DISCLAIMER

- This session was conducted for members of county-based teams in CA that are working to expand access to Medications for Addiction Treatment in jails and drug courts. The project is funded through California's Department of Health Care Services (DHCS) with State Opioid Response funding from SAMHSA. The content is being made available to all interested parties. Please note this content has not been professionally edited and the session was conducted using Zoom.
- In the case of any security issues that may occur, this session will immediately end. A separate email will be sent to all participants with further instruction.
- Any data and information collected through polls and chats will only be used to inform future webinar/learning collaborative topics and to provide DHCS with evaluation results.

CHILDREN AND RECOVERING MOTHERS (CHARM)

County Touchpoints: Effective Child Welfare and Justice Systems for Families Impacted by Opioid and Stimulant Use Learning Collaborative

A Joint Effort of the California Department of Health Care Services Medication Assisted Treatment Expansion Project, Health Management Associates, and California Health Policy Strategies

May 25th, 2022
10:30 am – 12:00 pm

INTRODUCTIONS

Sally Borden, M.Ed.,KidSafe Collaborative

Vermont's CHARM (Children and Recovering Mothers) Team:

A collaborative approach to supporting pregnant and parenting women with opioid use disorders and their infants

Sally Borden, M.Ed., KidSafe Collaborative

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Vermont Department for Children and Families

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University of Vermont Larner College of Medicine

Shara Tarule, APRN
Howard Center Chittenden Clinic

May 25, 2022
DHCS SORII County Touchpoints Child Welfare Learning Collaborative

CHARM: Children and Recovering Mothers is an **inter-disciplinary** and **cross-agency team** whose *goal* is to improve the **health** and **safety outcomes** of babies born to women with a history of opioid use disorder

- *CHARM is a model collaborative approach*
  (US Dept. of Health and Human Services, SAMHSA 2016)

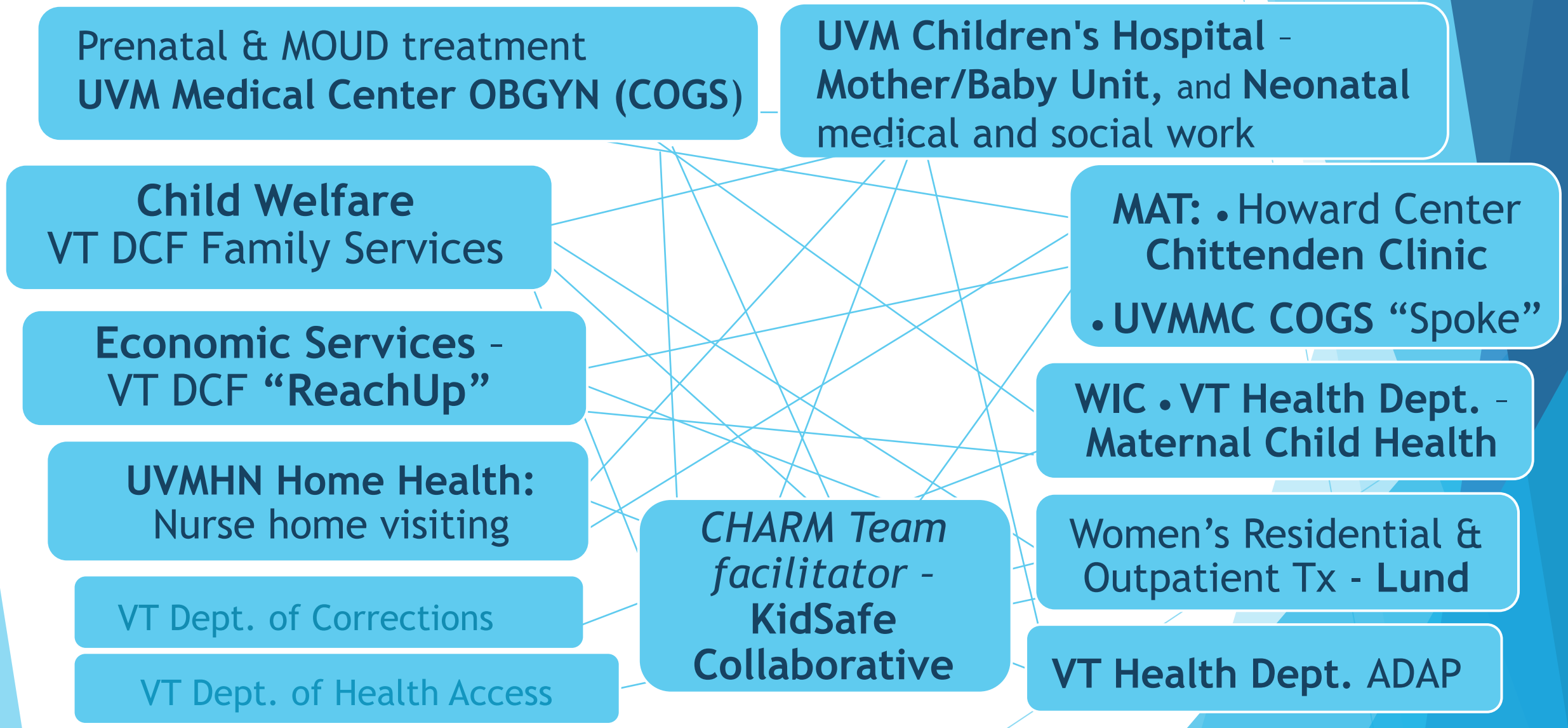
CHARM is based on a collaborative approach to supporting pregnant and postpartum mothers with a history of OUD and their infants, by coordinating

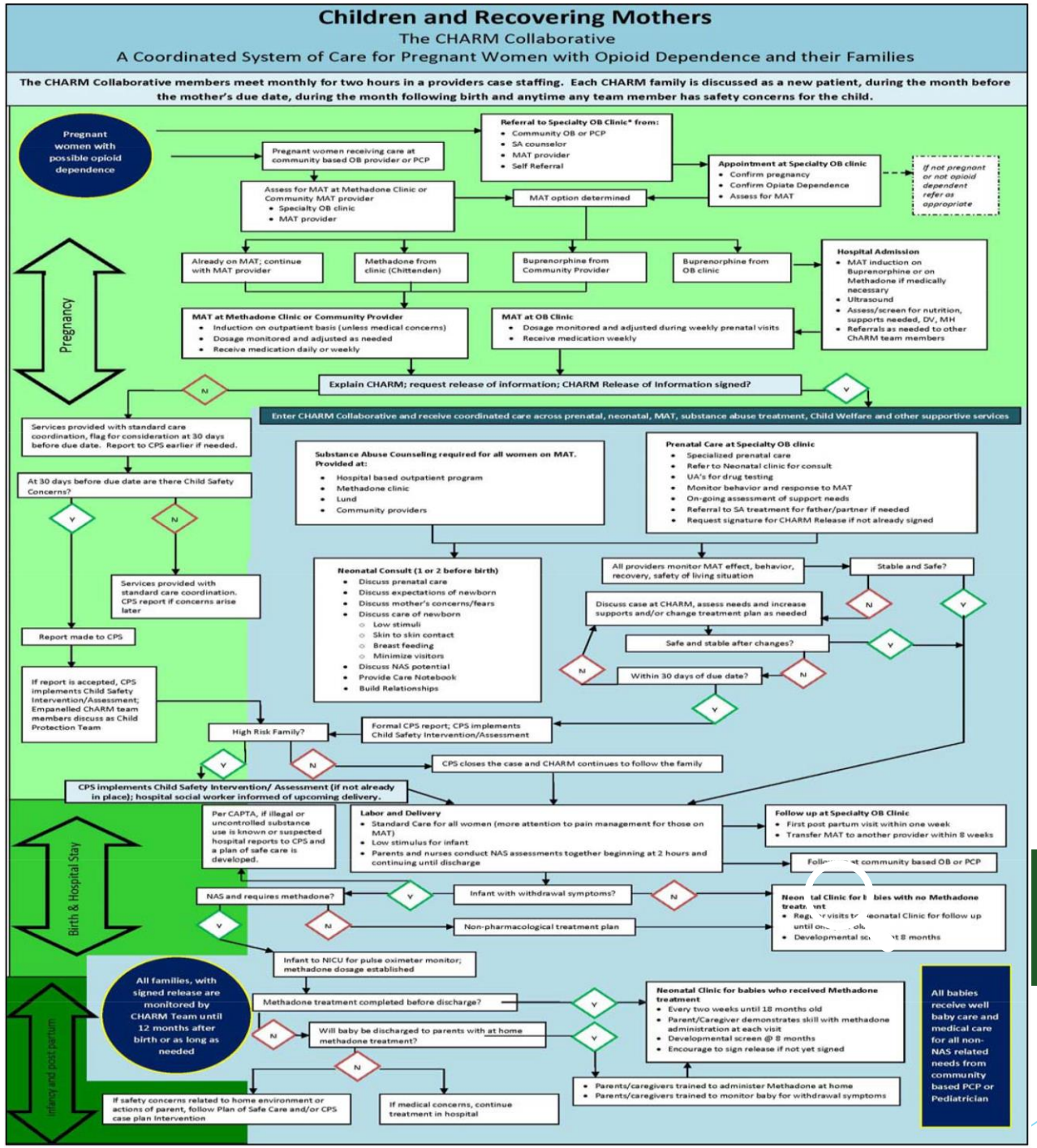
- **medical care**
- **substance abuse treatment**
- **child welfare**
- **social service supports**

