  - **CAPTA (1988; including 2016 amendments from CARA):**
    - Requires states to track/report data on infants born “affected by” substance abuse or withdrawal symptoms
    - Requires states to report such infants to CPS
    - Remove the term “illegal” as applied to maternal substance abuse affecting infants
    - Requires providing “plan of safe care” for *both mother* and infant
    - State monitoring system of referrals and delivery of appropriate treatment

Federal Administration for Children and Families program instructions to states:
https://www.acf.hhs.gov/sites/default/files/cb/pi1702.pdf
Federal law re: substance-affected infants

What does CAPTA require of states?

• “policies and procedures (including appropriate referrals to child protection service systems and for other appropriate services) to **address the needs of infants** born and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder....”

Federal Administration for Children and Families program instructions to states: https://www.acf.hhs.gov/sites/default/files/cb/pi1702.pdf
Current Virginia law (through June 30)

- **Virginia’s Tracking and Reporting Law:**
  - In 2017, in response to CARA, language was changed: added prescription substances, and removed reporting exception for women receiving treatment.
  - Located in the Virginia Code section detailing required reporting of suspected child abuse and neglect to Child Protective Services (CPS)
  - Does not align with 22 VAC 40-705-40(A)(6)(h): “Facts solely indicating that the infant may have been exposed to controlled substances prior to birth are not sufficient to render a founded disposition of abuse or neglect...”
  - Does *not* mention continuing care related to Plan of Safe Care.
  - *Does* mandate CPS assessment track (vs investigation track)

- **Virginia’s prenatal and neonatal treatment:**
  - **Prenatal:** Doctors required to advise women of potential for poor birth outcomes.**
  - **Prenatal:** No requirement to connect women with treatment options.
  - **Neonatal:** Requires doctors to discuss discharge with patient and make appropriate referrals.
  - **Neonatal:** Requires hospitals to notify, subject to federal law restrictions, the community services board of the jurisdiction in which the woman resides to appoint a discharge plan manager.

* §63.2-1509(B); ** §54.1-2403.1; *** §32.1-127(B)(6)
§63.2-1509(B) does not distinguish between different types of circumstances when infants may be exposed to substances in utero:

**Group A**
- Responsibly using prescribed medications while pregnant.
- Medications for seizure disorders
- Opioids for Pain Management
- Anxiety/Depression Medication
- Anesthesia administered for surgery while pregnant
- Anesthesia during labor (i.e. as part of epidural)

**Group B**
- Receiving Medically Assisted Treatment for Opioid-use Disorder
- Methadone
- Suboxone

**Group C**
- Using Prescription substances without the supervision of a doctor or not as prescribed
- Recreational, Illicit Drugs
- Alcohol
- Cigarettes

*Virginia’s CPS Manual provides differentiation in its recommended Plans of Safe Care for each group, as well as who is responsible for creating/monitor a Plan depending on typology, and whether pre- or post-natal.*

Source: Rockwell & Siddall, 2018
Mandatory Reporting to CPS

Inconsistency / confusion for health and CPS workers?

- The Virginia Department of Social Services July 2017 Child and Family Services Manual Section C: Child Protective Services, at 10.3.1 states:

  “The Code of Virginia requires health care providers to make a report of abuse or neglect when there is a reason to suspect that a mother exposed a newborn infant to controlled substances during the pregnancy” [emphasis added].

- However, this is not entirely true. The language of the law is:

  Statute: §63.2-1509(B): “For purposes of subsection A, ‘reason to suspect that a child is abused or neglected’ shall include (i) a finding made by a health care provider within six weeks of the birth of a child that the child was born affected by substance abuse or experiencing withdrawal symptoms resulting from in utero drug exposure; (ii) a diagnosis made by a health care provider within four years following a child’s birth that the child has an illness, disease, or condition that, to a reasonable degree of medical certainty, is attributable to maternal abuse of a controlled substance during pregnancy; or (iii) a diagnosis made by a health care provider within four years following a child’s birth that the child has a fetal alcohol spectrum disorder attributable to in utero exposure to alcohol.” [emphasis added]

The manual goes on to provide more clarity, outlining the three circumstances that require reporting:

- **CPS Manual: 10.3.2 Health care provider responsibilities**
  - **10.3.2.1 Report to CPS** (22 VAC 40-705-40 A6). Pursuant to § 63.2-1509 B of the Code of Virginia, whenever a health care provider makes a **finding or diagnosis**, then the health care provider or his designee **must make a report to child protective services immediately**.
  - Whenever a health care provider makes a finding or diagnosis of one (1) of the three (3) circumstances... the health care provider shall make a report to CPS **as soon as possible, but no longer than 24 hours after having reason to suspect a reportable situation**.
  - When reporting SEI, health care providers are required to release, upon request, medical records that document the basis of the report. Disclosure of child abuse or neglect information is also permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and federal Confidentiality of Alcohol and Drug Abuse Patient Information Regulations. (CFR 42 Part 2)

