Changing the Culture: Pregnant Women Impacted by the Opioid Crisis

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EXECUTIVE SUMMARY

Pregnancy is a critical time for the development of the unborn child, mothers’ actions have a major influence on the development of the child. Pregnant women who use illicit or prescribed opioids face many barriers when seeking care or treatment for themselves and their children. The culture surrounding these women and their children needs to improve to provide better care to this vulnerable population. Pennsylvania legislators, health care providers, and organizations have instituted reform to better support pregnant women who use opioids. Laws, Health Information Exchanges, and medication-assisted treatment (MAT) can be improved to change the culture surrounding these women and improve the care they receive.

Statutes and regulations discussing pregnant women with opioid use disorder (OUD) vary greatly from jurisdiction to jurisdiction. The laws range from punitive for having any substance in the mother’s system to protective by giving pregnant women priority access to treatment. Pennsylvania has worked towards more supportive legislation surrounding pregnant women. However, the consistent execution of the law is of the utmost importance to this vulnerable population. Criminal laws, child welfare law, and MAT access laws are areas of law relevant to pregnant women who use opioids.

Sharing health information between health care facilities is important in any environment. However, in women who use opioid it is even more important. Efficient knowledge transfer supports MAT clinics and the women who use them. Data interoperability requires communication of Health Information Exchanges (HIEs) between facilities and across state lines. Better information sharing for patients with a history of substance abuse can help current practitioners provide the best care based on the patient’s health status. The sharing of information is critical for pregnant women with opioid use disorder as it can make the difference between successful recovery and relapse.

One of the best options for women who use opioids is medication-assisted treatment (MAT) for care throughout their pregnancy. MAT has been shown to be an effective harm reduction approach for both the mother and child. Building a successful MAT clinic requires many considerations including the services provided, appropriate location, and sufficient funding source. Building an ideal treatment facility which utilizes best practices can greatly improve the care these women receive.

A cultural change of the attitude towards pregnant women with opioid use disorder is imperative in providing better care for them and their children. Focusing on legal protections instead of punitive actions will help these women receive better treatment. Improving interoperability between health information exchanges will allow access to medical information to ensure comprehensive transfer of care. Building MAT clinics that focus on collaborative care can increase the efficacy and effect of treatment. Implementing these recommendations together can synergistically jump-start the culture change that is needed to improve the care of pregnant women with opioid use disorder.
RECOMMENDATIONS

Legal Barriers

1. Pennsylvania legislators should continue to strive to protect and support pregnant women who use opioids.

2. Allegheny County Health Department Maternal and Child Health Services should partner with organizations, such as the Nurse-Family Partnership, to centralize information about services and treatment options for pregnant or post-partum women who use opioids per 71 P.S. 553.

Health Information Sharing

1. Pennsylvania’s health information sharing laws, which are currently stricter than federal law, should be brought in line with the federal standard.

2. Pennsylvania's individual HIOs should opt-in to a single statewide health information exchange system similar to CliniSync in Ohio. This exchange system should be interoperable and allow different HIOs to share information with each other quickly and without delaying care for the mother and infant.

3. Pennsylvania health care providers and their delivery systems should adopt a new consent form to streamline the information sharing process. The consent form should have no expiration date and have explicit language granting providers the ability to access and share a patient’s substance abuse and mental health history.

Medication Assisted Treatment for Pregnant Women

1. Pregnant women with OUD should receive treatment that includes: MAT with increased social services, behavioral health counseling, gynecological and prenatal appointments, as well as specialized infectious disease services.

2. Treatment providers should practice collaboratively to create tailored, multidisciplinary, and comprehensive treatment plans for pregnant women with OUD.

3. Warm handoffs and referrals should be used to ensure women with OUD can continue treatment after they give birth.

4. MAT clinics should be funding by utilizing a combination of federal, state, county, and private grants. In addition, partnerships with existing health systems and Medicaid Managed Care Organization should be explored.
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GLOSSARY

Allegheny County Health Department (ACHD)—health department serving Allegheny County residents

Buprenorphine—a partial opioid agonist used in the treatment of opioid dependence (SAMHSA, 2016)

Charm Collaborative—multidisciplinary group of agencies, serving pregnant women with opioid addiction and their infants

CliniSync—main health information exchange in Ohio, headquartered in Columbus (Hagland, 2015)

Contingency Management—tangible positive reinforcement for abstaining from opioids

European Monitoring Center for Drugs and Drug Addiction (EMCDDA)—agency in Portugal providing “factual, objective, reliable, and comparable information” dealing with drug addiction

Health Information Exchanges (HIE)—allows health care professionals and patients to access and share medical information in a secure, electronic format (HealthIT.gov, 2014)

Health Information Organization (HIO)—organization that administers the HIE, often in a regional setting

Health Information Technology (HIT)—concept encompassing an array of technologies to store, share, and analyze health information (HealthIT.gov, 2014)

Maternal Opiate Medical Support (MOMS)—Ohio program for pregnant women and mothers dealing with opioid use

Medication Assisted Treatment (MAT)—treatment option combining behavioral therapy and medications to treat substance use disorders (SAMHSA, 2016)

Methadone—full agonist opioid used to treat opioid addiction (SAMHSA, 2016)

Motivational Interviewing—style of counseling to help the patient become more self-motivated and set personal goals to change behavior

Narcan—brand of naloxone, an opioid reversal agent

Neonatal Abstinence Syndrome (NAS)—group of problems occurring in a newborn after exposure to addictive substances in utero

Nurse Family Partnership (NFP)—maternal health program connecting first-time parents to maternal health nurses

Ohio Health Information Partnership (OHIP)—nonprofit entity whose mission is to assist physicians and other providers with the adoption and implementation of health information technology throughout Ohio (HealthIT.gov, 2014)
ONC Office of the National Coordinator of Health Information Technology—highest federal entity in charge of coordinating national efforts to implement and use the most advanced health IT and the electronic exchange of health information (About ONC, 2016)

Opioid Use Disorder (OUD)—disorder characterized by a strong desire for opioids, inability to control use, and continued use despite interference with daily life (SAMSHA, 2016)

Opioids—class of opium-like drugs chemically related and interact with the opioid receptors on nerves cells (NIDA, 2016)

Pennsylvania Organization for Women in Early Recovery (POWER)—organization dedicated to assisting women recover from addiction to alcohol and other drugs (POWER, 2017)

Pregnancy Recovery Center—outpatient treatment program for opioid-addicted pregnant women in Pittsburgh

Return on Investment (ROI)—measures the gain or loss generated from an invested in comparison to the amount of money invested (Investing Answers, 2017)

Substance Abuse—overuse or dependence on addictive substance

Supervised Injectable Heroin—programs allowing a safe place where opioids dependent people can inject heroin under medical supervision

UPMC St. Margaret Family Health Center—Pittsburgh-based family health clinic

West Virginia Health Information Network (WVHIN)—West Virginia’s statewide health information exchange
INTRODUCTION

Pregnant Women Using Opioids

Pregnant women who use opioids face significant barriers when seeking treatment; these barriers includes social and environmental barriers that can prevent them from enrolling in or completing MAT. These women experience obstacles in the prenatal, intrapartum, and post-partum stages of pregnancy that can impede the success of the MAT program in which they are participating.

One barrier to MAT enrollment for pregnant women using opioids is the fear of experiencing social backlash because of their situation. Women fear judgment or mistreatment due to their status as an opioid user during pregnancy (Jones et al., 2014). These individuals may feel using opioids during pregnancy equates to general inadequacy as a mother (Terplan, Kennedy-Hendricks, Chisolm, 2015). The stigma associated with using opioids during pregnancy is one factor that contributes to low enrollment of pregnant women using opioids in MAT programs.

Another barrier pregnant women using opioids face is access to treatment, both regarding physical and economic access. Transportation can impede enrollment into a MAT program (Lindsay, 2014). Difficulty or inability to physically get to an outpatient MAT clinic is a barrier resulting in low attendance of treatment. Another barrier faced by potential participants is the economic impact attending MAT can have for pregnant women and their families. Participation in MAT can induce costs for transportation, loss of work, and childcare (Letourneau, Campbell, Woodland, & Colpitts, 2013). The cost of attending treatment could deter pregnant women using opioids from enrolling in and continuing treatment.
Once enrolled in a MAT program, there are additional barriers to retention of women using opioids during the intrapartum and post-partum stages. MAT should be continued during labor and after birth (Wilder, Lewis, Winhusen, 2015). Pain management during these stages presents as a barrier because commonly used medications are contraindicated with the medications received during opioid MAT (Wilder et. al, 2015). Access can reappear as a barrier women using opioids face after pregnancy because their coverage by insurance or Medicaid can expire (Wilder et. al, 2015). This new cost increases the burden to the mother for continued MAT attendance.
CURRENT CLIMATE IN PENNSYLVANIA

Opioid Crisis in Pennsylvania

Pennsylvania’s drug overdose death rate of 20.1 per 100,000 in 2015 is significantly higher than the national average of 16.3 per 100,000 people (Centers for Disease Control and Prevention, 2016; Rudd, Seth, David, & Scholl, 2016). In the last two decades, overdose deaths in Pennsylvania have increased 470 percent (The Center for Rural Pennsylvania, 2014) and ten people are estimated to die every day in the state from drug-related causes (Pennsylvania State Coroners Association, 2015).

Allegheny County’s number of drug overdose deaths exceeds the national average. In 2015 alone, there were 414 drug overdose deaths in Allegheny County, an increase from 111 in 2014 (Pennsylvania State Coroners Association, 2015). During the same year, there were 33.6 drug-related deaths for every 100,000 individuals in Allegheny County (Pennsylvania State Coroners Association, 2015). This rate is higher than the 22.7 deaths per 100,000 people in rural counties and 29.1 deaths per 100,000 people in urban counties of Pennsylvania (Pennsylvania State Coroners Association, 2015). Most incidents occurred in the Mount Oliver and Perry South neighborhoods, with the majority of the deaths involving heroin although there has been an increase of deaths where multiple drugs were involved (Overdose Free PA, 2017).

While 52,150 state residents are currently receiving treatment for any substance abuse, an additional 760,703 Pennsylvanians are still in need of treatment (The Center for Rural Pennsylvania, 2014). Services in the state are being fully utilized and there are only enough resources to serve one-eighth of individuals living with substance abuse in the state (The Center for Rural Pennsylvania, 2014). The seriousness of the epidemic calls for immediate action.
**Political Climate**
The opioid abuse crisis has impacted millions of people throughout the U.S. Opioid abuse is a critical issue due to the sheer number of people impacted. Legislation such as the 21st Century Cures Act of 2016 has recently been enacted into law. Under Title I, Section 1003 of the 21st Century Cures Act, provisions are made for addressing the opioid abuse crisis. The Account for the State Response to the Opioid Abuse Crisis was created, and its funds are to be used to provide grants to states for addressing the opioid abuse crisis. The amount of $500 million has been allocated to this fund for the 2017 and 2018 fiscal years. States with higher incidence or prevalence of opioid abuse may be given preference when grants are awarded.

In Pennsylvania, six hearings are to be held from 2016 to 2017 by the Pennsylvania Department of Drug and Alcohol Programs (DDAP) to discuss current legislation regarding drug and alcohol treatment access (Bauer, 2016). A report detailing the findings includes recommendations for future action is due to the Pennsylvania General Assembly in May of 2017 (Bauer, 2016). The current legislation aims to provide coverage for the entire continuum of treatment for addiction and is perceived by the public as not being followed (Bauer, 2016).

Legislation to address the opioid abuse crisis has been consistently introduced and reintroduced in current and past Regular Sessions of the Pennsylvania General Assembly. See Appendix A for a list of pending bills and analysis of 2017-2018 legislation.
LEGAL BARRIERS
Recommendations

1. Pennsylvania legislators should continue to strive to protect and support pregnant women who use opioids.

2. Allegheny County Health Department Maternal and Child Health Services should partner with organizations, such as the Nurse-Family Partnership, to centralize information about services and treatment options for pregnant or post-partum women who use opioids per 71 P.S. 553.

Methodology
To retrieve laws relevant to pregnant women using opioids, LexisNexis, a subscription-only legal database, was utilized. Three separate searches were completed with a combination of keywords and Boolean search terms. Each search was limited by selecting ‘Statutes and Legislation,’ ‘Codes,’ and ‘Municipal Codes.’ The search terms were the following:

- mother OR pregnant AND drug use OR opioid OR opiate OR overdose
- medication OR medicine OR medical AND assisted /3 treat! AND pregnant AND drug OR opioid OR opiate
- controlled /3 substance pregnant! OR mother AND NOT manufacture

These searches returned 2,221, 36, and 1,640 laws, respectively, and resulted in 71 laws being deemed applicable to pregnant women who are using opioids.

Certain search limitations were required. Laws regarding murder, manslaughter, or similar topics were excluded due to the common law nature required to complete such research. Also, only laws which directly and specifically spoke about pregnant women using opioids, drugs, or substances in the text were included. Laws which have been applied to these women through case law only were not included.
To review the laws, a Google Forms page was created and utilized to code the law by specific categories. The categories included the authority level of the law, code number, type of law, impacted party, a summary of the law, and whether the law was a mandate or prescriptive. The authority level of the law included state, federal, or international. The impacted parties included mother, child, prescriber, practitioner, health care organization, or MAT clinics. Results of this law coding process are summarized in Appendix B.

Data
Of the laws deemed applicable, 50 percent were MAT access laws, 38.2 percent were child welfare laws, and 11.8 percent were criminal laws. The majority of applicable laws fell into a select group of states: Ohio held 30 percent and Illinois possessed 20 percent, while all other states had minimal percentages of analyzed laws. Not all states returned results; of the laws specifically found to refer to pregnant women with opioid use disorders, 15 states had returns. Of the total examined laws, 90 percent of laws were state and 10 percent were federal laws.

Analysis
In order to properly analyze the current legal status regarding pregnant women who use opioids in the U.S., the laws were categorized into three groups: criminal laws, child welfare laws, and MAT access laws. The purpose of this analysis was to understand what area states have focused their efforts regarding pregnant women who are using opioids, as well as to focus our recommendations. Per the Legal Information Institute, criminal law “is a system of laws concerned with punishment of individuals who commit crimes” (Legal Information Institute, 2007). Child welfare laws refer to laws intending to protect children from neglect and abuse and to ensure they live in a healthy and safe environment (“Child Welfare Laws and Legislation”, 2017). Finally, MAT access laws are a fairly new focus for legislators. This legislation can take many different avenues, including health care providers being
required to direct opioid addicted mothers to treatment, priority being given to pregnant women to
treatment, and funding from states for pregnant women addicted to opioids wishing to begin treatment.
All three of these areas of law have an influence on pregnant women who are using opioids and their
ability to seek treatment. Laws can improve access for this group of women, or incite fear while creating
a legal barrier to accessing treatment.

The legal status currently surrounding pregnant women with opioid use disorders must continue to shift
towards a more comprehensive and strategic approach. Shifting criminalizing laws from the primary to
the secondary stage of interaction will require ideological change and would allow these pregnant
women to have necessary treatment options made available to them before being penalized. This
cultural shift must occur across the continuum of care with buy-in and integration from law
enforcement, social and behavioral health counselors, social service organizations, and medical
practitioners who will work in a more collaborative system. By minimizing the initial barriers created by
criminal laws set in place on a state by state basis, an emphasis on the warm hand-off will be more
achievable.