Key Collaborative Partners:

- Obstetric care
- Pediatrics/Neonatology
- Medication Assisted Treatment providers
- Child Welfare/Child Protective Services
- Public Health/Maternal Child Health
- Home Health
- Medical Social Work
- Social service and community supports
- Residential women's SUD treatment

CHARM Team – Partner Organizations





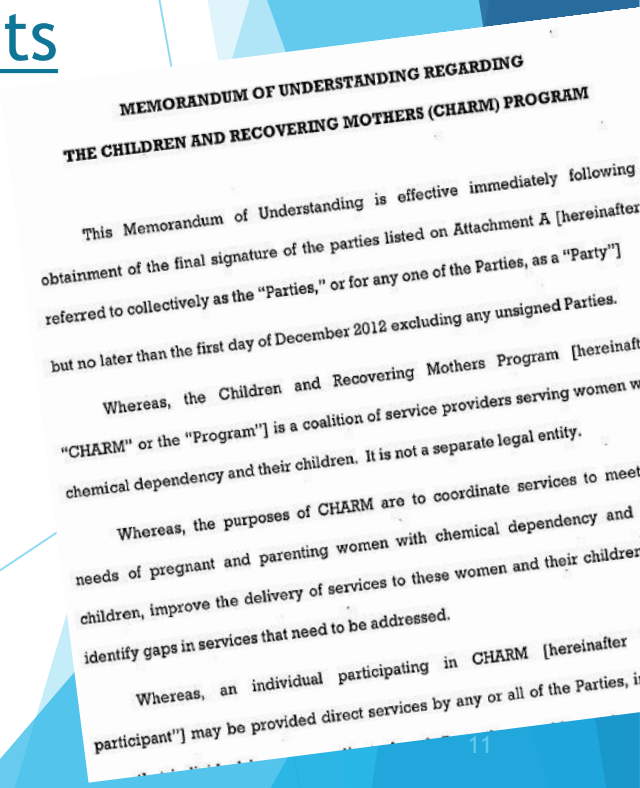
ZOOM IN ON FLOWCHART

Key Elements of CHARM Collaboration

- **Shared Goal:** Team Members *and* Patients/Clients want a **healthy and safe infant**
  - **A Shared Philosophy:** Improving ***care and supports for mothers*** is the most important factor in helping to ensure healthy and safe infants
  - **Framework for Operation:** ***Shared Information*** across agencies improves child safety and healthy outcomes.

Framework for Collaboration

- **Memorandum of Understanding:** framework for sharing information and coordinating services. Signed by leaders of all agencies/departments
  - **Consent to Release Information** - Signed by patients
- **Vermont Law:** "Empaneled" as a multi-disciplinary "child protection" team (VSA Title 33 §4917)
- **Infrastructure and facilitation**
- **Regular** (monthly) **Team Case Review Meetings** Structure for case review



MEMORANDUM OF UNDERSTANDING REGARDING

THE CHILDREN AND RECOVERING MOTHERS (CHARM) PROGRAM

This Memorandum of Understanding is effective immediately following obtainment of the final signature of the parties listed on Attachment A [hereinafter referred to collectively as the "Parties," or for any one of the Parties, as a "Party"] but no later than the first day of December 2012 excluding any unsigned Parties.

Whereas, the Children and Recovering Mothers Program [hereinaft "CHARM" or the "Program"] is a coalition of service providers serving women w chemical dependency and their children. It is not a separate legal entity.

Whereas, the purposes of CHARM are to coordinate services to meet needs of pregnant and parenting women with chemical dependency and children, improve the delivery of services to these women and their children identify gaps in services that need to be addressed.

Whereas, an individual participating in CHARM [hereinafter participant"] may be provided direct services by any or all of the Parties, i

Key Elements – Prenatal Care

- ✓ Criteria: “low threshold” – pregnant; opioid use disorder
- ✓ Multiple points of referral – no wrong door
- ✓ Pregnancy = key opportunity for intervention
- ✓ Focus: Reduce shame and stigma
- ✓ Best practice: health and treatment of mom, family
  - ✓ Provide clear and accurate information
  - ✓ Respectful, non-judgmental
  - ✓ MAT: important component of care
  - ✓ Integrated care; team approach;
  - ✓ Cross-disciplinary continual learning

CHARM Team Meetings: *How it Works*

- **Team members:**
  - Average of 11 agencies/departments represented at each CHARM team meeting
- **Meet Monthly**
  - 12- 13 participants per month
- **Systems Issues**
  - First 10-15 minutes of each meeting
- **★ Case Reviews ★**
  - Average 12-15 case reviews per meeting

Information Sharing at CHARM Meetings

At each monthly meeting the CHARM team reviews a list of current cases, and prioritizes cases for discussion:

- All **pregnant** patients due in upcoming month
- *Prioritized* **high risk prenatal** patients
- All **new pregnant** patients
- All **new babies** / post-partum patients within past month
- *Prioritized* **high risk post-partum patients** and their babies

Focus: ***How are they doing? What do they need? Who and how can we help address barriers?***

Information Sharing at CHARM Meetings

- Prenatal new patient: Confirm pregnancy and due date; assess OUD and initiate treatment
- Monitor compliance with prenatal visits and monitoring; referrals for specialty or community services
- Medication Assisted Treatment: consistent attendance and UDS's; dose adjustment; engagement in counseling
  - Post-partum MAT provider plan, transition care
  - Residential and outpatient treatment for moms and babies
- Financial: Economic Services/ReachUp; SNAP
- WIC; Home Health – nurse home visiting
- Family Support Referrals: peer support, parenting education, Children's Integrated Services, developmental services, child care domestic violence, kinship care, etc.

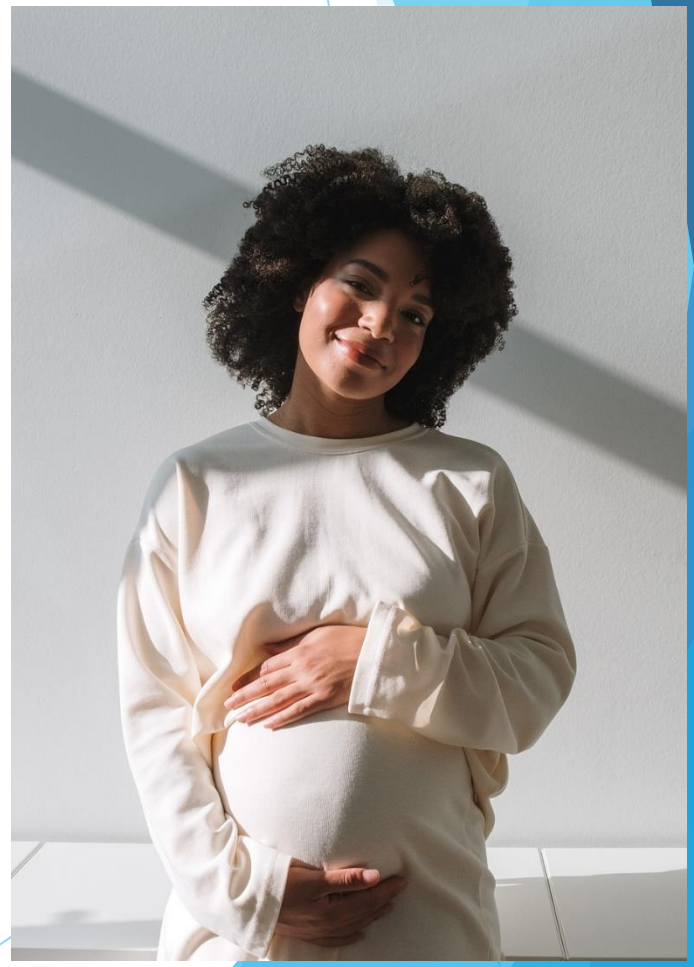
Information Sharing at CHARM Meetings: Key Indicators for Patient Success

- ✓ Start prenatal care early in pregnancy
- ✓ Initiate pharmacological treatment for opioid use disorder early in pregnancy
- ✓ Engage in substance abuse treatment, counseling
  - ✓ Attend prenatal care appointments
  - ✓ Attend Neomed clinic appointments
  - ✓ Family and social supports, stable housing
  - ✓ Peer support
  - ✓ Plan of safe care

Case Examples

Case “A”: Background

- 34yr old with a history of opioid-use disorder currently not on MOUD. Second pregnancy.
- Discovered pregnancy at 26 weeks gestation after visit to ED for chest pain
- Entered prenatal care at Comprehensive Obstetric and Gynecologic Services (COGS) clinic at 28 weeks gestation
- Immediately started on Buprenorphine and followed at co-located MOUD clinic
- Consented to CHARM multi-disciplinary team participation



Case “A”: pregnancy management

CHARM Team monitors progress:

- COGS: Received regular prenatal care and MOUD management throughout remainder of the pregnancy. Attends consistently.
- Met and continued engagement with affiliated counselor and psychiatric provider to address SUD and co-occurring anxiety.
- Received assistance with smoking cessation and counseling regarding cannabis use.
- Routine urine screening tests after starting buprenorphine were negative other than THC.