[emphasis added]
Mandatory Reporting to CPS

- **CPS Manual: 10.3.1.1 First circumstance**
  - The first circumstance is a finding is made by a health care provider **within six (6) weeks of birth** that the child is born affected by substance abuse or is experiencing withdrawal symptoms resulting from in utero drug exposure. This includes dependency on controlled substances prescribed for the mother by a physician or an opioid treatment program (OTP).
    --Including Neonatal Abstinence Syndrome (NAS)

- **CPS Manual: 10.3.1.2 Second circumstance**
  - The second circumstance is **within four (4) years of a child’s birth**, a health care provider can diagnose the child as having an illness, disease or condition which, to a reasonable degree of medical certainty, is attributable to in utero exposure to a controlled substance.

- **CPS Manual: 10.3.1.3 Third circumstance**
  - The third circumstance is **within four (4) years following a child’s birth**, a health care provider can make the diagnosis that the child has a fetal alcohol spectrum disorder (FASD) attributable to in utero exposure to alcohol.

[emphasis added]

Mandatory Reporting to CPS

- **CPS Manual: 10.3.2.2 Report to the Community Services Board**
  - The Code of Virginia (§ 32.1-127 (B)(6)) “requires that each licensed hospital develop and implement a protocol requiring written discharge plans for identified, substance-abusing, postpartum women and their infants. The discharge plan should be discussed with the patient and appropriate referrals made and documented. The discharge planning process shall involve, to the extent possible, the father of the infant and any members of the mother’s extended family who may participate in the follow-up care for the mother and the infant. Hospitals are required to notify the Community Services Board (CSB) of the jurisdiction in which the woman resides to appoint a discharge plan manager for any identified substance-abusing postpartum woman. The CSB shall implement and manage the discharge plan.” [emphasis added].

- **2019 law change**: the above requirement from VA Code § 32.1-127 has been ADDED to the mandatory reporter section.

⇒ **Nota bene**: I am not providing legal advice on when/what to report!

CPS Manual: 10.3.2.2.1 Hospital discharge plan

- Post-partum women with substance use disorders and their newborns may have multiple health care, treatment, safety and environmental needs. Their hospital discharge plans should include, but are not limited to:

- A referral of the mother to the local CSB for a substance use assessment and implementation of the discharge plan.

- Information and medical directives regarding potential postpartum complications and, as appropriate, indicators of substance use withdrawal and post-partum depression.

- A follow-up appointment for pediatric care for the infant within two-four weeks.

- A referral to early intervention Part C services for a developmental assessment and early intervention services for the infant.

- A follow-up appointment for the mother for postpartum gynecological care and family planning. The CPS worker should obtain a copy of the hospital discharge plan and document the details in the automated data system.

CPS Response: assessment vs investigation

§ 63.2-1504. Child-protective services differential response system.
The Department shall implement a child-protective services differential response system in all local departments. The differential response system allows local departments to respond to valid reports or complaints of child abuse or neglect by conducting either an investigation or a family assessment.

- **Family Assessment**
  - Assess child safety
  - Strengthen and support families
  - Assess risk of future maltreatment
  - Prevent further abuse

- **Investigation**
  - Assess child safety
  - Strengthen and support families
  - Assess risk of future maltreatment
  - Prevent further abuse
  - Determine if abuse or neglect occurred

  “Facts solely indicating that the infant may have been exposed to controlled substances prior to birth are not sufficient to render a founded disposition of abuse or neglect…”

- This regulation misstates the law. A founded disposition of child abuse cannot be made based on ANY occurrence prior to birth, since a fetus prior to birth is NOT a child under Virginia law.
CPS Manual: 10.4.1 Who creates a Plan of Safe Care?

- A Plan of Safe Care should begin when the mother is pregnant and be initiated by her health care providers. Once CPS becomes involved in a SEI referral, the CPS becomes a part of this Plan of Safe Care.

Three populations of pregnant/post-partum women, and who would typically take the lead in creating/monitoring a Plan of Safe Care.

1. Using legal/illegal drugs, on an opioid medication for chronic pain or on a medication that can result in dependency/withdrawal and does not have a substance use disorder. Prenatal: Prenatal care provider in concert with pain specialist or other physician. Postpartum: Maternal and Child Health service providers (e.g. home visiting provider, Healthy Families); CPS or community prevention services.