_Criminal Laws_
Some states have laws establishing pregnant women as a vulnerable population and, therefore,
increasing punishment if illicit drugs are sold to them. In North Carolina, the act of selling illicit drugs to
pregnant women increases the penalty for the person selling by increasing the level of the felony.
Illinois, also, recognizes the person selling or distributing controlled substances to pregnant women as
criminals who will be subject to additional jail time. In California, the distribution of controlled
substances to pregnant women will be subject to an increased fine or imprisonment sentence.
Although the intention of these laws is to protect pregnant women, they are placing the focus on an inappropriate population and encouraging the negative stigma surrounding opioid use during pregnancy. Laws focusing only on punishment of the person selling drugs misses the big picture of the opioids crisis and, specifically, the rehabilitation of the people with OUD. These laws are a façade of protection without actually doing anything for pregnant women. Furthermore, by making pregnant women a vulnerable population in the law, the law furthers the stigma and can result in these women being too embarrassed to admit they need help during their pregnancy. Laws designating pregnant women as a vulnerable population to sell drugs to does not aid in positively changing the culture around pregnant women who use opioids.

**Child Welfare Laws**

Child welfare laws have a variety of purposes ranging from requiring health care providers to report infants exposed to certain substances, terminating parental rights because an infant is exposed to certain substances, or discontinuing governmental assistance from the family due to drug use by the mother. Some laws are vastly protective and risk averse, such as Missouri law, 211.447 R.S.Mo, which states that placing the child in the custody of the mother is inappropriate if any other children were removed from her custody within three years prior to this decision; if the mother tests positive to drug testing within eight hours after the birth of the baby; or the mother did not complete suggested treatment. Custody is also unfit if the mother admitted guilt or was convicted of drug possession, distribution, or production of drugs. In Nebraska, the law states a mother with illicit drugs or alcohol in her system is seen as 'inadequate' to have custody of the child.
Nevada law provides an example of aiding a pregnant woman using opioids; Nev. Rev. Stat. Ann. 422A.345 states a physician can demonstrate, in writing, the well-being of a pregnant mother and her unborn child is dependent upon receiving public assistance benefits.

Kentucky law, KRS 214.160, states a newly postpartum mother with a positive toxicology blood specimen within eight hours of birth must be evaluated by the physician for potential abuse or neglect of the welfare of the child. Likewise, North Dakota law, N.D. Cent. Code 50-25.1-17, states even if a newly postpartum mother has a negative toxicology test for any controlled substance or alcohol, the evaluating physician has a right to report her to the Department of Child Abuse and Neglect solely based on suspicion of drug use and potential child neglect or abuse.

The ultimate goal of these laws is to serve as protection for the child born to women using opioids. Additionally, if a pregnant woman using opioids is drug tested by their physicians, the mothers need to be educated on the dangers of the drug on their baby, followed by a referral to treatment services rather than punished for the use of illicit drugs.

Requiring reporting of children born to mothers using opioids is necessary but should be reported to the appropriate services. Reporting to law enforcement or child services with the intent to remove the child is not beneficial to the mother or the child. Reporting requirements should be utilized to protect the child but also to teach the mother how to care for her child while focusing on her treatment.

In considering a cultural change of perspective, Pennsylvania serves as a great model for positive transition as supported by the law. Pennsylvania has changed the nature of child welfare laws from the
assumption that pregnant women with OUD are unfit to care for their newborn child, to the
implementation of a law component that propels these women towards inter-disciplinary treatment
while providing the needed child services for her initial treatment period. This change promotes these
women to be parents while recovering from OUD.

**MAT Access Laws**

MAT access laws exist to enhance treatment continuity and funding for programs assisting individuals
with OUD. Medical professionals, in most states, are obligated to refer women using opioids for
treatment, whether it be an inpatient hospital setting, counseling service, or local substance abuse
treatment provider. The current status of these laws vary in their funding, comprehensiveness, and
support; 305 ILCS 5/5-5 states that in accordance with the Illinois Medicaid Program and Department of
Human Services, a pregnant woman seeking treatment should have the cost of doing so covered, and
any medical practitioner who interacts with the patient should immediately refer them to treatment.
Likewise, Puerto Rico law, 24 LPRA 6164, is a comprehensive law focusing on the welfare of the unborn
baby, while calling for an interdisciplinary team in order to provide a person with OUD with an
evaluation, long-term rehabilitation treatment, community-based organization support, child psychiatry
appointments, and no less than a six-month treatment period in addition to a six-month follow up.

The Protecting Our Infants Act of 2015 calls for the Department of Health and Human Services to
"review its activities related to prenatal opioid use, including neonatal abstinence syndrome, and
develop a strategy to address gaps in research and gaps and overlap in programs (Congress, 2015)."
Many of these robust laws focus on integrated, supportive treatment for pregnant women with OUD.
Pennsylvania Law, 71 P.S. 553, states the Department of Health can make grants available to mothers, with or without custody, to ascertain their treatment. This includes transportation, child day care services for women seeking counseling or jobs, and the opportunity to receive residential treatment.

The nature of medical service and addiction treatment laws tend to focus on changing the protocol for reporting laws to disseminate to social service organizations as a primary intervention source. Passing more supportive laws would ensure women receive treatment, allowing them to focus on being better caretakers for their children without the fear of being penalized. By modifying MAT access laws to include outpatient addiction treatment centers, pregnant women with substance use disorders would have greater access to care. Outpatient clinics would provide a greater number of women with treatment in comparison to an inpatient setting. This would allow women to integrate care into their lives more easily, in addition to reducing the wait time for receiving essential treatment.

**HEALTH INFORMATION SHARING**

**Recommendations**

1. Pennsylvania’s health information sharing laws, which are currently stricter than federal law, should be brought in line with the federal standard.

2. Pennsylvania’s individual HIOs should opt-in to a single statewide health information exchange system similar to CliniSync in Ohio. This exchange system should be interoperable and allow different HIOs to share information with each other quickly and without delaying care for the mother and infant.

3. Pennsylvania health care providers and their delivery systems should adopt a new consent form to streamline the information sharing process. The consent form should have no expiration date and have explicit language granting providers the ability to access and share a patient’s substance abuse and mental health history.
Health Information Sharing

An important barrier to receiving comprehensive and adequate treatment for substance abuse is the lack of medical related information sharing among providers. The treatment of opioid addiction is often multifactorial and can require the combined efforts of MAT, which includes behavioral health therapy, to see positive results (NIH, 2016). Helping individuals living with OUD successfully recover requires real-time and continuous access to their medical history. Expediting access to any information regarding the history of substance abuse can help current practitioners more accurately assess the patient’s health status and make more informed decisions for the patient. The development of Health Information Exchanges (HIEs) has in theory made the concept of sharing information among providers easier by allowing practitioners to view medical information on an electronic chart that integrates all of the patients care in participating health systems rather than having full patient charts from multiple providers faxed to their office or relying on patients to bring paper charts. However, medical information involving substance abuse and mental health are considered highly sensitive and, by law, require extra levels of protection. Federal regulations and state regulations have been put into place to better protect sensitive health information, but they act as barriers for HIEs and providers when health information needs to be exchanged (Vest and Gamm, 2010).

Federal Health Information Sharing

Federal regulations protecting confidentiality and privacy with regards to sensitive health information were put into place to prevent a patient’s medical information from being distributed to unwanted entities. Unfortunately, they become significant barriers for HIEs, which focus on the efficient release of mental health and substance abuse information. Confidentiality of Substance Use Disorder Patient Records, 42 CFR 2, is applicable to any entity advertising as or considers itself to be providers for
diagnosing, treating, or providing referrals for drug and alcohol abuse; or is regulated and gets assistance from the federal government (SAMHSA, 2014; Electronic Codes of Federal Regulations, 2017). 42 CFR 2.12 applies these restrictions to any health information identifying the patient as someone who has abused alcohol or drugs. The issue with restrictions put in place by 42 CFR 2 is, often, it is difficult to separate highly protected health information from overall physical health information within an information exchange, creating an “all or nothing” response from HIEs. As a result, HIEs must be strategic about how to include highly protected health information without breaking the law. While some laws impact the sharing of all health information of a patient through the exchange, others prohibit the exchange of highly protected information for fear of not being able to filter through what is sensitive and what is not (SAMHSA, 2014).

The “Privacy Rule” (45 CFR Part 160 and 45 CFR Part 164 subsections A and E) established under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) states protected health information can be disclosed for the use of treatment, payment, or health care operations with or without a consent (Health Information Privacy Law and Policy, 2014). The practice of obtaining a written consent is at the discretion of the facility (Health Information Privacy Law and Policy, 2014). With regards to highly sensitive information, such as substance abuse, written consent must be obtained for non-emergent health information sharing. The consenting process for highly sensitive information has nine main components that must be addressed under 42 CFR 2.13:

1. The name of the patient
2. The specific names of the entities permitted to make the disclosers
3. The specific information that is to be disclosed and how much of it
4. The names of the individuals and entities who are to receive the medical information
5. The purpose of the discloser (information must be limited to fulfill the needs for this stated purpose)

6. Statement that the consent can be rescinded at any time, at which point on services provided up until that point under the valid consent can be used for providers to receive payment

7. A given date, event, or condition that will cause the consent to become expired once it is reached and require the obtainment of another consent for further treatment and action

8. Signature of the patient or legal representative provided under 42 CFR 2.14 and 42 CFR 2.15

9. The date when the consent was signed (Electronic Code of Federal Regulations, 2017).

These components protect the patient but also create challenges for data sharing. The U.S. has strict data sharing laws designed to protect citizens' privacy. There are also federal programs designed to encourage data sharing between health care providers. The federal government has established various programs with the purpose of encouraging health plans to utilize HIEs. A review of applicable laws and government programs produced information on the barriers and the openings that these laws and programs present.

The Health Insurance Portability and Accountability Act of 1996, or HIPAA, is the most significant piece of legislation to be considered for this project. Among other things, HIPAA requires the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans, and employees (The Health Insurance Portability and Accountability Act (HIPAA)). HIPAA is important to electronic HIEs because the providers can inform their patients of their right to allow their health information to be shared electronically, but they are not required to do so. Key purposes for health information to be shared include treatment, payment, and health care operations (The Health
Insurance Portability and Accountability Act (HIPAA). However, there are federal laws requiring written consent, even for key purposes, in certain situations which may impact the ability to disclose patient health information. The Health Information Technology for Economic and Clinical Health Act, or HITECH Act, a part of the American Recovery and Reinvestment Act of 2009 (ARRA Title XIII), was signed into law on February 17, 2009, to promote the adoption and meaningful use of health information technology. It widens the scope of privacy and security protections available under HIPAA; it increases the potential legal liability for non-compliance, and it provides for more enforcement. Project Grants for Family Planning Services dictates all personal information and circumstances about patients getting services may not be shared without the patient's documented consent. Information is only allowed to be disclosed in the form of summaries without identifying individuals (42 CFR 59.11, 2007). 42 CFR Part 2 Confidentiality of Substance Use Disorder Patients imposes restrictions on the disclosure and use of substance use disorder patient records, which are maintained in connection with the performance of any part 2 program (42 CFR Part 2, 2017). Genetic Information Nondiscrimination Act (GINA) was signed into law on May 21, 2008. It protects individuals against discrimination based on their genetic information in health coverage and in employment. Prohibiting discrimination based on genetic information in health coverage is in Title I of GINA (Title I Sec 105), and prohibiting discrimination based on genetic information in employment is Title II of GINA (Title II Sec. 202). Section 618 of the Food and Drug Administration Safety and Innovation Act of 2012 (FDASIA) called for the Secretary and Health and Human Services to create a report of proposed strategies and recommendations on a risk-based regulatory framework for health IT that promotes innovation, protects the safety of patients, and avoids redundant regulation duplications (FDASIA Title VI Sec 618).
The Office of the National Coordinator of Health Information Technology (ONC) is the highest federal entity in charge of coordinating national efforts to implement and use the most advanced health IT and the electronic exchange of health information. It is a resource for all the nation’s health systems to support the adoption of health IT and promote national health information exchanges to improve health care (About ONC, 2016). The State Health Information Exchange Cooperative Agreement Program was established by the ONC in March of 2010. It funds states' efforts to increase their capacity for exchanging health information across the health system, both in-state and out-of-state. It identified 56 eligible states, territories, and qualified State Designated Entities to receive financial awards of varying magnitude. It also has the goal of advancing regional and state-level HIEs to achieve national interoperability (State Health Information Exchange, 2014). In January of 2011, another $16 million was made available to states through the HIE Challenge Grant program. It provides ten awards from one to two million dollars for grantees identified in the State HIE Cooperative Agreement Program to develop innovations in five key areas. Those areas include: create and implement up-to-date privacy and security requirements for HIEs, coordinate with Medicaid and state public health programs to establish an integrated approach, monitor and track meaningful use of HIE capabilities in their state, set strategies to meet gaps in HIE capabilities, and ensure consistency with national standards (State Health Information Exchange, 2014). The American Recovery and Reinvestment Act of 2009 (ARRA) created a HIT Policy Committee and an HIT Standards Committee. The Policy Committee makes recommendations on policy framework for the purpose of development and adoption of a national health information infrastructure. The Standards Committee is responsible for making recommendations on standards, implementation specifications, and certification criteria for electronic exchange and use of health information. It is also responsible for testing (ARRA Title XIII "Sec 3002-3003, 2009). Health IT Workforce Development Programs are federal grants, mostly funded by the ONC, designed to train a new
workforce of health IT professionals that can help providers implement electronic health records to improve health care quality, safety, and cost-effectiveness. Components include the Community College Consortia to Educate Health Information Technology Professionals Program, which aims to create or improve health IT education and training programs at the community college level. Another is the Curriculum Development Centers Program, which provides $10 million to higher education institutions to develop health IT curriculum (Health IT Adoption Programs, 2014). The Agency for Healthcare Research and Quality has a health IT initiative as part of the nation’s strategy to incorporate IT work in health care. They have a Health IT Portfolio that develops and disseminates evidence to inform policy and practice of how health IT can improve health care quality. The Portfolio has invested in research grants and contracts to over 180 different institutions in 47 states and the District of Columbia (Health Information Technology Portfolio Program Overview, 2016).

**Tristate Area Health Information Exchanges**

Although OUD is an issue of national public health concern, certain states have rates of overdose deaths that exceed the national average. For this white paper, the tristate area of West Virginia, Ohio, and Pennsylvania. West Virginia and Ohio was highlighted because of its proximity to Pittsburgh.

West Virginia does not currently have state regulations that further restrict the exchange of sensitive health information than required by federal regulation. Due to the detrimental impact of opioid addiction in West Virginia, the state legislature, in conjunction with other opioid addiction stakeholders, is trying to identify and implement strategies that can improve the epidemic. The implementation of a HIE within the state was created to improve access and quality of health care, including those patients suffering from substance abuse. The primary HIE of West Virginia, West Virginia Health Information
Network (WVHIN), was created in 2006 (WVHIN, 2015). There are currently over 400 providers who are using WVHIN as an electronic exchange for medical records including hospitals, private doctors’ offices, rehab facilities, nursing homes, and health departments (WVHIN, 2017). Current policy dictates a participating organization must tag any information that can be associated with drug and alcohol abuse and mental health before submitting it into the exchange so that it can be properly assigned and separated from other medical information (WVHIN, 2015). The purpose of tagging is to prevent the dispersion of sensitive health information without proper consent (WVHIN, 2015).