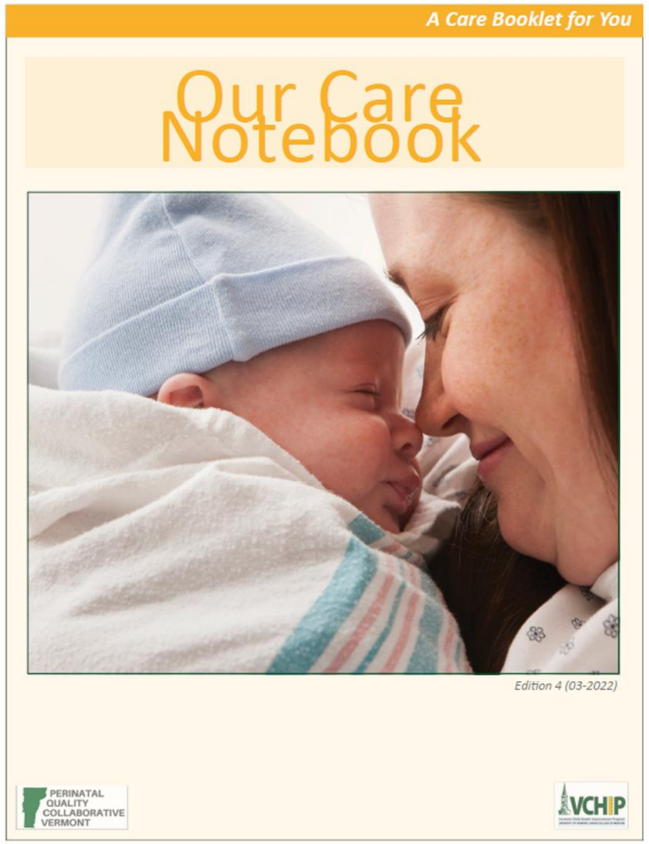
Component	Result	Reference Range
Amphetamine Screen	Negative	Negative
Barbiturate Screen	Negative	Negative
Benzodiazepine Screen	Negative	Negative
Buprenorphine Screen	Positive	Negative
Cocaine Screen	Negative	Negative
MDMA Screen	Negative	Negative
Methadone Screen	Negative	Negative
Methamphetamine Screen	Negative	Negative
Opiates Screen	Negative	Negative
Oxycodone Screen	Negative	Negative
Marijuana (THC) Screen	Positive	Negative

Case “A” family supports & needs

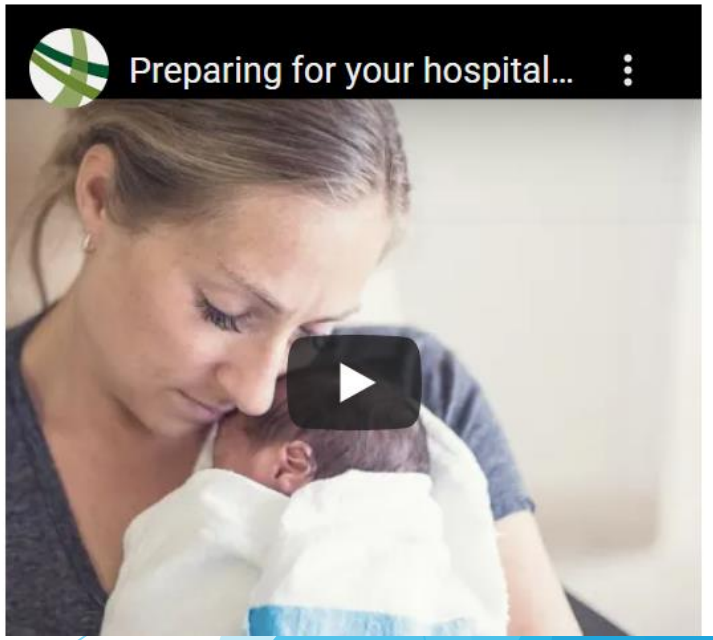
- Family new to area, limited supports
- Both parents working in restaurant industry
- Currently housed in 1 bedroom apartment
- They have a 2yr old at home, have not been able to secure childcare so parents working opposite shifts.
- Currently not enrolled in WIC or SNAP.
  - At CHARM meeting a plan for outreach and referral follow-up is made.
- Partner also with history of OUD, previously on MOUD
  - Referred to local Hub where methadone was started while awaiting appointment at local family practice clinic.

Case: prenatal preparation

- Received education regarding need for infant to stay in hospital x 96 hours for monitoring during visits
  - SW helps identify supports to care for toddler while admitted
- Also given resources to review:
  - Our Care Notebook (written materials)
  - Preparing for your hospital stay (video)
- CHARM Team reviews at 30 days prior: no substance use or safety concerns.



Preparing for your hospital stay and what to expect after your baby is born.
(video below)



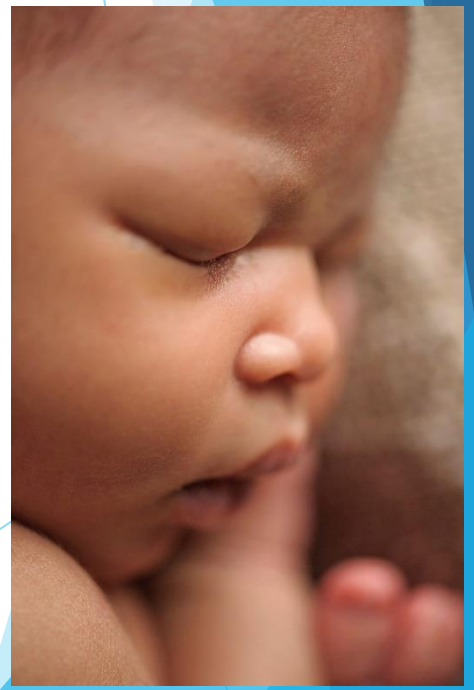
Case “A”: birth

- Presented in labor at 40+2 weeks and delivered without medications.
- MOUD team reports no concerns with non-prescribed medication or illicit substance use
  - No urine drug screening obtained on birth parent
  - No screening urine or meconium obtained from infant
- Healthy female infant admitted to the mother baby unit after birth.
- Eat, Sleep Console care tool is started to monitor for signs of clinically significant withdrawal after birth

TIME
EATING
Poor eating due to NAS? Yes / No
SLEEPING
Sleep < 1 hr due to NAS? Yes / No
CONSOLING
Unable to console within 10 min due to NAS? Yes / No
Consoling Support Needed **1:** Able to console on own **2:** Able to console with caregiver support within 10 min **3:** Unable to console with caregiver support within 10 min
NON-PHARM CARE INTERVENTIONS
Rooming-in: Increase / Reinforce
Parent/caregiver presence: Increase / Reinforce
Skin-to-skin contact: Increase / Reinforce
Holding by caregiver / cuddler: Increase / Reinforce
Safe swaddling: Increase / Reinforce
Optimal feeding at early hunger cues: Increase / Reinforce
Quiet, low light environment: Increase / Reinforce
Non-nutritive sucking / pacifier: Increase / Reinforce / Not Needed
Additional help / support in room: Increase / Reinforce
Limiting # of visitors: Increase / Reinforce
Clustering care: Increase / Reinforce
Safe sleep / fall prevention: Increase / Reinforce
Parent/caregiver self-care & rest: Increase / Reinforce
Optional Comments:

Case “A”: discharge

- After 96 hours of ESC monitoring with mild signs of withdrawal but no impairment in ability to eat, sleep or console, infant ready for discharge home.
- Infant currently breastfeeding, birth parent received lactation support and will obtain breast pump from WIC.
  - Parent counseled on risks of THC passage into breastmilk and goal to reduce to discontinue use
- Referral was placed to Home Health nursing for both parent and infant.