2. Receiving medication assisted treatment for an opioid use disorder (e.g. Methadone) or is actively engaged in treatment for a substance use disorder. Prenatal: Prenatal care provider in concert with OTP or other therapeutic substance use disorder treatment provider/CSB. Postpartum: OTP or other therapeutic substance use disorder treatment provider/CSB.

3. Misusing prescription drugs, or is using legal or illegal drugs, meets criteria for a substance use disorder, not actively engaged in a treatment program. Prenatal: Prenatal care provider or high-risk pregnancy clinic in concert with substance use disorder treatment agency/CSB. Postpartum: Child Protective Services.

CPS Manual 10.4.2 What is included in a Plan of Safe Care?

- A Plan of Safe Care should incorporate the mother’s (and potentially the other primary caregivers) need for treatment for substance use and mental disorders, appropriate care for the infant who may be experiencing neurodevelopmental or physical effects or withdrawal symptoms from prenatal substance exposure, and services and supports that strengthen the parents’ capacity to nurture and care for the infant and to ensure the infant’s continued safety and well-being.

- The plan should also ensure a process for continued monitoring of the family and accountability of responsible agencies such as substance use disorder treatment, home visiting, and public health and health care providers for the infant and mother.

CPS Manual 10.11 Appendix D: Sample Plan of Safe Care

SB 1436 (McClellan): Child abuse or neglect; prenatal substance exposure, mandatory reporters.

Effective July 1, 2019

§63.2-1509(B): For purposes of subsection A, “reason to suspect that a child is abused or neglected” shall, due to the special medical needs of infants affected by substance exposure, include (i) a finding made by a health care provider within six weeks of the birth of a child that the child was born affected by substance abuse or experiencing withdrawal symptoms resulting from in utero drug exposure; (ii) a diagnosis made by a health care provider within four years following a child’s birth that the child has an illness, disease, or condition that, to a reasonable degree of medical certainty, is attributable to maternal abuse of a controlled substance during pregnancy; or (iii) a diagnosis made by a health care provider within four years following a child’s birth that the child has a fetal alcohol spectrum disorder attributable to in utero exposure to alcohol. When “reason to suspect” is based upon this subsection, such fact shall be included in the report along with the facts relied upon by the person making the report. Such reports shall not constitute a per se finding of child abuse or neglect. If a health care provider in a licensed hospital makes any finding or diagnosis set forth in clause (i), (ii), or (iii), the hospital shall require the development of a written discharge plan under protocols established by the hospital pursuant to subdivision B 6 of § 32.1-127.
Thank You

Valerie L’Herrou
valerie@vplc.org • 804.351.5276
www.vplc.org
Questions?
Case Presentation #1
Faisal Mohsin, MD

• 12:35-12:55 [20 min]
  • 5 min: Presentation
  • 2 min: Clarifying questions - Spokes
  • 2 min: Clarifying questions – Hub
  • 2 min: Recommendations – Spokes
  • 2 min: Recommendations – Hub
  • 5 min: Summary - Hub

Reminder: Mute and Unmute to talk
*6 for phone audio
Use chat function for questions
QUESTION: How do we re-engage the client back into treatment? Client cancelled his upcoming appointment for medication management and Suboxone.

Background: 33 y.o. Caucasian Male, lives with girlfriend, and 5 children in their own house. He is not very close to his immediate family members. Given events pertaining to his past substance use. Patient had recently reported during one of his group meetings that his girlfriend was on the verge of leaving him. He owns his own landscaping business, but because of seasonal variations, business had slowed down which led him to seek a part time job and he is now working as a welder. He is the main provider for his family.
Treatment Plan: Plan is to re-engage the client and get him back in the program. This could mean also working with him and weaning him off safely if that is what his present goal is.
Case Presentation #2
Sunny Kim, NP

• 12:55pm-1:25pm [20 min]
  • 5 min: Presentation
  • 2 min: Clarifying questions- Spokes (participants)
  • 2 min: Clarifying questions – Hub
  • 2 min: Recommendations – Spokes (participants)
  • 2 min: Recommendations – Hub
  • 5 min: Summary - Hub

Reminder: Mute and Unmute to talk
*6 for phone audio
Use chat function for questions
### No NBUP

<table>
<thead>
<tr>
<th>Substance</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buprenorphine, Urine</td>
<td>1.922 ng/mL</td>
</tr>
<tr>
<td>Norbuprenorphine, Urine</td>
<td>None Detected</td>
</tr>
</tbody>
</table>