For a participating organization to obtain sensitive health information, they must first submit a formal request stating their reason for needing the information, relationship to the patient, and a signed authorization from the patient. Then if the patient does not opt out of exchanging their information through WVHIN, the information can be obtained (WVHIN, 2015). Without consent from the patient for the provider and the HIE, sensitive information cannot be shared unless needed for emergency treatment, which then must be clearly stated in the request and approved as an appropriate reason (WVHIN, 2015).

Pennsylvania and Ohio have similar laws with regards to substance abuse and sharing of information. Health care providers in Ohio under ORC 5122.31(c)

May exchange psychiatric records and other pertinent information with other hospitals, institutions, and facilities of the department, and with community mental health agencies and boards of alcohol, drug addiction, and mental health services with which the department has a current agreement for patient care or services” (Jost, 2006).
The type of information that is shared is also regulated under ORC 5122.31(c). This information is limited to “medication history, physical health status and history, financial status, summary of course of treatment in the hospital, a summary of treatment needs, and discharge summary, if any” (Jost, 2006).

Since the information that can be shared is limited by both type of information and with whom it can be shared, this limitation can cause issues with patient treatment. To provide a patient who is dependent on opiates with the best care, health care information must be shared more effectively across different health care providers. Under Ohio Revised Code 3701.17, protected health information cannot be released without the written consent of the patient unless there is a subpoena, warrant for this information, or if the information is determined necessary to avert a threat to and protect public health. (Ohio Revised Code, title 37 § 3701.17).

In the state of Ohio, patient health information is shared through health information exchanges, such as CliniSync. CliniSync is the main HIE in Ohio and is headquartered in Columbus, Ohio (Hagland, 2015). It is a statewide HIE under the Ohio Health Information Partnership (OHIP) (Hagland, 2015), which is funded by the Department of Health and Human Services (Healthit.gov, 2013). CliniSync allows health care providers to connect with other health professionals to electronically maintain patient health information. CliniSync’s website allows for providers to sign up and participate in the HIE (Ohio Health Information Partnership, 2015). Through CliniSync, providers can message other providers, and upload information regarding discharges, admissions, lab results, while also searching for other providers and learning about relevant policies impacting the HIE, among other resources (Ohio Health Information Partnership, 2015). Currently, their directory has over 15,000 email addresses of participating providers (Ohio Health Information Partnership, 2015). As of 2015, CliniSync was used by 143 hospitals, 73 of
which were actively engaged in their data sharing system (Hagland, 2015). Also, 600 practices, employing over 3,000 providers, outside of these hospitals also are using CliniSync’s services, and each month there are between one and two million exchanges on their site (Hagland, 2015).

Sharing of patient health information through CliniSync is impacted by both state and federal laws. For example, ORC 3798.01-3798.16 impacts exchange of mental health records and ORC 3701.243 addresses sharing information regarding HIV/AIDS status (Ohio Revised Code, title 37 § 3798.01-3798.16; Ohio Revised Code, title 37 § 01.243). Federal laws, such as 42 CFR Part 2 impact sharing of histories of drug and alcohol use and 45 CFR 164.508 restricts sharing of psychotherapy notes (C.F.R., title 42, chapter 1, subchapter A; C.F.R., title 45, chapter A, subchapter C, subpart E § 164.508). In cases where the patient is a minor, federal and state laws address sharing patient information after obtaining the minor’s consent, as addressed in 45 CFR 164.502 and ORC 3798.07 (C.F.R., title 45, chapter A, subchapter C, subpart E § 164.502; Ohio Rev. Code, title 37 § 98.07). If information that is being shared for the minor is related to sexually transmitted infection (STI) status or treatment of a condition related to substance abuse, additional state laws, such as ORC 3709.241 and ORC 3719.012 can further complicate the information sharing process (Ohio Rev. Code, title 37, § 3709.241; Ohio Rev. Code, title 37, § 3719.012). At the state level, ORC 5119.28 also impacts sharing a patient’s mental health information, as well as the implementation of mental health services, and payment for these services (Ohio Rev. Code, title 51 § 5119.28). As a result of these laws, behavioral health information can only be shared directly between providers, and this information is not searchable in CliniSync records (Ohio Health Information Partnership). Personal correspondence with CliniSync personnel confirmed that patients can opt in or opt out to CliniSync at any time. It is recommended that providers treating
patients who are in the CliniSync system get patient consent for sharing information during each appointment (Ohio Health Information Partnership, 2015).

While the CliniSync system has been highly successful in creating a comprehensive statewide data sharing HIE, providers using CliniSync face many barriers in data sharing due to federal and state laws. Requirements to obtain patient consent at each follow-up restrict providers from sharing mental health and substance use history information that can better inform patient care. It is recommended that CliniSync and Pennsylvania HIos develop a consent form that facilitates sharing of mental health and substance abuse-related information from each visit. Ideally, this form should not have an expiration date and should allow the patient to opt out when they prefer that certain personal information not be shared. The CHARM collaborative in Vermont has developed a consent form, included in the Appendix C, that facilitates information sharing for records from each patient visit, thus eliminating the need to obtain patient consent at each follow-up. This form would address restrictions to providers sharing and accessing mental health and substance abuse histories, while still ensuring that patients control what personal health information is shared, and that practices of data sharing are in compliance with state and federal laws.

As the data sharing implications for Ohio and West Virginia have been described, the following will focus on the laws of the Commonwealth of Pennsylvania. Pennsylvania poses a peculiar stage in regards to data sharing, being as the Commonwealth’s confidentiality laws are more strict than those of HIPAA and 42 CFR Part 2 (Petrila, 2013). Records relating to drug and alcohol abuse or dependence prepared or obtained by a private practitioner, hospital, clinic, drug rehabilitation, or drug treatment center must remain confidential and can only be disclosed with the patient’s consent (Pa. Cons. Stat. Ann. tit. 71 §
1690.108(b)). Like Ohio and West Virginia, Pennsylvania also has a health information exchange. However, unlike the other states in the tri-state region, Pennsylvania’s HIE consists of eight smaller organizations, known as Health Information Organizations (HIOs), that are privately owned and funded. This difference creates barriers to the openness of typical HIEs. Known as the Authority, the Pennsylvania eHealth Partnership Authority is trying to forge connections between all of the HIOs to establish a statewide HIE, which would be housed through the Pennsylvania Patient and Provider Network, or P3N. The intent of the P3N is to "establish a statewide, interoperable system for participating organizations to move health information in a manner that ensures the secure and authorized exchange of health information to provide and improve care to patients" (PA.GOV). While the goal of the P3N is to create an interoperable system, it reaches a major limitation when trying to share super protected health information. As it currently stands, all participating providers of each of the HIOs need to filter out their super protected health information before it is sent to the HIO (DHS.gov).

Best Practices for Health Information Exchanges

Health information exchanges are an essential tool for improving care among mothers with OUD and their children. Consolidating Pennsylvania's HIOs into a statewide health information exchange, like P3N, which accepts super protected health information would streamline the data-sharing process for health care providers across the state. This change would allow providers across the state to be able to access information when it is most critical to treat these women, especially when they have overdosed. For example, a physician treating a woman with OUD who is expecting or has recently delivered can learn from accessing her medical history to prescribe accordingly and not increase her risk for relapse. Federal
funding sources can be used to support the expansion of a statewide health information exchange by involving health IT professionals in its design and support strategies to incentivize health care professionals to use the system for data-sharing, which can help eliminate barriers to seeking comprehensive care for mothers with OUD and ensure treatment when it is most needed. It is paramount a statewide health information exchange for Pennsylvania prioritize the adoption of a one-time consent form for all patients. This form would expedite the data-sharing process for patients, by eliminating the need to seek patient consent for data-sharing at every appointment. Additionally, the incorporation of language allowing the sharing of mothers' histories of substance abuse and mental health concerns can help health care providers better understand the patient's needs to prevent future adverse health outcomes for the mother and their child.

**TREATMENT FOR PREGNANT WOMEN USING OPIOIDS**

**Recommendations**

1. Pregnant women with OUD should receive treatment that includes: MAT with increased social services, behavioral health counseling, gynecological and prenatal appointments, as well as specialized infectious disease services.
2. Treatment providers should practice collaboratively to create tailored, multidisciplinary, and comprehensive treatment plans for pregnant women with OUD.
3. Warm handoffs and referrals should be used to ensure women with OUD can continue treatment after they give birth.
4. MAT clinics should be funding by utilizing a combination of federal, state, county, and private grants. In addition, partnerships with existing health systems and Medicaid Managed Care Organization should be explored.

**Maternal MAT Clinic**

Opioid misuse among women first became a problem in the United States in the years following the Civil War. While soldiers wounded on the battlefield were given a variety of opiate-derived compounds to
assuage their pain, middle- and upper-class women were prescribed proprietary opiate concoctions for menstrual discomfort, menopausal side-effects, and other “female troubles” (Center for Substance Abuse Treatment, 2005). By the end of the 19th century, roughly two-thirds of persons thought to be suffering from opioid use disorder were women (Center for Substance Abuse Treatment, 2005). In 1905, Congress recognized the dangers of the opiate poppy and accordingly banned the importation of opium; by 1940, however, a thriving opium black market in New York City gave American public health its first taste of the opioid epidemic that would soon spread to all 50 states (pbs.org, 1998).

In 1964, the first methadone maintenance program sought to combat this growing problem. Since then, MAT programs using methadone and buprenorphine have consistently demonstrated clinical efficacy in treating individuals with opioid use disorder, by reducing or eliminating the use of opioids, reducing death rates and opioid-related criminality, and improving social productivity (Joseph et al., 2000). Pregnant women using opioids, however, present a unique challenge to this putative panacea. Opioid detoxification typically results in withdrawal, which is especially problematic during pregnancy because it can cause uterine contractions, miscarriage, or trigger the premature onset of labor (Substance Abuse & Mental Health Services Administration, 2014). Assuming the mother gives birth to an otherwise healthy child, another major concern is the occurrence of NAS, which includes respiratory complications, feeding problems, jaundice, and seizures—these can be life-threatening if not treated appropriately (fda.gov, 2016). Methadone treatment of pregnant mothers can result in NAS (Vimont, 2012) or altered fetal activity and heart rate (Jansson, et al., 2005 & Ramirez-Cacho et al., 2006).
Nevertheless, methadone “has been accepted since the late 1970s to treat opioid addiction during pregnancy” (Center for Substance Abuse Treatment, 2005) and is recognized as the “most effective treatment [in this population]” (Joseph et al., 2000), and remains the “most widely prescribed medication for the treatment of opioid dependence during pregnancy” (Jones et al., 2013). Thus, although “benefits [of methadone maintenance therapy] are less well documented [for nonheroin opioid addiction]” (Committee Opinion No. 524, 2016), it remains the standard treatment (as recommended by the World Health Organization, the National Institutes of Health, and the American College of Obstetricians and Gynecologists) in all opioid-related MAT settings (Calhoun, 2014). Compared with pregnant women using opioids who do not seek methadone treatment, methadone-treated pregnant mothers have “better maternal and neonatal outcomes” (Jones et al., 2013). Despite the specter of NAS, studies investigating neonatal outcomes other than NAS have underscored the safety and efficacy of methadone treatment.

In 2005, the National Institute of Health funded a five-year project called The Maternal Opioid Treatment: Human Experimental Research, which examined the effectiveness of buprenorphine to methadone. This “double-blind, double-dummy, flexible-dosing, parallel-group clinical trial” was the first large study of its kind, “formally examin[ing] the relative merits of each of the currently available opioid agonist agents in pregnant opioid dependent women” (Jones et al., 2008). The results, published in the 2010 issue of the New England Journal of Medicine, found minimal difference between the two drugs and further found no dose-response relationship between maternal methadone administration and neonatal outcomes, including “peak NAS score, total amount of morphine needed to treat NAS, duration of neonatal hospital stay, duration of treatment for NAS, estimated gestational age at delivery, Apgar score at five minutes, and neonatal head circumference, length, and weight at birth” (Jones et al., 2010).
The benefits of maternal MAT, therefore, are clearly demonstrated in the literature—and these programs are only growing in their importance.

Empirically, maternal MAT clinics are more in demand now than ever. In 2003, Congress amended the Child Abuse Prevention and Treatment Act, which mandated the creation of state-level reporting systems for children born to women using opioids. A decade after the amendment, the number of babies diagnosed with NAS nationally nearly quintupled, jumping from 5,000 in 2003 to roughly 27,000 in 2013 (Wilson & Shiffman, 2015). As this data suggests, the number of pregnant women using opioids is increasing at an alarming rate despite legislative efforts to stem the rising tide of the current epidemic. Add this disturbing trend to the fact that overdose deaths in women, between 1999 and 2010, increased more than 400 percent (compared to 237 percent among men) and, according to the American Society of Addiction Medicine, “women are more likely to have chronic pain, be prescribed prescription pain relievers, be given higher doses, and use them for longer time periods than men [and] may become dependent . . . more quickly than men” (Opioid Addiction 2016 Facts & Figures, 2016). The need for and potential benefit to be derived from the establishment of maternal MAT clinics is self-evident.

International Best Practices

European Monitoring Center for Drugs and Drug Addiction Recommendations

The European Monitoring Center for Drugs and Drug Addiction (EMCDDA) has composed a list of best practices that is working as a guide for the countries in this region. First, MAT needs to be paired with psychosocial support to increase a patient’s chance of adherence to treatment and have a positive
mental health outlook. They also recommend either methadone or buprenorphine for MAT as they are equally effective suppressing opioid use. Pregnant women using opioids are highly recommended to engage in MAT over detoxification. They noted psychosocial interventions including contingency management and/or motivational interviewing. Contingency management is tangible positive reinforcement for abstinence from opioids. Motivational interviewing is a style of counseling that helps the patient become more self-motivated and set personal goals to change their behavior, in this case, opioid abuse. If relapsing is an issue for the individual, the EMCDDA recommends naltrexone to be used to support a patient in situations where loss of a job or probation violations may be a concern (EMCDDA, 2012).

_Innovative Treatment Solutions Internationally_

While the best practices from the EMCDDA look similar to those in the U.S., there are treatment programs that have been in progress and undergoing rigorous studies to prove efficacy and economic value. These progressive countries are taking what may seem like radical moves to the U.S. to care for their citizens that are seeking treatment for their opioid addiction. Interventions have been divergent from the standard oral MAT treatments that focus on assisted injection treatments.