Case “A”: discharge

- **DCF was not involved** since there were no safety concerns and parent was stable on MOUD with occasional cannabis use.
- **A Plan of Safe Care** was completed with care management at the hospital and both birth parents
  - Copy given to parents
  - Scanned into infant’s medical record
  - Faxed to infant’s PCP with discharge summary
  - NOT shared with DCF

Case “A”: follow-up

- Home health and Children’s Integrated Services connect with the family and provide ongoing community-based services
- Family is able to access childcare for both children which allows them to work more regular schedules.
- Both parents are transitioned to local family practice provider for ongoing health care and MOUD management.
- Parents engage with local peer-based parenting and recovery support group to connect with other families.
- Infant is followed by the primary care provider and CIS without any concerns for developmental delays.

Case “B”: Background

SAME background and family supports as Case “A”

Case “B”: pregnancy management

CHARM Team monitors progress:

- COGS: Initiated prenatal care and MOUD management. Attends consistently then misses appointments
- Referred to affiliated counselor and psychiatric provider to address substance use disorder and co-occurring anxiety. Met after numerous delays. Does not appear to be engaged.
- Received assistance with smoking cessation and counseling regarding cannabis use.
- Routine urine drug screens show positive for cocaine and opiates as well as THC at about 30 weeks.

Component	Result	Reference Range
Amphetamine Screen	Negative	Negative
Barbiturate Screen	Negative	Negative
Benzodiazepine Screen	Negative	Negative
Buprenorphine Screen	Positive	Negative
Cocaine Screen	Positive	Negative
MDMA Screen	Negative	Negative
Methadone Screen	Negative	Negative
Methamphetamine Screen	Negative	Negative
Opiates Screen	Positive	Negative
Oxycodone Screen	Negative	Negative
Marijuana (THC) Screen	Positive	Negative

Case “B”: pregnancy management

- CHARM Team develops plan to coordinate MOUD care, suggest transition to Chittenden Clinic for closer monitoring. COGS and Chittenden Clinic coordinate.
- Prenatal Care plan includes outreach to offer support attending appointments:
  - ✓ Provide gas card, grocery card
  - ✓ Referral to Children’s Integrated Services for help finding child care
- At CHARM Meeting, discuss enrollment in WIC, SNAP, and ReachUp (TANF). Outreach plans made by those service providers
- 30 days prior to due date: COGS reports to DCF-Family Services for prenatal assessment

Case “B”: pregnancy management

- **DCF Family Services opens Assessment at 30 Days**
  - ✓ “B” is fearful of DCF involvement. They work to address her fears, develop safety plan.
  - ✓ Coordinate with COGS and Chittenden Clinic; monitor UDS’
  - ✓ “B” discloses history of domestic violence leading to potential eviction; referred to DV Agency for crisis support and housing referral.
  - ✓ Referral to Home Health for support
  - ✓ Outreach to extended family for support

- CHARM Meeting: 30 Days prior to due date, review case, updates from DCF Family Services and other service providers.

Case “B”: birth

- Presented in labor at 40+2 weeks and delivered without medications.
- MOUD team reports “B” is stable for past four weeks, UDS’s are (-)
  - Urine drug screen obtained on birth parent due to recent history
  - No screening urine or meconium obtained from infant
- Based on communication at CHARM meeting, Mother/Baby Unit nurse notifies DCF worker of birth of baby.
- Eat, Sleep Console care tool is started to monitor for signs of clinically significant withdrawal after birth. Baby transitioned to NICU briefly due to possible signs of withdrawal.

Case “B”: Discharge and Followup

- Baby discharged home with “B” and her mother, based on safety plan DCF developed with her prenatally.
- No custody or court intervention is needed.
- DCF keeps a case open, continues to monitor and coordinate with MOUD treatment provider and community support services.
- “B” attends peer support “Moms Group” at Recovery Center
- **Plan of Safe Care** completed by DCF Family Services Worker as part of ongoing case plan.

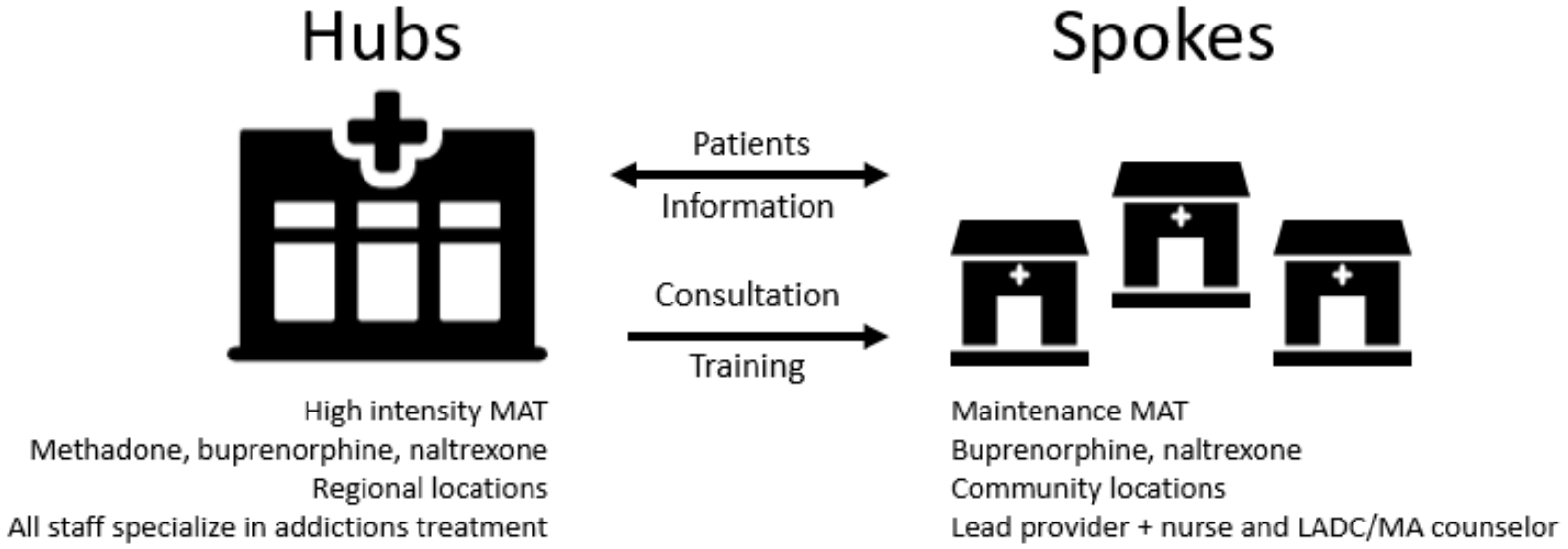
Medication for Opioid use Disorder/ Medication Assisted Treatment MOUD/MAT In Pregnancy

Shara Tarule, APRN
Chittenden Clinic
Howard Center, Burlington VT

Vermont's Opioid Use Disorder Treatment System

Medication Assisted Treatment: The Evidence-Based Approach to Opioid Use Disorder

- **Hubs Offer Intensive Treatment for Complex Addictions**
  Hubs are Opioid Treatment Programs with expanded services and strong connections to area Spokes
- **Spokes Provide Ongoing Treatment in Community Settings**



Source: Vermont Department of Health, Alcohol and Drug Abuse Programs
https://blueprintforhealth.vermont.gov/about-blueprint/hub-and-spoke

Prenatal Care and MAT in Pregnancy

- **Integrated on-site MAT and Prenatal Care:**

  Spoke: UVM Medical Center COGS (Comprehensive Obstetric and Gynecological Services)

  - On-site initiation and administration of Buprenorphine
  - COGS Social Workers and Licensed Alcohol and Drug Counselor provide counseling, care coordination, referrals to housing, community-based services for COGS MAT patients

- **Community-based MAT, coordinated with Prenatal Care:**

  Hub: Chittenden Clinic, Howard Center

  - Initiation and administration of Methadone and Buprenorphine
  - Coordination with UVM Medical Center COGS clinic and other primary prenatal care providers

Opioid Use Disorder : Treatment options

- Detoxification – not safe in pregnancy

- Medication Assisted Treatment (MAT): the standard of care in pregnancy
  - Methadone

  - Buprenorphine

- Harm Reduction
  - Needle exchange

Barriers to Care During Pregnancy

- ✓ Stigma and shame
- ✓ Myths and Misconceptions about MAT
- ✓ Fear and Mistrust
- ✓ Lack of Access
- ✓ Lack of Transportation, child care, etc.

Why is medication assisted treatment during pregnancy the best alternative?

- Decreases prematurity and low birth weight
- Improves the health of the pregnancy
- Lowers infant mortality
- Pregnant woman feels well (not “high”) and has no cravings
- Successful engagement in treatment increases the probability of good parenting
- Detoxification during pregnancy is rarely successful and dangerous to the fetus

Child Welfare: Vermont Department for Children and Families
Family Services Division

Skyler Bryan, Supervisor
Burlington, VT District Office
Family Services Division
Vermont Department for Children and Families

Vermont Statutes & Early Intervention

- "Chapter 49" (33V.S.A.§4912): guides acceptance for an investigation or assessment with a specific allegation of child abuse or neglect:
  - Physical abuse, sexual abuse, neglect, emotional maltreatment, risk of harm

- "JPA Assessments" or "CHINS B Assessments" (33V.S.A.§5106): Collective concerns without specific incident that suggest a child(ren) may be "in need of care and supervision."