### “spiked”

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Substance</th>
<th>Result</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/11/2019</td>
<td>14:35</td>
<td>Buprenorphine, Urine</td>
<td>&gt;5000 ng/mL</td>
<td>Trend</td>
</tr>
<tr>
<td>03/11/2019</td>
<td></td>
<td>Norbuprenorphine, Urine</td>
<td>23 ng/mL</td>
<td>Trend</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Buprenorphine, Urine</td>
<td>&gt;2000 ng/mL</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Norbuprenorphine, Urine</td>
<td>129 ng/mL</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Buprenorphine, Urine</td>
<td>&gt;2000 ng/mL</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Norbuprenorphine, Urine</td>
<td>353 ng/mL</td>
<td></td>
</tr>
</tbody>
</table>

### Normal

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Substance</th>
<th>Result</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/11/2019</td>
<td>13:15</td>
<td>Buprenorphine, Urine</td>
<td>25 ng/mL</td>
<td>Trend</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Norbuprenorphine, Urine</td>
<td>49 ng/mL</td>
<td>Trend</td>
</tr>
<tr>
<td>03/12/2019</td>
<td>09:30</td>
<td>Buprenorphine, Urine</td>
<td>77 ng/mL</td>
<td>Trend</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Norbuprenorphine, Urine</td>
<td>182 ng/mL</td>
<td>Trend</td>
</tr>
<tr>
<td>03/12/2019</td>
<td>09:05</td>
<td>Buprenorphine, Urine</td>
<td>1,542 ng/mL</td>
<td>Trend</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Norbuprenorphine, Urine</td>
<td>1,202 ng/mL</td>
<td>Trend</td>
</tr>
</tbody>
</table>

### Closed to normal?

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Substance</th>
<th>Result</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/12/2019</td>
<td>09:05</td>
<td>Buprenorphine, Urine</td>
<td>1,542 ng/mL</td>
<td>Trend</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Norbuprenorphine, Urine</td>
<td>1,202 ng/mL</td>
<td>Trend</td>
</tr>
</tbody>
</table>
Case Studies

• Case studies
  • Submit:  www.vcuhealth.org/echo
  • Receive feedback from participants and content experts
Thank You

The success of our telehealth program depends on our participants and those who submit case studies to be discussed during clinics. We recognize the following providers for their contributions:

- Diane Boyer, DNP from Region Ten CSB
- Michael Fox, DO from VCU Health
- Shannon Garrett, FNP from West Grace Health Center
- Sharon Hardy, BSW, CSAC from Hampton-Newport News CSB
- Sunny Kim, NP from VCU Health
- Thokozeni Lipato, MD from VCU Health
- Faisal Mohsin, MD from Hampton-Newport News CSB
- Jennifer Phelps, BS, LPN from Horizons Behavioral Health
- Jenny Sear-Cockram, NP from Chesterfield County Mental Health Support Services
- Bill Trost, MD from Danville-Pittsylvania Community Service
- Art Van Zee, MD from Stone Mountain Health Services
- Sarah Woodhouse, MD from Chesterfield Mental Health
Submit Feedback

Opportunity to formally submit feedback

- Survey: www.vcuhealth.org/echo
- Overall feedback related to session content and flow?
- Ideas for guest speakers?
Claim Your CME and Provide Feedback

- [www.vcuhealth.org/echo](http://www.vcuhealth.org/echo)

- To claim CME credit for today's session
- Feedback
  - Overall feedback related to session content and flow?
  - Ideas for guest speakers?
Access Your Evaluation and Claim Your CME
Access Your Evaluation and Claim Your CME
Access Your Evaluation and Claim Your CME

• [www.vcuhealth.org/echo](http://www.vcuhealth.org/echo)

• To view previously recorded clinics and claim credit
Access Your Evaluation and Claim Your CME
Access Your Evaluation and Claim Your CME
VCU Virginia Opioid Addiction TeleECHO Clinics

Bi-Weekly Fridays - 12-1:30 pm

Mark Your Calendar --- Upcoming Sessions

March 29: Motivational Interviewing - Lori Keyser-Marcus, PhD & Courtney Holmes, PhD

April 5: Medical and Non-Medical Cannabis: An evidence-based review - Mishka Terplan, MD

April 19: Addressing Vocational Needs of People with SUD— Rebecca Farthing & Elizabeth Phillips

Please refer and register at vcuhealth.org/echo
THANK YOU!

Reminder: Mute and Unmute to talk
*6 for phone audio
Use chat function for questions