There have also been policy changes, in Portugal, that have shifted views on drugs and people who use drugs. This country has taken a more social approach to help end this epidemic. The decriminalization of drugs in this country, including heroin, happened in 2001 and helped them overcome major hurdles. This decriminalization was in hopes of changing the mindset of the population to move away from associating people using drugs with crimes who needed to be reprimanded towards associating this
behavior with a disease that needs treatment. Studies have shown this policy has led to decreases in heroin use, as well as drug-related deaths and an increase in numbers for those entering treatment for their addiction (Hughes and Stevens, 2007). In 2010, Hughes and Stevens revisited this subject and reported a continuous increase in those entering drug treatments and a continuous decrease in deaths related to opioid use and infectious diseases. They also observed a reduced burden on the criminal justice system. They saw a reduction in use among adolescents, which could translate to the population of interest in this paper, as some of these individuals are female and enter into reproductive age (Hughes and Stevens, 2010). Fifteen years after the decriminalization in Portugal, studies have shown they now have one of the lowest drug overdose-related death rates in the European Union (Cabral 2017). Decriminalizing drugs decreased Portugal’s overall social costs in indirect health costs as well as in the legal system related to drug use by about 18 percent from 2000 to 2010 (Goncalves, Lourenco, and Nogueira da Silva, 2015). Many other countries are analyzing Portugal’s unreserved 2001 policy change to implement and reproduce these outcomes in their countries. By incorporating this policy into the American legal system, the U.S. could also see a shift in culture. Changing how the country thinks about opioid dependence from a crime to a mental illness could lead mothers to be more open about their dependence which could allow for an increase in mothers seeking treatment.

U.S. Best Practices
While international best practices can provide a vision for the future, U.S. best practices can be used currently. A 2014 presentation given by NIDA to the Senate Caucus on International Narcotics Control explained that MAT would be most effective when offered with services including behavior health interventions, infectious disease treatment, treatment of psychiatric diseases, and overdose protection,
but very few systems in the U.S. offer this “bundle of effective services” (National Institute on Drug Abuse, 2014). NIDA has published a report outlining research-based drug addiction treatment, and numerous papers have outlined best practices for treating OUD in pregnant women. The recommendations are based on findings from literature reviews focusing on OUD treatment in pregnant women nationally and internationally, and from case studies of selected clinics treating OUD.

A literature search was performed in PubMed, using the search terms “opioid addiction treatment in pregnancy United States.” When the search was limited to humans, 75 results were returned; after reviewing titles and abstracts, when necessary, we found 13 applicable results were found. We were unable to review four of those 13 articles, as we did not have access to them.

Of the nine remaining articles, a few themes emerged regarding treatment of opioid-addicted pregnant women in the United States. A majority of the articles focused on MAT—methadone, and buprenorphine in particular. They acknowledged methadone has long been the standard of care for opioid addiction during pregnancy, but recent studies have found buprenorphine to have similar efficacy as methadone, while potentially resulting in less severe cases of NAS in infants (Howard, 2016; Jones, Finnegan, & Kaltenbach, 2012; Jones, Heil, et al., 2012; Krans, Cochran, & Bogen, 2015).

For the papers discussing more than MAT, the focus is on the importance of all-encompassing, comprehensive treatment. Some articles discussed the stigma that exists for women seeking care, and recommended health care practitioner training to educate them on how to treat this patient population (Howard, 2016; Kremer & Arora, 2015). There was also an emphasis on the necessity of social services, as pregnant women who use opioids are at a higher risk for sexual violence, homelessness, prostitution,
and incarceration (Howard, 2016; Jones, Finnegan, et al., 2012; Krans et al., 2015). Only two articles discussed further comprehensive services—behavioral and mental health screenings, infectious diseases screenings, and case coordination and referral services (Howard, 2016; Winklbaur et al., 2008). A different article offered the insight that currently, legal sanctions in the U.S. against pregnant women who use opioids are harmful and deter them from seeking care (Kremer & Arora, 2015).

By focusing on clinics already treating pregnant women with OUD, it is possible to see how best practices recommendations translate into reality. Three case studies are presented below: the CHARM Collaborative, the Pregnancy Recovery Center, and UPMC St. Margaret Family Health Centers.

**The CHARM Collaborative: Burlington, Vermont**

*Discussion with Sally Borden*

The Children and Recovering Mother (CHARM) Collaborative began out of necessity—in 1998, there were no methadone clinics or opioid treatment programs where a pregnant woman could receive MAT. Under state law, a physician was able to apply for a waiver to prescribe methadone in their clinic, and so a physician did so—first treating only one woman, and then treating several more as demand grew. The physician worked with an obstetrician and neonatologist to coordinate care for the women he was treating, and this continued until Vermont opened their first methadone clinic in 2002.

As the demand for MAT among pregnant women who use opioids continued to increase, a few state agencies began to consider how to best provide treatment for these women. The CHARM Collaborative grew out of these conversations—a team made up of a physician, an addiction specialist, an obstetrician, a neonatologist, the state Alcohol and Drug Abuse Program’s women’s services coordinator, the directors of two treatment centers in the area, and a representative from the Virginia Department of
Children and Families (VCDF). The Director of the KidSafe Collaborative, a local agency that supports cross-agency collaborations to address child abuse and neglect, joined these team members.

KidSafe was brought in to help with the information sharing issues creating by having physicians and health care professionals on the same team. The representative from the VCDF wanted all information to be shared. The physicians, in an effort to protect their patients’ privacy, wanted no information to be shared. The turning point came when the group shifted their vision—rather than focusing solely on the mother; they began to focus on both the mother and the child, which brought together all the team members and gave them a common vision. After approximately two years, the team was able to agree to the creation and terms of a Memorandum of Understanding (MOU) that allowed the information to be shared safely and legally between members of the CHARM team.

Patients who were treated by the CHARM team were asked to sign a Release of Information (ROI) to allow their case to be discussed by team members. Though patients were hesitant initially, most agreed to sign after the obstetrician took the time to go over and explain the ROI to them.

The CHARM team members came together monthly to discuss the patients in the program. Sometimes, if a patient was doing well, they might only be discussed when they entered and when their due date was approaching. Other patients were discussed more frequently—the team would discuss if patients were compliant with their MAT if they were involved in counseling, if they had completed their neonatal visit, and if they needed anything from VCDF. Vermont is unique in that a state law exists where a case with VCDF can be opened pre-emptively if the safety or health of the child is in danger.
The CHARM team also treats infants with NAS in a manner different than many other treatment centers. Rather than treating the infant with morphine during an inpatient hospital stay, infants are treated on an outpatient basis with methadone. The parent, or caregiver, is trained how to administer the methadone to the infant, and the infant can go home rather than stay in the hospital for a few weeks or months. The program is cost-saving, though not inexpensive to run as someone is on call 24/7 to answer any questions parents/caregivers may have. The program has obvious benefits for the infant and parent/caregiver in addition to the financial benefits.

The collaborative aspect is key to the success of the CHARM team. The team realized they shared common goals—to support and provide care for the family and ensure the safety of the child. They have developed a rapport allowing them to disagree without sacrificing the relationships between the group members. An unexpected outcome was that the team members gained a better understanding of the responsibilities of each of the other members of the CHARM team, which allowed them to all better treat the patient. The success of the program is proof that concerns about privacy and data confidentiality should not be an automatic barrier to the creation of a similar program.

*Pregnancy Recovery Center: Pittsburgh, Pennsylvania*
*Discussion with Marie Hackshaw*

The Pregnancy Recovery Center (PRC) began in 2014—an outpatient treatment program for pregnant women who use opioids. The PRC offers buprenorphine-based MAT, counseling, social services, and access to prenatal care. Run by two CARN-certified registered nurses, the PRC assess newly referred patients when they are off opioids and in the early stages of detoxification. From there, patients return on a weekly basis for the first six weeks, and then every two weeks. Patients are given an open-door, urine drug screen during every visit, and are required to complete an hour per week of counseling,
remain compliant with their MAT, and attend all scheduled prenatal visits. The case managers work closely with a social worker, and the social worker provides referrals to a variety of programs—transportation and housing assistance, and assistance with domestic violence and abuse issues. The PRC can only treat patients for six weeks postpartum but help to transition the patients to another buprenorphine provider or a methadone clinic.

Privacy and confidentiality issues do create some limitations for the program—participation in the PRC cannot be noted in a patient’s record, and it is possible for the patient to be prescribed an opioid, especially after giving birth.

The PRC recently received a Center of Excellence Grant, and is planning to expand to additional sites throughout Allegheny County. Assessment and intake will take place at Magee, but weekly sessions will take place at satellite locations.

_UPMC St. Margaret Family Health Centers_  

_Discussion with Dr. Jonathan Han_

In 2012, the New Kensington branch of UPMC St. Margaret Family Health Centers received a grant to allow them to add a full-time behavioral specialist and a part-time Psychiatrist to their staff. Though the practice is a family health clinic and does not focus specifically on OUD, it is a part of their practice. In fact, the practice sees it frequently enough they began handing out Narcan to their patients struggling with OUD, free of charge.

The clinic discovered how important it is for all services to be offered in the same location and available for referrals on a same-day basis. At first, a therapist was only available for one-half day each week, and
only about 20 to 30 percent of patients came back to see the therapist after a referral. When the therapist’s hours were increased, practitioners found if the patient saw the therapist on the same day the referral was made, then approximately 60 to 70 percent returned.

The clinic focuses on a cooperative, collaborative environment. The offices for clinic staff are in one common area, bullpen-style, and do not hesitate to consult the others about an issue with a patient. Weekly meetings are held, and patient’s plans of care can be further discussed during this time, as necessary. The New Kensington office also serves as a training program for medical school residents, pharmacy fellows, and student social workers—there is a true emphasis on team-based care.

*Pittsburgh Partners*

An outpatient MAT program must address these barriers to engage pregnant women using opioids. Partnerships with organizations in Allegheny County specializing in addiction is a solution that should be explored further. A potential partnership exists with the Pennsylvania Organization for Women in Early Recovery (POWER). Their programs provide gender-specific treatment, which includes counseling, skills classes, case management, and referrals (POWER, 2017). A partnership with this organization can help connect women to MAT during pregnancy, as well as exist as a resource for post-partum treatment.

The Nurse Family Partnership (NFP) program at the Allegheny County Health Department is another potential resource an outpatient MAT facility can utilize. The NFP provides home visits to women during pregnancy and for two years post-partum. The program enrolls pregnant women using opioids into their service and provides them with referrals to addiction services in addition to their maternal education materials. Women who are not first-time mothers can also receive similar services through the Allegheny County Health Department Maternal Child Health Division. These services can be used as partnerships for a pregnant woman enrolled in MAT for opioid use.
Location

Early common law valued individual rights to the extent they did not infringe on important rights held by others. Nuisance law, premised on the maxim the use of one’s property should not unreasonably interfere with another’s enjoyment of their property, addressed competing societal interests. This area of the law weighs the utility of one property owner’s conduct (a positive right) against another’s right to enjoyably make use of their property without unreasonable and substantial interference (a negative right). Nuisances are commonly divided into two distinct categories: private and public. As relevant here, a public nuisance is a non-trespassory invasion of others’ interests that “threatens the public health, safety or welfare, or does damage to community resources” (Feirick, 2000). Pennsylvania law recognizes the existence of a public nuisance where “conduct involves a significant interference with the public health, the public safety, the public peace, the public comfort, or the public convenience . . . .” (Restatement (Second) of Torts). Because this definition may appear to capture an impermissibly wide range of activity, disputes over the existence of a public nuisance are often fact-intensive and involve judicial balancing. In practice, local nuisance laws allow law enforcement officials to order the closure of premises engaging in the offending activities when there have been reports of certain criminal or other undesirable activities occurring in and around the property (Owens, 2011).

Given this legal backdrop, halfway houses, dependency clinics, and all types of drug and alcohol rehabilitation facilities are easily singled out as sources of public nuisance when they move into a community (Andrews and Radel, 2014) Misgivings expressed by community members range from qualms over increased neighborhood traffic to concern over the influx of individuals with supposedly undesirable behavioral inclinations (Lanahan, 2016). Methadone and MAT clinics are no exception. People struggling with OUD are stereotypically lumped into the category of society’s ne’er-do-wells, at
best, and, at worse, are treated as criminals. A factor that, perhaps, militates for a maternal MAT clinic is there may be less public condemnation of pregnant mothers as criminals or undesirables.

Challenges to methadone clinics in the judiciary have, absent a clear violation of the law, (Palella v. Leyden Family Serv. & Mental Health Ctr., 1980) typically resulted favorably for the operators of the clinics. The following is a brief survey of this area of the law.

In *Maywood v. Health Inc.*, an Illinois appellate court upheld a trial court’s denial of an injunction against a methadone clinic. The clinic performed methadone maintenance, detoxification, group and single therapy sessions, educational services, and job training for 90 patients. The complaint alleged the clinic violated zoning laws and its activities constituted a nuisance. The court found the methadone clinic complied with the village ordinance which specifically set forth allowable uses; thus, because the zoning law authorized the establishment of “an office of professional persons” the methadone clinic was a permissible establishment.

A Pennsylvania Commonwealth Court case reached a similar conclusion in *THW Group, LLC v. Zoning Board of Adjustment*. The plaintiffs in the case argued a methadone treatment facility did not meet the criteria of a medical office, for zoning purposes, which functionally would prohibit its operation. The court disagreed, holding the methadone clinic qualified as a medical office. This case is important because it demonstrates the willingness of Pennsylvania courts to construe zoning language for methadone clinics.
The law in Pennsylvania regarding methadone clinics is also informed by the 3rd Circuit Court of Appeal’s decision in *New Directions Treatment Services v. City of Reading*. In this case, a state statute restricted the locations where methadone clinics could operate within the state. The restrictions, the court found, violated the Americans with Disabilities Act and thus invalidated the statute. Given this recentness of this case, Pennsylvania legislators, at the state and local levels, are likely to be wary about imposing restrictions on the operation of methadone clinics.

The plaintiffs in *People v. HST Meth, Inc.*, on the contrary, succeeded in securing an injunction against a methadone clinic by alleging the clinic was creating a nuisance. With close to 500 patients, the clinic was operating over capacity, serving 200 more patients than recommended by a local governmental health care council. Also, police reports revealed significant drug trafficking activity had been conducted inside the clinic by both patients and staff. Despite these abuses, the court deemed the clinic a public nuisance and granted the plaintiffs’ injunction against the clinic, but only to the extent that the clinic was violating the law (i.e., the zoning restriction of 300-patient maximum and the drug trafficking). The court ordered the clinic to exercise greater control over its patients and staff and to reduce its caseload. This case, therefore, stands for the proposition that courts confronted with a nuisance complaint will not “enjoin and destroy the whole operation, but will enjoin and abate only those activities which constitute and make it a nuisance.”

Plans to open a clinic in downtown Louisville, Kentucky this past summer faced opposition from community groups for various reasons. Principal among the reasons was the “appropriateness of the . . . location” due to the fact the proposed clinic would be housed in the same building as an existing clinic. The new MAT center, a private cash-based clinic, cited public transit accessibility and favorable zoning
laws as justifications for the location, but critics lamented the duplication of services would inevitably result from the proximity of two clinics (Sonka, 2016).

An investigative length article published last year by Baltimore’s City Paper notes the city's difficulties with its methadone clinics (Lanahan). Based on the widespread nature of the problem, the author cites oversaturation as the primary concern of methadone clinic critics, echoing the same trepidations of the critics in Louisville. In certain areas of the Baltimore, there is a great concentration of clinics, resulting in a disproportionate allocation of resources in those areas while leaving other areas bereft of similar resources.