- Provides for DCF to intervene in a variety of situations involving parental substance use, ***including 30 days prior to the anticipated due date of a pregnant mother who has tested positive for illicit substances during her third trimester.***
  - ✓ These reports are not accepted solely based on a mother receiving MAT or a mother's use of marijuana unless there are secondary concerns.
    - ✓ VT DCF rarely receives reports when the sole concern is MAT or Thc use.
    - ✓ Four years ago: how VT shifted policy related to marijuana use.

VERMONT POLICY - DCF Reports

Prenatal Report Acceptance

- Maternal illegal substance use in 3rd trimester
- Maternal non-prescribed medication use or misuse 3rd trimester
- Maternal substance use is serious threat to child health/safety

Newborn Report Acceptance

- Infant with positive tox screen for illegal substance or non-prescribed medication
- Infant with NAS due to illegal substance or non-prescribed medication
- Infant with fetal alcohol syndrome disorder

VT "JPA Assessments"

- **Acceptance Criteria:** A physician, provider, or self-admission of illegal substance use, use of non-prescribed prescription medication, or misuse of prescription medication during the last trimester of pregnancy.
- **OR**: a newborn has a positive toxicology screen for illegal or nonprescribed medication at birth, newborn has been deemed to have Neonatal Abstinence Syndrome or Fetal Alcohol Syndrome.
  - ✓ Intervention before a child's birth may assist the family to remediate the issues and avoid the need for DCF custody after the birth.
  - ✓ Assessments may begin approximately *one month* before the due date or sooner if medical findings indicate that the mother may deliver early.

Child Protection/Safety

DCF Policy: Family Assessment *("JPA Assessment")* may begin 30 days before due date, where:

- serious threat to a child's health or safety,
- mother's substance abuse during third trimester

Innovative approach:

- Allows time for family engagement prior to birth
- Focus: planning for safe environment for the infant
- Child maltreatment prevention: earlier indication of risk if parent is unable to parent safely
- Avoid unnecessary/crisis placement at birth!

CARA Federal Requirement: VERMONT's POLICY DCF Reports and Notifications

- **Child safety concerns:**
  - DCF **report** made via central intake
  - DCF-FS develops **Plan of Safe Care**

- **NO child safety concerns:**
  - CAPTA **notification** sent by birthing hospital to DCF after birth of infant
    - De-identified notification
  - **Plan of Safe Care** completed by hospital staff
    - Copies sent to infant's PCP and given to family

CHARM: Child Protection Role

- Collaboratively partner with other community professionals specific to child safety concerns for mother's prescribed MAT and their post/pre-natal babies
  - Share general practice, policy, or programmatic changes
  - Share any CPS information known with the group if there is an active case
- Disseminate any case specific concerns, progress, barriers/challenges to:
  - The assigned social worker and supervisors, both within my jurisdiction and others.
  - Our Centralized Intake Hotline if a report concerning the specific pregnancy is pending.

Case Comparison

Report received before or during last trimester; accepted 30 days prior:

- Mother on MAT relapses on cocaine or another illicit substance
- DCF collaborates with co-located substance use screeners, client specific treatment providers, family and natural networks of support
- Administers additional UA's, monitors and assesses whether use continues.
  - ✓ Strive for the process to allow infants to remain with mothers
  - ✓ Develops Safety Plans to avoid court intervention
  - ✓ Court intervention only when necessary

Report received by Labor & Delivery upon a positive tox for newborn:

- Mother and/or baby test positive upon delivery
- DCF receives report, responds to hospital
- Vulnerability, resistance, immediate fear, less openness and cooperation
- Limited/minimal time to collaborate with current service providers or make appropriate service referrals
- More frequently results in court intervention

The Vermont Plan of Safe Care:
Development & Rollout

Michelle Shepard MD, PhD,
Assistant Professor of Pediatrics
UVM Larner College of Medicine & UVM Children's Hospital

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VERMONT DEPARTMENT OF HEALTH
VCHIP Vermont Child Health Improvement Program UNIVERSITY OF VERMONT LARNER COLLEGE OF MEDICINE
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Goal of the POSC- decrease silos and improve communication to support families

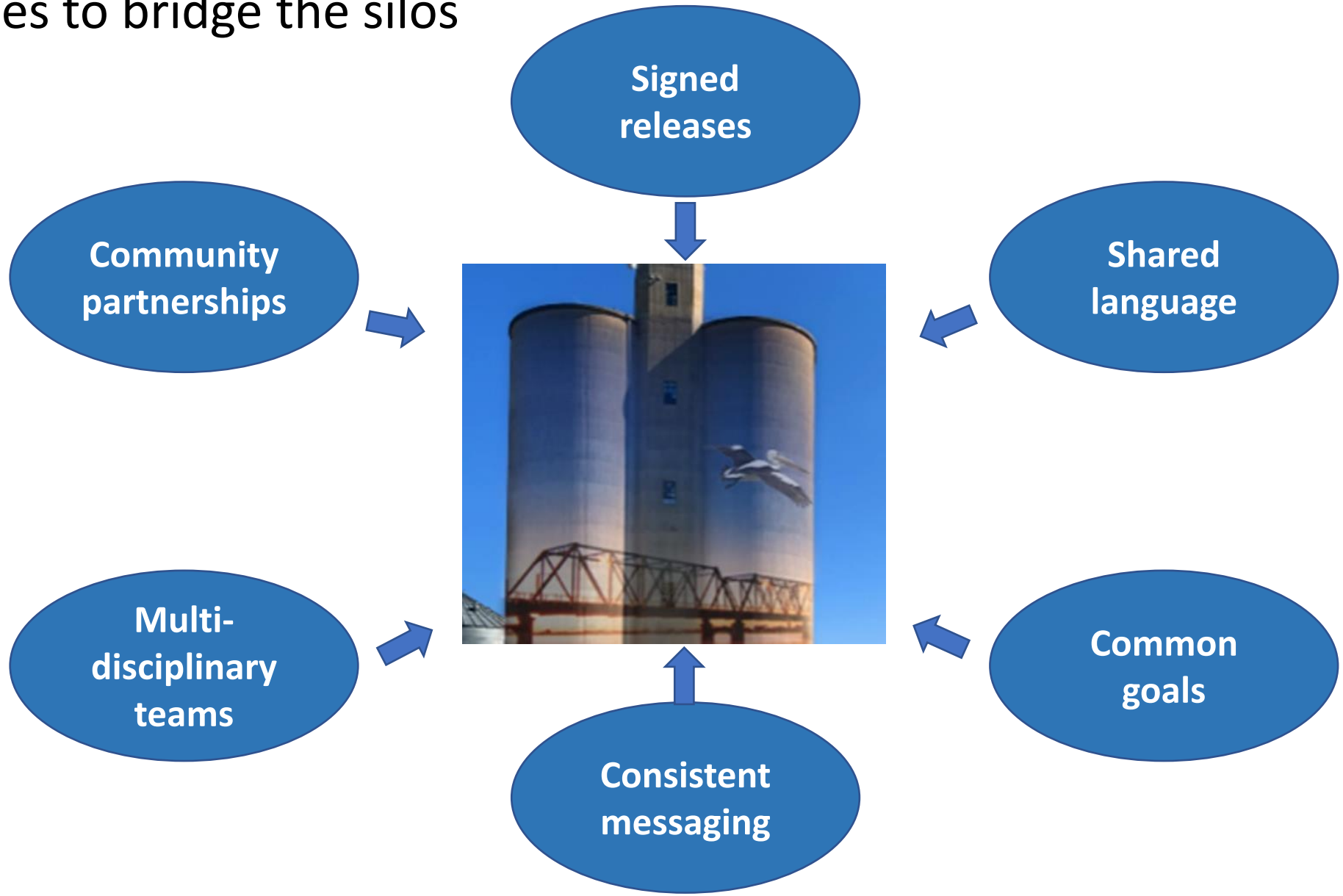
Mother's providers (PCP, MAT)