To summarize, locating a clinic in an area where other MAT clinics already serve different populations would be an appropriate proxy for a due diligence investigation by ensuring there are no automatically disqualifying geographical features present (i.e., the propinquity of a school district) and by further assuring that if there is not any vacant space to either construct a new clinic or rent an appropriately zoned "medical office". Also undersanding the myriad issues that MAT clinics bring with them and having a risk mitigation plan is of the utmost importance.

**Funding**
Paying for and creating financial viability for MAT clinics is of the utmost importance. Without funding and partnerships, MAT clinics face an uphill battle to open and survive. There are multiple ways to fund a MAT clinic including private, state or federal grants to fund the clinic or a joint venture with the Managed Care Organizations for Medicaid. The research shows many of these options are a viable way to fund the clinic. Therefore each is presented. Return on investment is important for this clinic; the paper sought to use the difference in neonatal care cost through the use of MAT as opposed to the cost
of neonatal care without MAT care as the sole ROI factor. There are many benefits to MAT for both the mother and the newborn that are not counted in this ROI. The limited scope of the ROI presents a limitation to this paper because these benefits were not measured. Therefore, the ROI presented is possibly a gross underestimate of the benefits of this program compared to the investment needed.

Grants are a crucial tool for funding MAT clinics. Grants for programs such as M.O.M.S (Maternal Opiate Medical Support) which funded administrative resources, and co-location of psychiatry, addiction psychiatry, OB/GYN resources cost around $400,000 for a two-and-a-half-year period for the program in Cleveland. This program was run throughout Ohio. Diving deeper into one city where the program was run, Cleveland, the program partnered with MetroHealth Medical Center. Partnering with a health system helped the funding of the program. MetroHealth was expecting billings from Medicaid of $3.75 Million for 125 babies and their mothers. Also, they received funding from a March of Dimes Grant (Maternal Opiate Medical Support (M.O.M.S.) Pilot Project Program Abstracts). This combination of funding from grants, revenue from the services provided by their physicians, and revenue from the hospital services drove down the cost of the grant.

Grants can be funded from private benefactors and from the state and the federal government. MAT clinics that center on helping pregnant women using opioids may have more private grant funding sources because of the nature of the problem. The Commonwealth of Pennsylvania often funds programs such as a multidisciplinary clinic for pregnant women with OUD. In fact, in January of 2017, Temple announced a $500,000 grant from the Commonwealth of Pennsylvania to launch a Center of Excellence called the Temple Wedge Opioid (TWO) Treatment Program, according to the press release (Temple Launches Center of Excellence to Address Opioid Use in Pregnancy, 2017):
Offers evaluation by experts in high-risk pregnancy and psychiatry, and offers much-needed access to drug treatment, counseling, and specialized prenatal consultation. Rather than simply treating the addiction, the Center will treat the entire person, integrating behavioral health, primary care and, when needed, evidence-based, medication-assisted treatment.

The Commonwealth of Pennsylvania can provide much needed grant money to fund this program, but in addition to the state, the federal government is important for grant funding. This federal grant money may be allocated to the states. In the case of SAMHSA’s Substance Abuse Prevention and Treatment (SAPT) Block Grant, it is.

Finally, an innovative idea that has been done at UPMC, specifically Magee Women’s Hospital, is a MAT clinic that is partially funded by the region’s Medicaid Managed Care Organizations such as Gateway Health, Community Care Behavioral Health Organization, United Healthcare for Families and Communities, and UPMC for You. Those four MCOs funded the previously mentioned Pregnancy Recovery Center in Pittsburgh (Magee-Women’s Hospital of UPMC Launches First-of-its-Kind Recovery Center for Pregnant Women with Substance Use Challenges). The idea behind an MCO funding a program is the MCO would spend the excess money on care after birth for the women and newborns if they were not on MAT. Instead of spending the money on extended stays in the NICU, the money would better be spent on prevention.

Projecting the cost-effectiveness of a MAT clinic is challenging. Kaiser Permanente utilized a program called Early Start, which was an integrated prenatal intervention program for stopping substance use in
pregnancy to study the effects of substance uses in pregnancy. This study followed members of Kaiser who used any substance during pregnancy, including tobacco, alcohol, and other drugs. The study did not break down each substance. The results were impressive and the program on average saved $7,000 per mother and child in the first year (Gosler et al. 2012). This amount of savings is on the low end that could be attributed to this program because NAS costs Medicaid and other insurers much more than $7,000. In fact, the average charge in 2009 for NAS was $53,400. Even applying a conservative cost to charge ratio of 0.5, the costs to Medicaid and other insurers would be $26,700 (Zupancic, 2012). If the program could reduce the length of stay by half for the newborn, the program could save $13,350 per birth for Medicaid.

Evidence-based clinic

The literature reviews and case studies presented above can be used to come up with the needed components for an evidence-based treatment clinic for pregnant women with OUD. A clinic should be staffed by obstetrician/gynecologists who are approved buprenorphine prescribers, nurse case managers, social workers, and a psychologist. MAT is a vital part of this clinic, and should be encouraged for all patients, but patients should be made to feel they are taking an active part in the decision to begin MAT, rather than feeling like they are being forced or guilted into the decision. While behavioral counseling is already technically a concurrent requirement for patients using MAT, a greater emphasis needs to be placed on it, and it needs to be used more consistently. Social services cannot be neglected. Patients should be able to talk to a social worker who is knowledgeable about available resources and assistance that may be available, including housing assistance, help to find employment, help with childcare, and information about government benefits they may be eligible to accept. It is not only
important all of these services are offered to patients, but also they take an active role in their treatment and are involved in all conversations about their care.

Using the model of UPMC St. Margaret's, a clinic should strive to practice collaboratively. Weekly team meetings should be held, where all health care practitioners can discuss the best plan of care for each patient. However, staff should not wait until these weekly meetings to discuss patient care needs because everyone is in one physical location, conversations between practitioners should happen daily.

In the event this evidence-based clinic does not have a service the patient is in need of, warm hand-offs should be utilized. These hand-offs are to ensure the patients are receiving the best care possible in the area. Physicians will refer and secure appointments for the patients with trusted health care professionals they have established relationships with and can offer the care the facility is lacking. Appointments should be set up as quickly as possible with as little hassle for the patient as possible. With the changes in law mentioned above these warm hand-offs will be more achievable.

**Conclusion**
Medication assisted treatment programs have been shown to be an effective technique for treating opioid abuse. Currently, pregnant women using opioid face barriers preventing them from receiving MAT. A cultural shift regarding legal considerations, information sharing, and best practices are necessary to overcome the present obstacles this population faces.
A cultural change towards prioritizing legal protections over punitive actions for pregnant women using opioids is imperative to helping them to receive treatment. Best practices, including those with a strong emphasis on collaboration, should be implemented in current MAT programs to increase the efficacy and effect of treatment. Best practices should also incorporate health information exchange organizations that allow access to medical information to ensure comprehensive transfer of care during MAT. Also, diverse funding options including utilization of grants and Medicaid Managed Care Organizations can be considered to alleviate the financial barrier to treatment. Changing the culture for MAT in the U.S. will help to improve outcomes for individuals using opioids and advance treatment towards more progressive and effective options that are being utilized in other countries.
## Appendix A: Pending Pennsylvania Legislation

<table>
<thead>
<tr>
<th>Bill</th>
<th>Printer Number</th>
<th>Details</th>
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<tbody>
<tr>
<td>House Bill 235</td>
<td>201</td>
<td>Task force and its powers and duties to address opioid epidemic’s impact on children includes improving outcomes for pregnant women addicted to opioids</td>
</tr>
<tr>
<td>House Bill 498</td>
<td>522</td>
<td>Develop ANGEL program through police, help opioid addicted individuals seek treatment, individuals must meet certain criteria</td>
</tr>
<tr>
<td>House Bill 676</td>
<td>722</td>
<td>$5,000,000 appropriated annually from Tobacco Settlement Fund to establish eight regional detoxification centers to address opioid overdoses, Pittsburgh is one location</td>
</tr>
<tr>
<td>Senate Bill 301</td>
<td>311</td>
<td>Uniform state standards for providers of opioid addiction treatment, shall be evidence-based, establishes minimum requirements; added definitions to Pennsylvania Drug and Alcohol Abuse Control Act</td>
</tr>
<tr>
<td>Senate Bill 428</td>
<td>472</td>
<td>Patient-centered opioid treatment certification provides for program that certifies office-based opioid treatment providers, opioid treatment providers, and abstinence-based treatment providers</td>
</tr>
</tbody>
</table>
### Appendix B: Laws and Regulations

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Law #</th>
<th>Category of Law</th>
<th>Who it Impacts</th>
<th>Meaning/Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal</td>
<td>P.L. 110-233</td>
<td>Public Law</td>
<td>Health plans, consumers</td>
<td>GINA - Prohibits a group health plan from adjusting premium or contribution amounts for a group on the basis of genetic information.</td>
</tr>
<tr>
<td>Federal</td>
<td>P.L. 111-5 Title XIII</td>
<td>Public Law</td>
<td>Healthcare consumers, government and commercial providers</td>
<td>HITECH Act - Widens the scope of privacy and security protections available under HIPAA.</td>
</tr>
<tr>
<td>Federal</td>
<td>P.L. 112-144 § 618</td>
<td>Public Law</td>
<td>The FDA, FCC, ONC</td>
<td>Requires the FDA to develop and post on their respective web sites a report that contains a proposed strategy and recommendations on an appropriate, risk-based regulatory framework pertaining to health information technology.</td>
</tr>
<tr>
<td>Federal</td>
<td>42 CFR § 59.11</td>
<td>Civil Law</td>
<td>Practitioner, MAT Clinic, Healthcare Organization</td>
<td>All personal information collected by project staff cannot be disclosed without the documented consent of the patient.</td>
</tr>
<tr>
<td>Federal</td>
<td>42 CFR 8.12</td>
<td>MAT Access Law</td>
<td>Practitioner, MAT Clinic, health care Organization</td>
<td>Federal guidelines for opioid treatment programs (OTPs)</td>
</tr>
<tr>
<td>Federal</td>
<td>45 CFR 2</td>
<td>Information Sharing Law</td>
<td>Mother, Practitioner, MAT Clinic, health care Organization</td>
<td>HIPAA-related, deals with sharing of information by &quot;covered entities&quot; in HIEs, among others.</td>
</tr>
<tr>
<td>AL</td>
<td>Code of Ala. 12-15-319</td>
<td>Child Welfare Law</td>
<td>Mother, Child</td>
<td>Any juvenile court who finds a parent unfit to have custody, may rule to terminate the rights of the parents’ custody upon grounds of abandonment or abuse.</td>
</tr>
<tr>
<td>CA</td>
<td>Cal Wel &amp; Inst Code 361.5</td>
<td>Child Welfare Law</td>
<td>Mother</td>
<td>Reconciliation between the mother and the child will not occur if the mother has a long history of drug or alcohol use or abuse. Additionally, reconcile will not occur if the mother did not attend or complete treatment on at least 2 occurrences.</td>
</tr>
<tr>
<td>CA</td>
<td>Cal Pen Code 1170.82(a)</td>
<td>Criminal Law</td>
<td>Person Selling Drugs</td>
<td>Placing the child with the mother presents an opportunity of physical and mental risk to the child, due to the mother's history of drug use upon conception.</td>
</tr>
<tr>
<td>DE</td>
<td>13 Del. C. 1103</td>
<td>Child Welfare Law</td>
<td>Mother, Child, Respondent</td>
<td>If an infant tests positive for drug or alcohol substances upon the time of birth, which were not administered in the hospital, and if that mother has endangered her previous children by using drugs or alcohol after having the opportunity to seek treatment, parental rights may be terminated.</td>
</tr>
<tr>
<td>Jurisdiction</td>
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<tr>
<td>GA</td>
<td>OCGA 49-4-193</td>
<td>Child Welfare Law</td>
<td>Mother, Child, Individual appointed to receive benefits on behalf of a child</td>
<td>If the mother is no longer eligible for Temporary Assistance for Needy Families, due to a positive drug test, the child's benefits will not be influenced; another individual will be designated to receive the child's benefits on their behalf, the parent may appoint an immediate family to take on this responsibility; if there are no immediate family members, or the mother chooses not to appoint someone, the department will do so. This person can be drug tested if there is suspicion of drug use, if they test positive, they will no longer receive the child's benefits.</td>
</tr>
<tr>
<td>IL</td>
<td>20 ILCS 301/35-5</td>
<td>MAT Access Law</td>
<td>Mother</td>
<td>This law provides a multidisciplinary approach to helping addicted mothers. It uses an open referral system, treatment consent, and availability updates. Residential and non-residential services are available to pregnant women.</td>
</tr>
<tr>
<td>IL</td>
<td>305 ILCS 5/5-5</td>
<td>MAT Access Law</td>
<td>Mother, Practitioner</td>
<td>This law is mandating that doctors who see pregnant, addicted mothers must recommend them to an addiction service. This can be an inpatient setting in the form of a licensed hospital for addiction services, or a local substance abuse treatment provider.</td>
</tr>
<tr>
<td>IL</td>
<td>305 ILCS 5/5-5</td>
<td>MAT Access Law</td>
<td>Mother, Child, Practitioner, health care Organization</td>
<td>In accordance with the Illinois Medicaid Program and Department of Human Services, any pregnant woman seeking treatment should have the cost of doing so covered. Any medical practitioner who interacts with the patient should immediately refer them to treatment.</td>
</tr>
<tr>
<td>IL</td>
<td>305 ILCS 5/5-5</td>
<td>MAT Access Law</td>
<td>Practitioner, health care Organization, Drug Free Families with a Future</td>
<td>Medical providers who are treating addicted mothers or pregnant women have access to materials through the Departments of health care and Family Services and the Department of Human Services.</td>
</tr>
<tr>
<td>IL</td>
<td>305 ILCS 5/5-5</td>
<td>MAT Access Law</td>
<td>Mother, Child, health care Organization</td>
<td>This subsection states that pregnant women or pregnant minors shall receive the proper resources to seek addiction treatment via &quot;facilities or services.&quot;</td>
</tr>
<tr>
<td>IL</td>
<td>705 ILCS 405/2-3</td>
<td>Child Welfare Law</td>
<td>Child</td>
<td>If a controlled substance, or molecule is found in a newborn's body or waste products, except those given for child birth, is considered neglect.</td>
</tr>
<tr>
<td>IL</td>
<td>706 ILCS 405/2-3</td>
<td>Criminal Law</td>
<td>Person Selling Drugs</td>
<td>Any person that knowingly supplies controlled medications to a pregnant woman has committed a felony and will be fined and/or imprisoned.</td>
</tr>
<tr>
<td>IL</td>
<td>305 ILCS 5/5-5</td>
<td>MAT Access Law</td>
<td>Prescriber, health care Organization</td>
<td>All FDA approved forms of opioid medications for medication assisted treatment shall be covered under both fee for service and managed care models.</td>
</tr>
<tr>
<td>IN</td>
<td>Burns Ind. Code Ann. 31-34-1-11</td>
<td>Child Welfare Law</td>
<td>Child</td>
<td>A child is at risk if it has a mother with a controlled substance disorder has custody and does not provide the child necessary support.</td>
</tr>
<tr>
<td>IN</td>
<td>Burns Ind. Code Ann. 31-34-1-12</td>
<td>Child Welfare Law</td>
<td>Child</td>
<td>Children are not in need of service if their mother had a prescribed drug and the child tested positive for that drug, or if the mother was not in violation of the IN legend drug act.</td>
</tr>
<tr>
<td>Jurisdiction</td>
<td>Law #</td>
<td>Category of Law</td>
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<tr>
<td>KY</td>
<td>KRS 214.160</td>
<td>MAT Access Law</td>
<td>Practitioner</td>
<td>All physicians responsible for pregnant women are to test the women for syphilis and Hepatitis B. The Cabinet for Health and Family Services will keep an updated list of the 8 most popular substance abuse drugs. Any physician is to test for substances in a mother or infant up to 8 hours after birth, the patient must be informed of and why the test is being conducted. All positive tests will be analyzed to see if the child should be removed from the mother's custody.</td>
</tr>
<tr>
<td>KY</td>
<td>KRS 214.175</td>
<td>MAT Access Law</td>
<td>Practitioner, health care Organization</td>
<td>The Cabinet for Health and Family Services can conduct surveys to collect data on which drugs, including alcohol, are most commonly used during pregnancy. All health care facilities must conduct these surveys, in order to keep their licenses, with or without patient acknowledgement. All testing results are to be kept confidential with no patient information released. These test results cannot be used in court, and practitioners cannot be held liable. State grands and funds can be utilized for these purposes.</td>
</tr>
<tr>
<td>KY</td>
<td>KRS 218A.274</td>
<td>MAT Access Law</td>
<td>MAT</td>
<td>Treatment facilities that receive state funding are to make pregnant women a priority, and cannot deny services to a pregnant woman.</td>
</tr>
<tr>
<td>LA</td>
<td>La. Ch.C. Art. 610</td>
<td>Child Welfare Law</td>
<td>Mother, Child, Practitioner</td>
<td>A physician is able to order toxicology screenings on newborns, without the consent of the parent, if prenatil drug use is suspected. If there is a positive finding, it must be reported, but it is not acceptable in court for prosecution. If a negative finding is present, test results should be destroyed, unless the parent requests otherwise. If a newborn presents signs of alcohol withdrawal, the physician should report it.</td>
</tr>
<tr>
<td>LA</td>
<td>La. R.S. 40.1094</td>
<td>MAT Access Law</td>
<td>health care Organization</td>
<td>Population specific towns may construct multidisciplinary teams, that will serve for two years, which will determine how regarding a pregnant women who tests positive for drugs that she is not legally prescribed will be charged.</td>
</tr>
<tr>
<td>MD</td>
<td>Md. FAMILY LAW Code Ann. 5-704.2</td>
<td>Child Welfare Law</td>
<td>Child</td>
<td>A newborn is substance exposed if their toxicology screen is positive after birth, they have fetal alcohol syndrome disorder, or displays symptoms of withdrawal as determined by medical personnel. The reporter must consult with a health care practitioner so that the child has proper care if this is discovered and attempt to interview the newborn's mother. This report must not assume that a newborn has been neglected or abused unless there is reasonable cause.</td>
</tr>
<tr>
<td>MI</td>
<td>MCL 722.623a,</td>
<td>Child Welfare Law</td>
<td>Child</td>
<td>Any person that suspects abuse or neglect due to the mother's use of a controlled substance, based upon confirmed knowledge or presented symptoms of the infant, should report it to the department.</td>
</tr>
<tr>
<td>Jurisdiction</td>
<td>Law #</td>
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<tr>
<td>MN</td>
<td>Minn. Stat. 2568.16</td>
<td>MAT Access Law</td>
<td>MAT</td>
<td>Federal funding is available for pilot programs for pregnant and postpartum women diagnosed with SUD or OUD. Programs must have flexible funding for treatment, provide treatment for families, find issues between continuation services, and discover new treatment approaches.</td>
</tr>
<tr>
<td>MN</td>
<td>Minn. Stat. 626.556</td>
<td>Child Welfare Law</td>
<td>Child</td>
<td>Persons who suspect child abuse (sexual, physical, neglect or mental) shall immediately report the incident to a local welfare agency.</td>
</tr>
<tr>
<td>MN</td>
<td>Minn. Stat. 626.556</td>
<td>Criminal Law</td>
<td>Mother, One who reports a pregnant mother using controlled substances</td>
<td>Any person who reports to section 626.556 should report a pregnant mother using controlled substances without a medical reason at a normal or excessive rate. Any person should report a pregnant mother using nonmedical controlled substances to their local welfare agency. Upon reporting, if the pregnant woman refuses to attend treatment, an emergency treatment admission is permitted.</td>
</tr>
<tr>
<td>MO</td>
<td>211.447 R.S.Mo.</td>
<td>Child Welfare Law</td>
<td>Mother, Child</td>
<td>Placing the child in the mother's custody is inappropriate if: any other children were removed from her custody within three years prior to this decision, if the mother tests positive to drug testing within 8 hours after the baby's birth or if any other children in her custody were neglected or abused, or the mother did not complete suggested treatment. Custody is unfit if a child tests positive for drugs at birth or within 8 hours of birth, or if the mother admitted guilt or was convicted of drug possession, distribution or production of drugs.</td>
</tr>
<tr>
<td>MO</td>
<td>191.725 R.S.Mo</td>
<td>Child Welfare Law</td>
<td>Mother, Child</td>
<td>Beginning Jan 1, 1992, all OB/GYN physicians must counsel patients on cigarette, alcohol, and controlled substance use upon seeing a pregnant patient. The DOH shall provide educational materials to further this process.</td>
</tr>
<tr>
<td>Puerto Rico</td>
<td>24 LPRA 3692</td>
<td>Criminal Law</td>
<td>Mother</td>
<td>Every mother has a right to know about the effects of drug use and how their bodies will be affected. Services available from physicians.</td>
</tr>
<tr>
<td>Puerto Rico</td>
<td>24 LPRA 6164</td>
<td>MAT Access Law</td>
<td>Practitioner</td>
<td>Puerto Rico has a comprehensive law to ensure that integrated services are available to all individuals, including at least six months of treatment for any substance dependencies and follow up as well. This law focuses heavily on the individual as the center point and their recovery.</td>
</tr>
<tr>
<td>NC</td>
<td>NC Gen. Stat. 90-95</td>
<td>Criminal Law</td>
<td>Dealer</td>
<td>18 year olds who deal an illegal drug to a minor or pregnant person will be punishable by law as Class D or C felon, depending on the age of the recipient.</td>
</tr>
<tr>
<td>ND</td>
<td>N.D. Cent. Code 50-25.1-16</td>
<td>Child Welfare Law</td>
<td>Child</td>
<td>Any person with reason to suspect child abuse or neglect may submit a report to the department. A report is not required if a pregnant woman voluntarily enters treatment, as long as she continues to comply with treatment procedures.</td>
</tr>
<tr>
<td>Jurisdiction</td>
<td>Law #</td>
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</tr>
<tr>
<td>ND</td>
<td>N.D. Cent. Code 50-25.1-17</td>
<td>MAT Access Law</td>
<td>Mother</td>
<td>If a woman tests positively on the toxicology test, a report must be filed; even if the test is negative and a physician has reason to believe she has a dependency issue, a report must be filed. Physicians and medical professionals are protected from lawsuit as long as they order a test within one month of birth of the child.</td>
</tr>
<tr>
<td>NE</td>
<td>RRS Neb. 43-292</td>
<td>Child Welfare Law</td>
<td>Mother, Child</td>
<td>A parent is seen as inadequate in terms of corruption if they regularly use alcohol, drugs, or sexual behaviors.</td>
</tr>
<tr>
<td>NH</td>
<td>RSA 318-B 10</td>
<td>MAT Access Law</td>
<td>Prescriber</td>
<td>Dispense and prescription of methadone to pregnant and postpartum women may be administered as part of a drug and alcohol abuse treatment program, including extended detoxification.</td>
</tr>
<tr>
<td>NV</td>
<td>Nev. Rev. Stat. Ann. 422A.345</td>
<td>Criminal Law</td>
<td>Mother, Practitioner</td>
<td>A pregnant women is eligible for public assistance if a doctor determines in writing that benefits are necessary for the wellbeing of the mother and fetus.</td>
</tr>
<tr>
<td>NY</td>
<td>NY CLS Soc Serv 384-b, Part 1 of 2</td>
<td>Child Welfare Law</td>
<td>Child</td>
<td>Any child who has been enrolled in foster care for 15 of the last 22 months due to their parent(s) being incarcerated or undergoing a residential substance abuse treatment program will have a petition filed on their behalf by the foster agency for other means of care.</td>
</tr>
<tr>
<td>OH</td>
<td>ORC 2108.31</td>
<td>Information Sharing Law</td>
<td>Practitioner, health care Organization, Minors</td>
<td>State law regarding blood donation among minors.</td>
</tr>
<tr>
<td>OH</td>
<td>ORC 3701.17</td>
<td>Information Sharing Law</td>
<td>Mother, Child, Prescriber, Practitioner, MAT Clinic, health care Organization</td>
<td>Ohio law detailing how health information is protected and in what specific cases it can be shared.</td>
</tr>
<tr>
<td>OH</td>
<td>ORC 3701.242</td>
<td>Information Sharing Law</td>
<td>Mother, Practitioner, health care Organization</td>
<td>State law regarding informed consent for an HIV test.</td>
</tr>
<tr>
<td>OH</td>
<td>ORC 3719.012</td>
<td>MAT Access Law</td>
<td>Prescriber, Practitioner, health care Organization, Minors</td>
<td>State law regarding treatment and diagnosis of a condition that was caused by drug or alcohol abuse.</td>
</tr>
<tr>
<td>OH</td>
<td>ORC 5122.04</td>
<td>Information Sharing Law</td>
<td>Mother, Prescriber, Practitioner, MAT Clinic, health care Organization, Minors</td>
<td>State law regarding outpatients services for minors without parent knowledge or consent.</td>
</tr>
<tr>
<td>OH</td>
<td>ORC 3701.243</td>
<td>Information Sharing Law</td>
<td>Practitioner, health care Organization</td>
<td>State law regarding sharing of test results, specifically when the individual diagnosis is related to HIV.</td>
</tr>
<tr>
<td>OH</td>
<td>ORC 3798.01-3798.16</td>
<td>Information Sharing Law</td>
<td>Practitioner, health care Organization</td>
<td>State law about how to initiate disclosure of information through HIEs.</td>
</tr>
<tr>
<td>Jurisdiction</td>
<td>Law #</td>
<td>Category of Law</td>
<td>Who it Impacts</td>
<td>Meaning/Summary</td>
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</tr>
<tr>
<td>OH</td>
<td>ORC 5122.31</td>
<td>Information Sharing Law</td>
<td>Practitioner, health care Organization</td>
<td>State law regarding sharing of mental health information of clients among providers. If space and staff are available, The Department of Mental Health and Substance Abuse will prohibit the denial of treatment services for pregnant women, require priority to treat pregnant women, and will provide funds for pilot programs.</td>
</tr>
<tr>
<td>OK</td>
<td>63 Okl. St. 1-546.4</td>
<td>MAT Access Law</td>
<td>Mother, MAT Clinic</td>
<td>The Department of Human Services will keep current records of all NAS infants, which will be used for research and future prevention. Information recorded will be the hospital of birth, toxicology reports, DOB, birth weigh, gestational age, race, residence, county reporting, demographics of the mother, treatment, if child was removed from parent.</td>
</tr>
<tr>
<td>OK</td>
<td>63 Okl. St. 1-550.3</td>
<td>MAT Access Law</td>
<td>Child, health care Organization</td>
<td>Prescribers test women in the first trimester of pregnancy for nonmusical substances. If they test positive, practitioners will provide education on the dangers of continued use and referral to counseling. Practitioners will provide positive test results to the Alcohol and Drug Policy Commission for data collection. If authorized the practitioner may also provide medication assisted therapy.</td>
</tr>
<tr>
<td>OR</td>
<td>ORS 430.920</td>
<td>MAT Access Law</td>
<td>Mother, Practitioner, health care Organization</td>
<td>The DOH has the power to make grants available to mothers, with or without current custody, who are anticipated to complete a recovery program successfully. This law includes that any women/children denied must be reported to the DOH with an explanation as to why they were not included. The DOH shall conduct annual meetings to get feedback from program members on how to improve services. The services covered are offered as residential services; these include family and child counseling services, daycare services for mothers seeking counseling or jobs, referral to outpatient counseling upon their discharge.</td>
</tr>
<tr>
<td>PA</td>
<td>71 P.S. 553</td>
<td>Child Welfare Law</td>
<td>Mother, Child</td>
<td>The DOH shall provide staffing to CYS, counseling programs, and addiction services clinics for mothers or pregnant women who are seeking addiction.</td>
</tr>
<tr>
<td>PA</td>
<td>71 P.S. 554</td>
<td>Civil Law</td>
<td>Mother</td>
<td>If a health care provider interacts with a child under one year of age who is suffering from withdrawal symptoms and has a mother with an illegal drug use disorder (in the case of a non-compliant mother or mother not under direct care for medical addiction treatment), that practitioner must report the event to the proper agency.</td>
</tr>
<tr>
<td>PA</td>
<td>23 Pa.C.S. 6386</td>
<td>Child Welfare Law</td>
<td>Mother, Child, Practitioner</td>
<td>Child abuse or neglect resulting in death is ruled as a homicide; if a person knowingly or unknowingly allows a child to have physical or other means of detrimental factors cause poor health and well-being, that person has committed.</td>
</tr>
<tr>
<td>SC</td>
<td>SC Code Ann. 16-3-85</td>
<td>Criminal Law</td>
<td>Child</td>
<td>Any medical provider that refers a pregnant mother to treatment services is immune to any possibility of liability.</td>
</tr>
<tr>
<td>SD</td>
<td>SD Codified Laws 34-23B-6</td>
<td>MAT Access Law</td>
<td>Prescriber</td>
<td></td>
</tr>
<tr>
<td>Jurisdiction</td>
<td>Law #</td>
<td>Category of Law</td>
<td>Who it Impacts</td>
<td>Meaning/Summary</td>
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<tr>
<td>TN</td>
<td>Tenn. Code Ann. 53-11-311</td>
<td>MAT Access Law</td>
<td>Practitioner</td>
<td>Prescribers must document if they have ordered buprenorphine treatment of 16 mg or more for 30 days or more consecutively. If the prescriber does not meet the above recommendations, then they must refer this individual to an addiction specialist for the purpose of proper treatment.</td>
</tr>
<tr>
<td>TN</td>
<td>Tenn. Code Ann. 53-11-311</td>
<td>MAT Access Law</td>
<td>Practitioner</td>
<td>Health practitioners who are not licensed to prescribe schedule II or III drugs are prohibited from prescribing buprenorphine, however they can assist in the assessment of an individual with opioid dependence.</td>
</tr>
<tr>
<td>TN</td>
<td>Tenn. Code Ann. 53-11-311</td>
<td>MAT Access Law</td>
<td>Mother, Prescriber</td>
<td>Any prescription for buprenorphine without use of naloxone shall only be permitted to a patient who is pregnant, a nursing mother, or who has documented history of adverse reactions to naloxone.</td>
</tr>
<tr>
<td>TX</td>
<td>Tex. Fam. Code 161.001, Part 1 of 2</td>
<td>Child Welfare Law</td>
<td>Mother, Child</td>
<td>A child will be taken away from their mother if the court system has solid evidence that the baby was born addicted to illicit drugs or alcohol at the time of birth.</td>
</tr>
<tr>
<td>UT</td>
<td>Utah Code Ann. 62A-15-103</td>
<td>Civil Law</td>
<td>Mother, Local substance abuse authority</td>
<td>If a local substance abuse authority member contacts the division for assistance in placing a pregnant woman or minor in treatment, the division shall refer that patient for treatment, or otherwise ensure that services are made available.</td>
</tr>
<tr>
<td>VA</td>
<td>Va. Code Ann. 16.1-283</td>
<td>Child Welfare Law</td>
<td>Mother, Child</td>
<td>It is not likely that the parent is fit to take care of the child if they continuously used alcohol or drugs to the point that they are unable to perform parental duties, and has not improved or continued recommended rehabilitation.</td>
</tr>
<tr>
<td>VA</td>
<td>Va. Code Ann. 63.2-1509</td>
<td>Child Welfare Law</td>
<td>Mother, Child, Prescriber, Practitioner</td>
<td>Child abuse/neglect can be suspected and can be reported if a baby is found to have drugs not prescribed to the mother in their system within 6 weeks of birth, if the baby is born with withdrawal symptoms from drugs not prescribed to the mother, if the child is diagnosed by a doctor with a condition which could have been gained through prenatal drug use, or if the child is born with fetal alcohol syndrome.</td>
</tr>
<tr>
<td>WA</td>
<td>Rev. Code Wash. 13.34.800</td>
<td>MAT Access Law</td>
<td>Mother</td>
<td>Upon referral of medical personnel, a mother may be placed into a treatment program for drug and alcohol misuse upon giving birth. This treatment is funded by the hospital.</td>
</tr>
<tr>
<td>Jurisdiction</td>
<td>Law #</td>
<td>Category of Law</td>
<td>Who it Impacts</td>
<td>Meaning/Summary</td>
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<tr>
<td>WI</td>
<td>Wis. Stat. 48.238</td>
<td>MAT Access Law</td>
<td>State Agencies</td>
<td>Any state agency that is informed of a pregnant woman with a SUD, will offer to provide treatment services to that woman.</td>
</tr>
<tr>
<td>WI</td>
<td>Wis. Stat. 48.193</td>
<td>Criminal Law</td>
<td>Mother</td>
<td>A pregnant woman may be placed into custody with a warrant, the order of the judge through the mother’s lack of self-control in terms of using, or a police officer finds reasonable evidence that there is risk or conditions have been violated. The arresting law enforcement individual must attempt to contact an adult relative or friend.</td>
</tr>
<tr>
<td>WI</td>
<td>Wis. Stat. 48.347</td>
<td>MAT Access Law</td>
<td>Child</td>
<td>The court will not remove the child from the mother’s home at the time of birth unless the mother refuses treatment services. If the child or mother requires protective services or treatment, those services will be provided in terms of counseling, county department supervision, placement with a family member or friend or county residential facility, special care, treatment or education, or inpatient.</td>
</tr>
<tr>
<td>WI</td>
<td>Wis. Stat. 905.04</td>
<td>Child Welfare Law</td>
<td>Mother, Child, Practitioner</td>
<td>&quot;There is no privilege&quot; for any information collected on an addicted mother or the child by a practitioner; I think this means that any chemical testing or results cannot be used in court for a case involving the mother/child in an addicted scenario.</td>
</tr>
<tr>
<td>WI</td>
<td>Wis. Stat. 146.0255</td>
<td>Child Welfare Law</td>
<td>Mother, Child</td>
<td>Any hospital employee may refer a pregnant mother or infant to be drug tested if controlled substance use is suspected.</td>
</tr>
</tbody>
</table>
Appendix C: CHARM Consent Form

CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION
FOR TREATMENT AND SOCIAL SERVICES

I, __________________________, date of birth ______________________, authorize the use and disclosure of my health and treatment information by and among each of the team members of the Children and Recovering Mothers (CHARM) Team, including any individual(s) involved in the direct service or service coordination within each organization. The Children and Recovering Mothers (CHARM) Team members participate from the following organizations:

- Fletcher Allen Health Care
- Northwestern MedicalCenter
- Visiting Nurse Association, Inc.
- Franklin County Home Health Agency, Inc
- LundFamilyCenter
- Northwest Counseling and Support Services, Inc
- HowardCenter (including the Chittenden Clinic and Rocking Horse Program)
- KidSafe Collaborative
- Vermont Agency of Human Services: Department of Health, Department for Children and Families (including Children’s Integrated Services), Department of Corrections, Department of Vermont Health Access, and Agency of Human Services Field Services Division

The means of this use of disclosure may be written, verbal or electronic.

I understand that the purposes of the CHARM Team are to evaluate the need for and facilitate the coordination of medical services, substance abuse treatment services, and social support services in order to best provide for the safety of my child and to support my successful treatment during pregnancy and post-partum.

I authorize the use and disclosure of my health and treatment information and that of my child by and among the participating organizations of the Children and Recovering Mothers (CHARM) Team solely for these stated purposes.

The health and treatment information that will be shared may include the following:
‐ Name, date of birth
‐ Address, phone number(s)
‐ Antenatal and post-partum medical care and treatment provided to me and my child(ren)
‐ Pregnancy and delivery
‐ Psycho-social history
‐ Current living situation
‐ History and attendance at alcohol/drug treatment, including methadone maintenance, and mental health services
‐ Lab test results, including drug testing
‐ Mental health and/or drug and alcohol assessment, diagnosis, treatment, progress and discharge summary (if applicable)
‐ Children’s health and safety assessments
‐ WIC program participation history
‐ Department for Children and Families history of involvement
‐ Criminal history and/or current involvement with Department of Corrections
‐ Other (specify) ___________

ADDITIONAL PROVISIONS CONCERNING YOUR CONSENT:

I understand that my alcohol and/or drug treatment records are protected under federal statutes and regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, including 42 C.F.R. Part 2, and my personal health information is protected by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 C.F.R. Pts. 160 & 164, and in some cases by 7 C.F.R. § 246.26, and such information cannot be disclosed without my written consent unless otherwise provided for in these provisions.

I also understand that my decision to use the services of the Children and Recovering Mothers (CHARM) Team is voluntary. My signature indicates that I understand the important information provided in this Consent. I may end CHARM Team services at any time.

I understand that if I want members of the CHARM Team to disclose information about me or my child to someone other than the members of the CHARM Team, I will need to sign a separate Consent or Authorization to release such health and treatment information for each party to whom such information is disclosed, except as specifically described below.

I further understand that if any of the members of the CHARM Team or the participating organizations want to use or disclose any information regarding me or my child for a purpose other than that described in this Consent form, except information required by law pertaining to the mandatory reporting of suspected child abuse or neglect, that member or participating organization must obtain my written permission, stating the purpose of the consent, prior to using or disclosing that information.

I also understand that I may request restrictions on the use or disclosure of treatment records. I understand that the CHARM Team will consider my request but is not bound to agree to it in which case I may decline to participate with the CHARM Team. However, my refusal to be involved with the CHARM Team will not affect my ability to receive services from the individual participating organizations.

I further understand that generally the participating organizations may not condition my treatment with them on whether I sign a consent form, but that in certain limited circumstances, I may be denied treatment with them if I do not sign such a form.
I may revoke this Consent at any time by notifying any member of the Children and Recovering Mothers (CHARM) Team, but revoking this Consent will not affect any actions that were taken by the CHARM Team or its participating organizations before I revoked it.

This Consent will remain in effect for the period while I receive services and for thirty (30) days after the termination of services by the last participating organization on the CHARM Team providing services to me unless I choose to terminate it on the following date, or as a result of the following event or condition:

I understand that the Vermont Department for Children and Families (DCF) may currently have opened, or in the future may open, a child-protection case that involves me or my child. If so, I specifically authorize the DCF representative on the CHARM Team to disclose and/or redisclose health and treatment information about me: (1) to other employees of DCF who have a need to know such information; and (2) to the Vermont Family Court and any party to a juvenile proceeding which involves me or my child brought under Chapters 51-53 of Title 33 of the Vermont Statutes.

I have read all of the above information, and I understand its contents and consent to the disclosure and/or redisclosure of the confidential information identified above to the participating organizations and staff members of the CHARM Team for the purposes specified.

Name of Patient (Please Print)   Date

Signature of Patient (18 and over or Emancipated Minor)   Date

or Signature of Parent/Guardian or Legal Representative

Witness: Name and Title   Date

This Consent to Release Information will be kept on file by the KidSafe Collaborative (Community Network for Children, Youth and Families, Inc.) or by another authorized organization on behalf of the CHARM team, unless revoked by the client or terminated as specified in this agreement.
Appendix D: Class Biosketches

Elizabeth Van Nostrand is a Robert Wood Johnson Public Health Law fellow. She is an Assistant Professor in the Department of Health Policy and Management at Pitt Public Health, an Adjunct Professor in the University of Pittsburgh's School of Law, and the Director of the JD/MPH program. She is also the director of the Mid-Atlantic Regional-Public Health Training Center, which provides trainings and resources on public health informatics. Her recent projects include the development of legal and public health interventions to address the opioid epidemic, researching the public health system with respect to emergency preparedness and response, integrating traditional legal analysis with social networking principles, and analyzing the public health implications of hydraulic fracturing. Previously, she was an attorney specializing in litigation with the U.S. Department of Agriculture in Washington, DC, and with law firms in Texas and Louisiana. She is an active member of the Louisiana Bar.

Marissa Andreassi is a first-year MPH candidate in the Department of Health Policy and Management at the University of Pittsburgh. She earned her Bachelor of Science in Psychology from the University of Pittsburgh in 2015.

Abigail Bartus is a second-year MPH Candidate in the Department of Infectious Diseases and Microbiology at the University of Pittsburgh Graduate School of Public Health with a concentration in Management, Intervention, and Community Practice. Abigail received a Bachelor of Science in Public Health from Slippery Rock University, is Certified in Public Health by the National Board of Public Health Examiners, and currently works on opiate use disorder intervention programs at the Program Evaluation and Research Unit at Pitt.

Jordonna Bowser is a current MPH candidate in the Department of Human Genetics at the University of Pittsburgh Graduate School of Public Health and will be graduating in April 2017. She received her Bachelor of Science in Biology from West Virginia University in 2015 and currently works as a Unit Secretary/ Nursing Assistant at Armstrong County Memorial Hospital in the Intensive Care Unit. She has completed an internship at the Center for Craniofacial and Dental Genetics and was a co-presenter for a poster on a GWAS study looking at genetic variants of fingerprint patterns.

Chris Dellana is a third-year JD and MPH candidate at the University of Pittsburgh School of Law and the Graduate School of Public Health in the Health Policy and Management Department. He has a Bachelor in Spanish Linguistics and Globalization Studies from Gettysburg College.
Joel Lowery is a second-year MPH student in the Department of Infectious Diseases and Microbiology at the University of Pittsburgh Graduate School of Public Health. Joel received a Bachelor of Science in Environmental Health Sciences from Western Carolina University in 2015. His research has primarily involved mosquito surveillance and control. In 2015, he interned in Big Cypress National Preserve and Everglades National Park conducting mosquito surveillance to identify new viruses and understand the distribution of mosquitoes in these environments. In 2016, he conducted West Nile virus surveillance with Allegheny County Health Department, and he also looked for the mosquitoes that could vector Zika in Allegheny County. His interest in the opioid epidemic came from seeing not only its presence here but its encroachment into his hometown in North Carolina.

Nicole Greer is a third-year graduate student earning her joint MPH and MPA at the University of Pittsburgh with a focus on public and nonprofit management. She earned a Bachelors of Nursing Degree at the University of Pittsburgh in 2012. Nicole’s focus is on health communication and decreasing preventable diseases. Working with patients prescribed opioids in her nursing career, she has a vested interest in providing better care and treatment to those addicted to opioids.

Chelsea Pallatino is a fourth-year PhD candidate in the Department of Behavioral and Community Health Sciences at the University of Pittsburgh Graduate School of Public Health. Before starting the PhD program, Chelsea earned her MPH and a Certificate in Global Health from GSPH. Chelsea holds a B.S. and a BPhil in Psychology and Anthropology from the University of Pittsburgh. For her dissertation, Chelsea is studying how acculturation to life in the United States impacts Asian Indian immigrant women’s definitions and experiences of, as well as related help-seeking behaviors in situations of domestic violence. Her research interests also include maternal and child health, the social determinants of health, gender-based violence, human rights, and gender equity. After finishing her PhD program this summer, Chelsea hopes to work in a research setting that addresses social and health disparities in women’s health and immigrant health. Her interest in the opioid epidemic stems from her relationships with individuals impacted by the intersection of intimate partner violence and substance abuse.

Harley Roth is a first-year MPH candidate in the Department of Infectious Diseases and Microbiology at the University of Pittsburgh Graduate School of Public Health. Prior to enrolling in this program, she obtained her B.S. in biology concentrating in microbiology from George Mason University. She is interested in sexually transmitted diseases, vaccine promotion, and policy. Harley was intrigued by the policy aspect in this class how it affects the opioid epidemic specifically in Allegheny County.

Mario Scarpinato is a second-year MHA candidate in the Department of Health Policy and Management at the University of Pittsburgh Graduate School of Public Health. Mario earned his B.S. in Kinesiology from Michigan State University. He took a leave of absence from medical school at Medical College of Wisconsin to pursue his MHA. He returns as a second-year medical student in August. His clinical
interests focus on cardiothoracic and vascular surgery with a focus on endovascular techniques that can replace open surgeries. His administrative interests lie in finance, quality improvement, and payment reform. Mario’s interest in opioid policy and development stems from improving the health of vulnerable and underserved populations.

Adam Spinelli is a first-year MPH candidate in the Department of Health Policy and Management at the University of Pittsburgh Graduate School of Public Health. He completed his B.S. in Applied Health Sciences at Bowling Green State University and is currently a clinical services resident at Highmark Inc.

Halley Sonntag is a first-year MPH candidate in the Department of Health Policy and Management at the University of Pittsburgh Graduate School of Public Health. She earned her Bachelor of Science in Sportsmedicine at Mercyhurst University in December 2015.

Heather Tomko is an MPH candidate in the Department of Health Policy and Management at the University of Pittsburgh Graduate School of Public Health. She earned her Bachelor of Science in Mechanical and Biomedical Engineering at Carnegie Mellon University. Heather is a Research Coordinator for the University of Pittsburgh GSPH, where she has worked for the past six years, focusing on topics such as end-of-life decision making, liver transplantation policies, and cost-effectiveness analyses.

Alix Ware is a second-year JD and MPH candidate at the University of Pittsburgh School of Law and Graduate School of Public Health in the Department of Health Policy and Management. She is also pursuing certificates in health law and public policy. She earned a Bachelor of Science in Community Health with concentrations in health administration and planning as well as health education and promotion at the University of Illinois at Urbana-Champaign.