OB/midwife

Infant PCP

Community Supports

Strategies to bridge the silos



Barriers

Shame

Isolation

Poor Communication

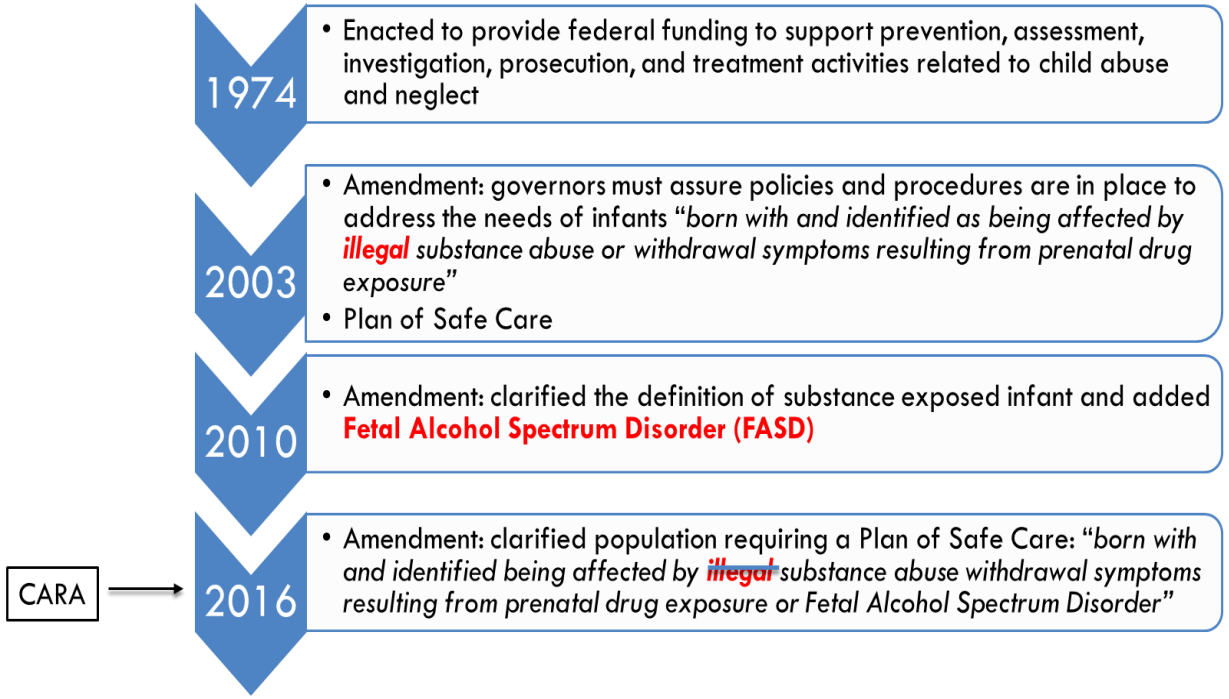
Fear

Uncertainty

Stigma

Review of Federal Legislation

CAPTA- Child Abuse Prevention and Treatment Act



Goal: To address the needs of infants affected by substance abuse, withdrawal or Fetal Alcohol Spectrum Disorder.

CARA- Comprehensive Addiction and Recovery Act

Requirements:

1. Identify infants affected by substance abuse, withdrawal or Fetal Alcohol Spectrum Disorder
2. Health care providers notify child protective services
3. Develop a Plan of Safe Care (POSC)
4. State child protective services agency report data to Children's Bureau annually

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Implementation: questions VT had to answer

- When will DCF reports be required?
  - Which substances?
  - When during pregnancy?
- What information should be included in the Vermont Plan of Safe Care?
- Who is responsible for developing the VT POSC?
- Who should receive a copy of the VT POSC and where should it reside?
- How will data be collected for reporting to the Children's Bureau?
- How can we continue to attract pregnant people with opioid use disorder into treatment while following CARA/CAPTA?

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Requirement 1: Identify Substance-exposed Newborns

Prenatal exposure

- Identified via conversations or on prenatal screening (reported use)
- Use of medications during pregnancy prescribed by healthcare providers

Identification after birth of infant

- Clinical signs/symptoms of substance exposure or withdrawal (Neonatal abstinence syndrome)
- Constellation of physical findings or symptoms after birth (Fetal Alcohol Syndrome Disorder)

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Requirement 2: Notify CPS

States instructed to set up their own definitions and systems- some opted for CPS involvement in all cases of substance use in pregnancy (including MAT/MOUD)

Vermont defined two separate pathways:

DCF Report	CAPTA Notification
Child safety concerns	No child safety concerns
Call DCF centralized intake with identifying information	Transmit de-identified data set to DCF
DCF develops Plan of Safe Care with family and relevant providers	Hospital staff develops Plan of Safe Care with family and transmits to PCP

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Substance use in pregnancy: DCF report vs. notification

DCF Report

- Use of illegal substances during 3rd trimester of pregnancy
- Use of non-prescribed or misuse of prescribed prescription meds in 3rd trimester
- Active alcohol use disorder in 3rd trimester or suspected FASD after birth

CAPTA Notification

- MAT/MOUD during pregnancy
- Prescribed opioids for pain during pregnancy
- Prescribed benzodiazepines during pregnancy
- Use of marijuana during pregnancy (after 1st trimester)

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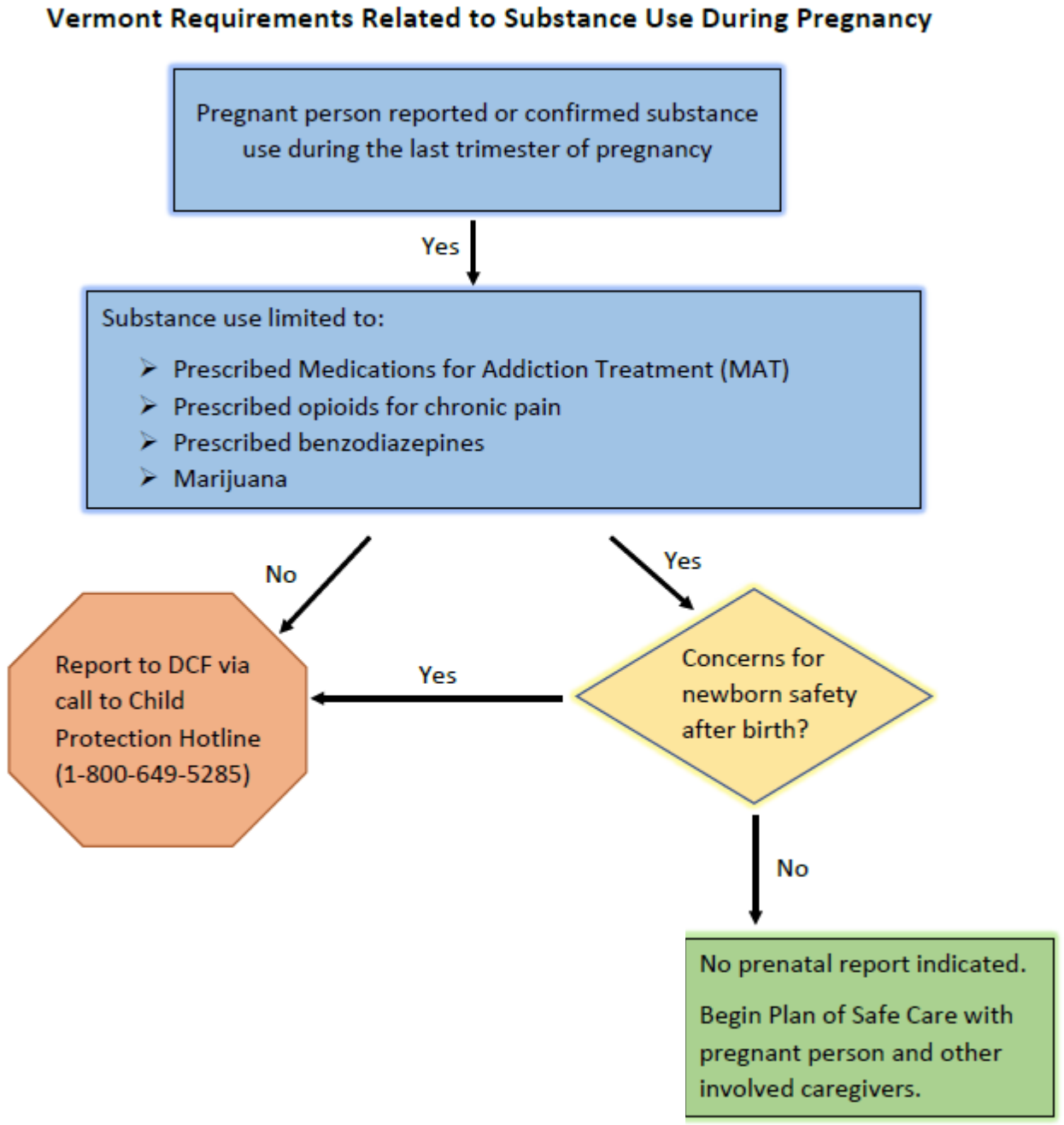
Prenatal reports:
Since January 2007, VT DCF is able to accept a report and open an assessment during pregnancy within 30 days of the estimated delivery date

Prenatal report acceptance criteria:
Use of an illegal substance or non-prescribed medication, or misuse of prescription medication during the last trimester of pregnancy.

<u>And/or</u>:
Concern for infant's health or safety related to ANY substance use (with the goal to address the safety concerns prior to birth).

Flowchart available on the DCF POSC Website:
https://dcf.vermont.gov/fsd/partners/POSC



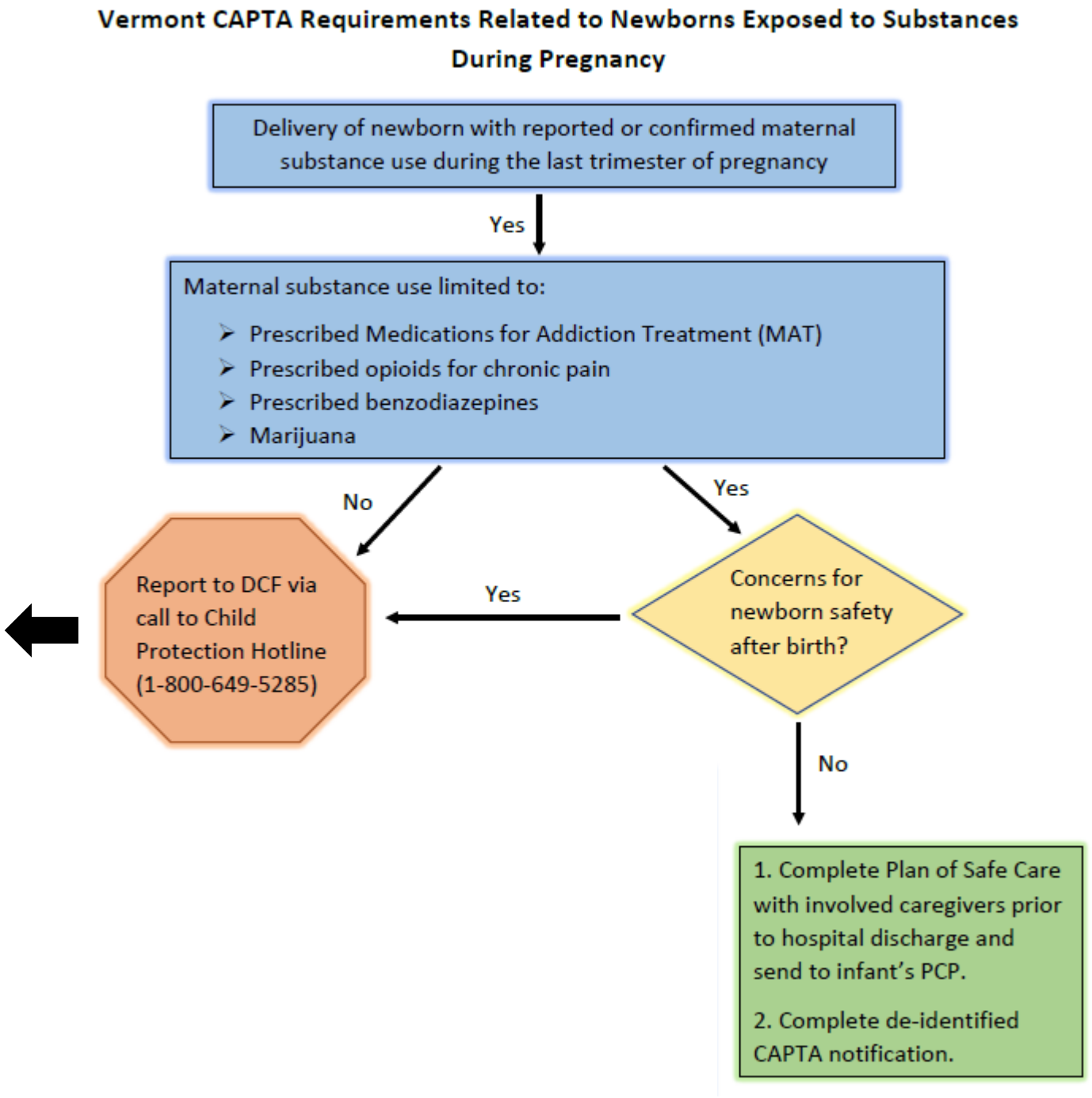
DCF policy on marijuana use:
Effective November 1, 2017, if there are no other child safety concerns, marijuana use during pregnancy will not be accepted as a report.

Update 2021: POSC and CAPTA notification for marijuana use after the 1st trimester

Newborn report acceptance criteria:

Positive toxicology screen or diagnosis of Neonatal Abstinence Syndrome related to maternal use of illegal substances or non-prescribed medication.

Diagnosis of Fetal Alcohol Spectrum Disorder.



Vermont CAPTA Notification

INSTRUCTIONS:

Infant exposures to certain substances during pregnancy are tracked by the Vermont Department for Children and Families (DCF) for reporting to the Children's Bureau based on federal law (CAPTA). The use of the prescribed substances listed below and/or marijuana during pregnancy requires the completion of the Vermont Plan of Safe Care (POSC) prior to infant discharge from the hospital and submission of this de-identified CAPTA notification form to DCF. Identifying information such as names, medical record numbers, and dates of birth should not be included on this form. The POSC and de-identified CAPTA notification should be completed by the hospital that discharged the infant.

Please submit via secure fax (802) 241-9060 or scan to AHS.DCFFSDCaptaNotification@vermont.gov
(No cover sheet necessary)

Reminder: A report to the DCF child protection hotline (1-800-649-5285) should be made in these situations:

- Substance use is a concern for child safety
- Use of an illegal substance or non-prescribed prescription medication, or misuse of prescription medication during the third trimester of pregnancy.
- Newborn has a positive confirmed toxicology result for an illegal substance or non-prescribed medication.
- Newborn develops signs or symptoms of withdrawal as the result of exposure to illegal substances, use of non-prescribed medications, misuse of prescribed medication, or due to undetermined exposure.
- Newborn is suspected to have fetal alcohol spectrum disorder, or the pregnant individual had active alcohol use disorder during the third trimester of pregnancy.

For reports that are accepted by DCF, the POSC will be completed by DCF.

Please check the boxes that apply to the current pregnancy:

The pregnant individual was treated by a healthcare provider with:

- ☐ Medications for Addiction Treatment (MAT): Methadone, Buprenorphine, Subutex, Suboxone, Naloxone
- ☐ Prescribed opioids for chronic pain
- ☐ Prescribed benzodiazepines

The pregnant individual used marijuana during pregnancy (use continued after the first trimester):

- ☐ Recreational THC
- ☐ Prescribed THC

Allows tracking of substance exposure(s) ➡

Additional exposures:

- ☐ Alcohol Amount if known: _____
- ☐ Nicotine/Tobacco/E-cigarettes Amount if known: _____
- ☐ Other prescribed medications (ex. SSRIs): _____

Allows tracking of POSC completion and referrals ➡

Please check if any of the following apply:

- ☐ A Plan of Safe Care was completed and was sent to the infant's primary care provider
- ☐ The pregnant individual was engaged in services prior to delivery (ex: counseling, treatment, parenting classes)
- ☐ New referrals were made for services for the infant and/or parents/caregivers after birth

Unique Record Identifier: ☐☐☐☐-☐☐☐☐

(Hospital code followed by last 4 digits of hospital medical record number)

Requirement 3: Develop a POSC

Vermont Goals:

- Continue to support pregnant people who are currently engaged or seeking treatment for substance use disorders.
- Support the existing relationships between the pregnant person and their current providers and supports.
- Facilitate referrals to local community resources for any identified needs for the family after the infant is born.
- Encourage communication with the infant's primary care provider to strengthen family centered care.

VT POSC: Who, What, When, & Where

- Who is responsible for developing the POSC
  - Prenatal providers
  - Hospital staff (nurses, care managers, social work)
- What information is included?
  - Identified supports & strengths
  - Services in place and new referrals placed
- When should the POSC be developed?
  - Ideally started prenatally, must be completed by hospital discharge
- Where does the POSC reside?
  - Copy given to parents/caregivers
  - Stored in hospital infant medical record
  - Sent to infant's PCP as part of discharge paperwork