Nina Yacovoni is a first-year MPH candidate in the Department of Health Policy and Management at the University of Pittsburgh Graduate School of Public Health. She graduated from the University of Pittsburgh in April 2016 with a degree in Environmental Studies.
Appendix E: Course Syllabus

Graduate School of Public Health
Department of Health Policy and Management
HPM 2133: Law in Public Health Practice
2 credits: Thursdays (3:30-5:20 p.m.), Room G46 BARCO

Professor: Elizabeth Van Nostrand, JD
Office: A733 Crabtree Hall
evannostrand@pitt.edu
412.383.2231
Office Hours: Please email me to schedule a mutually convenient appointment.

Teaching Philosophy
The most meaningful measure of effective teaching is student learning. If my students grow and are challenged, especially through practice based professional learning, my teaching is successful. I take a personal interest in every student I teach. Students respond to high expectations, both in terms of what they must accomplish and in terms of their capabilities. I believe that students learn best when they think, do, write, speak, collaborate, and reflect.

Course Description
Local health departments play increasingly pivotal roles in the provision of community public health services; however, they also are experiencing diminished funding and reduced workforces. This course is the first of its kind: a practice-based, interdisciplinary, collaborative learning experience. Together, students will develop legal and public health interventions to address an issue identified by a practice partner as requiring the expertise of both cohorts.

This semester, the course topic will focus on public health and legal interventions to address the opiate epidemic. Our practice partner is the Allegheny County Health Department (ACHD).

Effective communication, project management, and work plan development skills are critical for success. Students in this course will benefit by applying both theoretical knowledge and research skills to analyze a “real life” problem and formulate meaningful outputs. Throughout the course, communication skills will be refined and networking opportunities in the practice communities will be provided. It is our goal to improve community health by providing the ACHD and others with effective intervention strategies.

Learning Objectives
By the end of this course, students will be able to:

- Describe the federal, Pennsylvania and Allegheny County public health structure
- Articulate the source, scope, and limitations of public health law and policy
- Describe the legal rights and duties of the governmental public health system and its stakeholders
- Understand the role that law and lawyers play in preserving, protecting and promoting the health of populations
- Define the legal and policy implications of the opiate epidemic
- Develop a vocabulary of legal and public health terms and to use it to effectively communicate
- Draft model regulations, policies, and/or community outreach materials
- Apply theoretical knowledge and research skills to address the opiate overdose issue
- Demonstrate proficiency in project management and workplan development
- Develop a translation and dissemination strategy
- Conduct an informational presentation to stakeholders

Course Policies

Academic Integrity Policy:

All students are expected to adhere to the school’s standards of academic honesty. Any work submitted by a student for evaluation must represent his/her own intellectual contribution and efforts. The GSPH policy on academic integrity, which is based on the University policy, is available online at http://www.publichealth.pitt.edu/interior.php?pageID=126. The policy includes obligations for faculty and students, procedures for adjudicating violations, and other critical information. Please take the time to read this policy.

Students committing acts of academic dishonesty, including plagiarism, unauthorized collaboration on assignments, cheating on exams, misrepresentation of data, and facilitating dishonesty by others, will receive sanctions appropriate to the violation(s) committed. Sanctions include, but are not limited to, reduction of a grade for an assignment or a course, failure of a course, and dismissal from GSPH.

All student violations of academic integrity must be documented by the appropriate faculty member: this documentation will be kept in a confidential student file maintained by the GSPH Office of Student Affairs. If a sanction for a violation is agreed upon by the student and instructor, the record of this agreement will be expunged from the student file upon the student’s graduation. If the case is referred to the GSPH Academic Integrity Hearing Board, a record will remain in the student’s permanent file.

Attendance Policy:

The American Bar Association and the School of Law require regular and punctual class attendance (see http://www.law.pitt.edu/students/policies/attendance). At the beginning of class, I will circulate an attendance sheet. It is your responsibility to ensure that you have signed the attendance sheet before leaving class. Under the attendance policy, if you do not sign the attendance sheet before leaving class, you will be marked absent even if you were actually present in class.

In terms of punctuality, if, for whatever reason, you arrive at class more than 10 minutes late or leave class more than 10 minutes early, you cannot sign the attendance sheet (or, if you have signed the attendance sheet, will
nonetheless be marked absent). Regular attendance is defined as attendance and preparation at not less than 80% of the classes for the semester. **To be clear, if you are unprepared for class, you will be marked absent even if you are physically present in class.** Failure to satisfy these attendance requirements will result in your being certified out of the course with a grade of “U” (Unsatisfactory).

**Computer and Cell Phone Policy:**
Computers may be used for note taking, but not for purposes outside of the lecture (i.e., no use of Facebook, Twitter, or any other social media unconnected to the class). Students who use laptops, phones, other devices for purposes other than class-related tasks, as determined by the instructor, will reduce your grade.

**Special Accommodations:**
If you have a disability for which you are or may be requesting accommodation, please notify the instructor and the Disability Resources and Services no later than the second week of the term. You may be asked to provide documentation of your disability to determine the appropriateness of accommodations. To notify Disability Resources and Services, please call 412.648.7890 (Voice or TDD) to schedule an appointment. The Office is located in 216 William Pitt Union.

**Required Materials**
*Dreamland: The True Tale of America’s Opiate Epidemic*
Sam Quinones

Additional materials can be found on CourseWeb.

**Grading**
The final grade will be determined as follows:

- Professionalism – 20%.
- Peer Assessment - 20%.
- Dreamland Diary – 20%.
- Final Deliverable – 40%.

Grading rubrics for each of these areas can be found on CourseWeb and will be reviewed during the first class. The following scale will be used for letter grades. **THERE WILL BE NO Rounding.**

<table>
<thead>
<tr>
<th>Grade</th>
<th>Percentage Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>A+</td>
<td>100% - 97%</td>
</tr>
<tr>
<td>A</td>
<td>96.9% - 93%</td>
</tr>
<tr>
<td>A-</td>
<td>92.9% - 90%</td>
</tr>
<tr>
<td>B+</td>
<td>89.9% - 87%</td>
</tr>
<tr>
<td>B</td>
<td>86.9% - 83%</td>
</tr>
<tr>
<td>B-</td>
<td>82.9% - 80%</td>
</tr>
<tr>
<td>C+</td>
<td>79.9% - 77%</td>
</tr>
<tr>
<td>C</td>
<td>76.9% - 73%</td>
</tr>
<tr>
<td>C-</td>
<td>72.9% - 70%</td>
</tr>
<tr>
<td>D+</td>
<td>69.9% - 67%</td>
</tr>
<tr>
<td>D</td>
<td>66.9% - 63%</td>
</tr>
<tr>
<td>D-</td>
<td>62.9% - 60%</td>
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<tr>
<td>F</td>
<td>&lt;60%</td>
</tr>
</tbody>
</table>
Course Outline

The students are responsible for much of the decision-making in this course; therefore, the course outline must remain flexible. In addition, a number of professionals have graciously agreed to impart their expertise to the class. Their work schedules may precipitate changes in this outline. Also, depending on the chosen subject, additional readings may be assigned.

<table>
<thead>
<tr>
<th>Class</th>
<th>Date</th>
<th>Topics</th>
<th>Assignments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>01.05.2017</td>
<td>• Course Introduction</td>
<td>• Fighting the Opioid Crisis: An Ecosystem Approach to a Wicked Problem</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Introduction to Legislative and Regulatory Law</td>
<td></td>
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<td></td>
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<td>• Topic?</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>01.12.2017</td>
<td>• Guest Lecturer: LuAnn Brink, PhD, MPH, Chief Epidemiologist, ACHD</td>
<td>• Dreamland: Pages ix-31 (Intro-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Addressing the Opioid Epidemic as a Systemic Issue</td>
<td>The Adman)</td>
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<td></td>
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<td></td>
<td>• <a href="https://livestream.com/DHSWcast/events/6708440">https://livestream.com/DHSWcast/events/6708440</a></td>
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<tr>
<td></td>
<td></td>
<td>• Practical Skills: Conducting Meetings, Managing Projects, and Presenting Ideas</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>01.26.2017</td>
<td>• Drafting Policy Briefs and White Papers</td>
<td>• Dreamland: Pages 56-75 (Easier than Sugarcane- Enrique Adrift)</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>• Recommendations Regarding the Tattoo Industry in Allegheny County (CourseWeb)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Addressing the Opioid Epidemic: Naloxone Availability as a Public Health Intervention in Allegheny County (CourseWeb)</td>
</tr>
<tr>
<td>5</td>
<td>02.02.2017</td>
<td>• Guest Lecturer: Brian Demsey, DEA</td>
<td>• Dreamland: Pages 76-99 (Searching for the Holy Grail – The Revolution)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• How Federal Law Enforcement Looks at the Opioid Epidemic</td>
<td>• Chasing the Dragon <a href="https://www.youtube.com/watch?v=lqdmWRExOoQ">https://www.youtube.com/watch?v=lqdmWRExOoQ</a></td>
</tr>
<tr>
<td>6</td>
<td>02.09.2017</td>
<td>• Project Updates</td>
<td>• Dreamland: Pages 100-127 (All About the 501s- Purdue)</td>
</tr>
<tr>
<td>7</td>
<td>02.16.2017</td>
<td>• Guest Lecturer: Jonathan Han, MD</td>
<td>• Dreamland: Pages 128-152 (The Man and the Nayarit – Smack Clans in the Sanctuary)</td>
</tr>
<tr>
<td></td>
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<td>• Prescription practices</td>
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<td></td>
<td></td>
<td>• Project Updates</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>02.23.2017</td>
<td>• Guest Lecturer: Jeanine M. Buchanich, MEd, PhD, Assistant Professor, Pitt Public Health</td>
<td>• Dreamland: Pages 153-177 (Liberace Shows the Way – Enrique on Top)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Statistical Analysis of the Opioid Epidemic</td>
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<td>• Project Updates</td>
<td></td>
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<tr>
<td>9</td>
<td>03.02.2017</td>
<td>• Guest Lecturer: Eric Hulsey, DrPH, MA, Manager of Behavioral Health Analytics, Allegheny County</td>
<td>• Dreamland: Pages 178-201 (Heroin Like Hamburgers – Canaries in Coal Mines)</td>
</tr>
<tr>
<td></td>
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<td>• Project Updates</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>03.16.2017</td>
<td>• Guest Lecturer: Abby Wilson, JD, LLM, Deputy Director, ACHD</td>
<td>• Dreamland: Pages 202 – 240 (Fifty, Hundred Case a Month – Pentecostal Piety, Fierce Scratches)</td>
</tr>
<tr>
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<td>• Project Updates</td>
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<tr>
<td>11</td>
<td>03.23.2017</td>
<td>• Guest Lecturer: Alice Bell, MSW, Overdose Prevention</td>
<td>• Dreamland: Pages 240-282</td>
</tr>
<tr>
<td>Pitt Healthcare Management Competency Model</td>
<td>Will this Competency be Emphasized in this Course?</td>
<td>Teaching Methods (e.g., Reag, Lectures, Guest Speakers, Class Discussions, Presentations, Field Experiences, Simulation, Consulting Project)</td>
<td>How Will You Assess? (e.g. weekly participation score, debate, policy memo, business plan, term paper, multiple choice exam, short-answer exam)</td>
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<tr>
<td>Cross Cutting</td>
<td></td>
<td>Lectures; Class discussion; Presentations</td>
<td>Public Health Policy Brief; Presentation; Deliverables</td>
</tr>
<tr>
<td>Analytical Thinking</td>
<td>Yes</td>
<td>Class Discussion; Presentations; Drafting model regulations and policies</td>
<td>Presentation; Professionalism; Public Health Policy Brief; Deliverables</td>
</tr>
<tr>
<td>Communication</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Systems Thinking</td>
<td>Yes</td>
<td>Presentations</td>
<td>Public Health Policy Brief; Deliverables</td>
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<tr>
<td>Self-Actualization</td>
<td></td>
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<tr>
<td>Accountability</td>
<td>Yes</td>
<td>Deliverables; Public Health Policy Brief; Presentation</td>
<td>Public Health Policy Brief Rubric; Professionalism Rubric; Deliverables Rubric; Peer Assessment Rubric</td>
</tr>
<tr>
<td>Professionalism</td>
<td>Yes</td>
<td>Finishing deliverables timely; Interacting with the Allegheny County Health Department and guest lecturers</td>
<td>Professionalism Rubric; Deliverables Rubric; Peer Assessment Rubric</td>
</tr>
<tr>
<td>Self-Development</td>
<td>Yes</td>
<td>Class discussions; Formal and informal discussion on legal and ethical issues</td>
<td>Professionalism Rubric</td>
</tr>
<tr>
<td>Management</td>
<td></td>
<td>Working within a budget</td>
<td>Deliverables</td>
</tr>
<tr>
<td>Financial Skills</td>
<td>Yes</td>
<td>Working in groups on work product; presenting to the Allegheny County Health Department; Incorporating</td>
<td>Professionalism Rubric</td>
</tr>
<tr>
<td>Human Resources Management</td>
<td>No</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>Information Technology (IT) Management</td>
<td>No</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>Leadership</td>
<td>Yes</td>
<td>Working within a budget</td>
<td>Deliverables</td>
</tr>
<tr>
<td>Performance Measurement and Process Improvement</td>
<td>No</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Contextual-Environmental Understanding</td>
<td></td>
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<tr>
<td>Community Orientation</td>
<td>Yes</td>
<td>Working with the Allegheny County Health Department</td>
<td>Deliverables; Professionalism Rubric</td>
</tr>
<tr>
<td>Organizational Awareness</td>
<td>Yes</td>
<td>Lecture by the Allegheny County Health Department</td>
<td>N/A</td>
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<tr>
<td>Strategic Orientation</td>
<td>No</td>
<td>N/A</td>
<td>N/A</td>
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</tbody>
</table>

| Specify which particular methods you will employ to teach students: | Readings; Lectures; Guest Lectures | Interactive development of project | n/a |
| Estimated % of Course Time Relying on these Teaching Methods: | 30% | 70% | 100% |
| Specify which particular methods you will employ to assess students: | Health Policy Brief Rubric | Professionalism Rubric; Peer Assessment Rubric; Deliverables Rubric | n/a |
| Estimated % of Course Time Relying on these Assessment Methods | 20% | 80% |  |
References


About ONC. (2016). Received from the U.S. Department of Health and Human Services website, https://www.healthit.gov/newsroom/about-onc


Han, J. (2017, March 10). Personal Interview.


*Health Information Technology Portfolio Program Overview.* (2016). Retrieved from the U.S. Department of Health and Human Services website, [https://healthit.ahrq.gov/program-overview](https://healthit.ahrq.gov/program-overview)


Hughes, C. E., & Stevens, A. (2010). What Can We Learn From The Portuguese Decriminalization of Illicit Drugs?. *British Journal of Criminology*, 50 (6), 999-1022. doi: 10.1093/bjc/azq038


New Directions Treatment Servs. v. Reading, 490 F.3d 293 (3d Cir. 2007).


Ohio Revised Code of 1971 37.09.241

Ohio Revised Code of 1982 37.19.012
Ohio Revised Code of 2013 37.01.243
Ohio Revised Code of 2013 51.19.028
Ohio Revised Codes of 2013 37.98.01-37.98.16


Palella v. Leyden Family Serv. & Mental Health Ctr. 404 N.E.2d 228 (Ill. 1980) (holding that a methadone clinic’s operation was not permissible under zoning laws because it operated out of a building formerly authorized for use only as a nursing home).


Restatement (Second) of Torts, § 821B.