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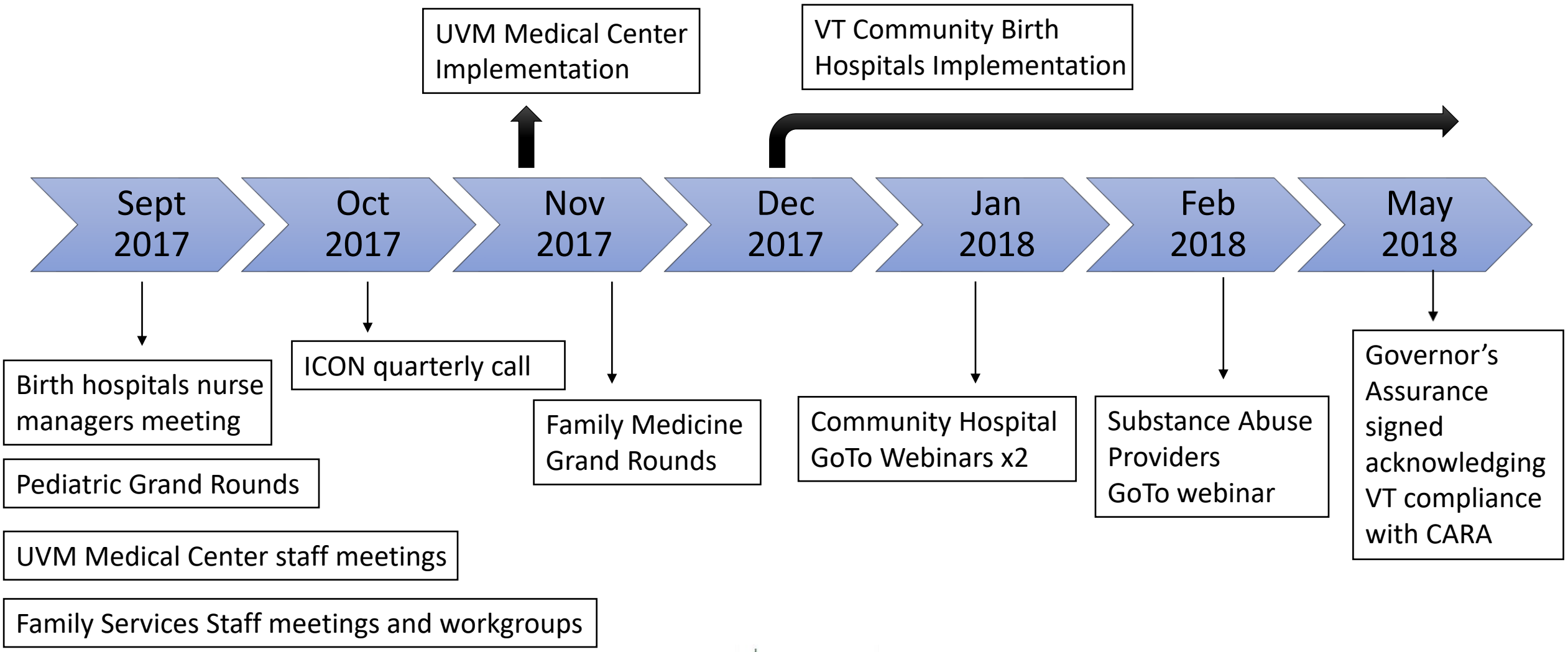
Timeline- VT POSC Rollout



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Feedback on the POSC

Collected feedback to increase uptake and use of the POSC as a communication tool.

Feedback from UVMMC:

- Double documentation of information in POSC and EMR discharge info
- Form inconsistently put in infant's chart
- OB providers not always discussing THC use so family surprised by need to complete the POSC
- Explaining a de-identified DCF notification to families was confusing

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Statewide Feedback on the POSC

Survey developed by a UVM honors nursing student regarding POSC use and experience

- Sent to Vermont birth hospital nurse managers
  - 37 responses received from 10 hospitals

Results:

- Those completing the POSC understand it's purpose and generally feel comfortable explaining this to families
- It is not always clear which families need a POSC completed prior to discharge
- The procedure for completing the POSC prior to hospital discharge could benefit from more clarity and/or standardization

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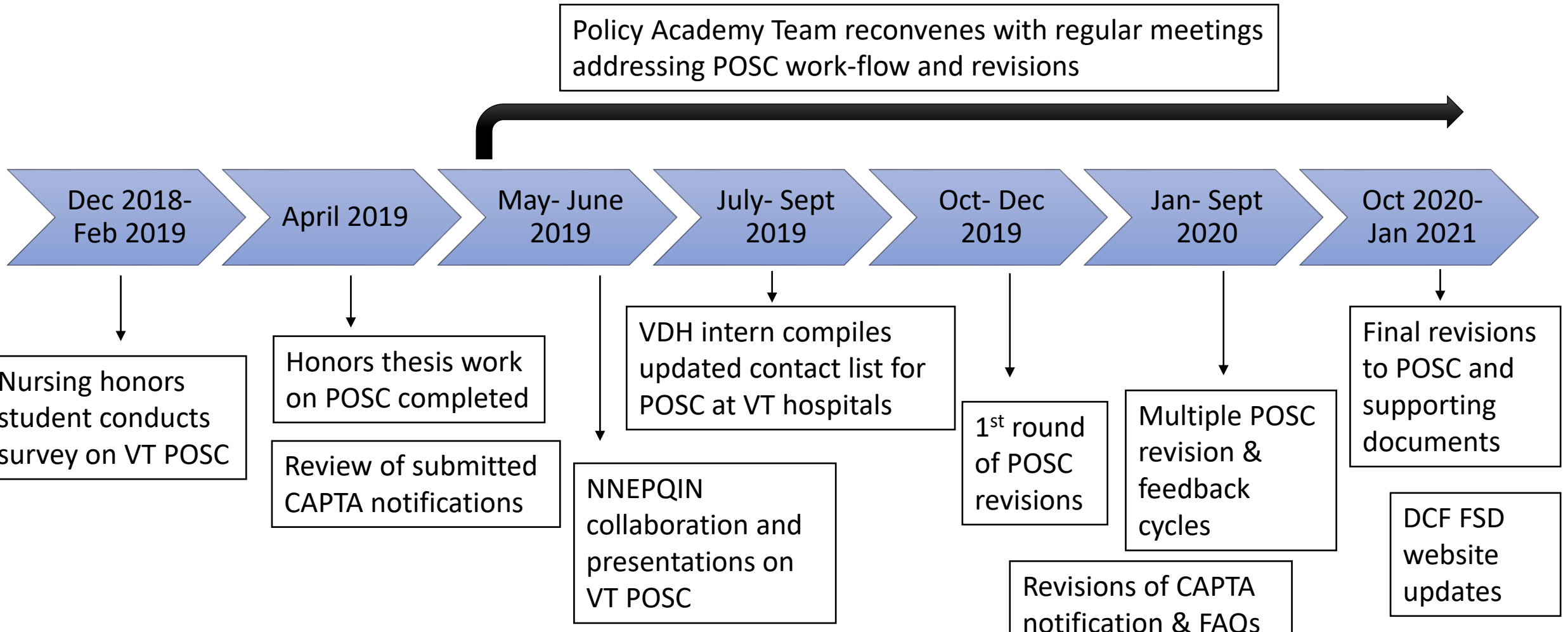
Timeline- VT POSC Revisions



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Vermont Newborn Plan of Safe Care (POSC)

INSTRUCTIONS
The Plan of Safe Care should be developed with the pregnant individual and other involved caregivers prenatally and completed after the infant is born. The goal of the POSC is to ensure infants and families are connected to supportive services in their communities. The completed POSC should be sent to the infant's primary care provider at hospital discharge to facilitate communication and follow-up of new referrals. It should be scanned into the infant's medical record and the family should also receive a copy.

POSC INDICATION
☐ MAT ☐ Prescribed Opioids ☐ Prescribed Benzodiazepines ☐ Marijuana use (prescribed or recreational after 1st trimester)

DEMOGRAPHIC INFORMATION		
Name of Parent:	Parent's DOB:	EDD:
Name of Infant:	Infant's DOB:	Infant discharge date:
Infant's primary care provider & contact information:		

HOUSEHOLD MEMBERS					
Name	Relationship to Infant	Age	Name	Relationship to Infant	Age

CURRENT SUPPORTS (include emergency childcare contact and other support people)		
Name	Role	Contact information

STRENGTHS AND GOALS *(ex: recovery, housing, parenting, smoking cessation, breastfeeding)*

SERVICES, SUPPORTS, and REFERRALS		
Infant Supports		
	Contact information	**Status**
Nurse home visiting (Home Health & Hospice, VNA, Children's Integrated Services Strong Families Vermont)		☐ Currently Receiving ☐ Discussed ☐ New referral placed ☐ Not applicable
Children's Integrated Services: Early Intervention		☐ Currently Receiving ☐ Discussed ☐ New referral placed ☐ Not applicable
Help Me Grow	Phone: 2-1-1 extension 6 or Online: https://helpmegrowvt.org/form/referral-form	☐ Currently Receiving ☐ Discussed ☐ New referral placed ☐ Not applicable
Pediatric specialist referral (NeoMed clinic)		☐ Currently Receiving ☐ Discussed ☐ New referral placed ☐ Not applicable

Vermont POSC (continued)

Caregiver Supports		
	Contact information	**Status**
Medications for Addiction Treatment (MAT)	**	☐ Currently Receiving ☐ Discussed ☐ New referral placed ☐ Not applicable
Mental Health Counseling	**	☐ Currently Receiving ☐ Discussed ☐ New referral placed ☐ Not applicable
Substance Use Counseling	**	☐ Currently Receiving ☐ Discussed ☐ New referral placed ☐ Not applicable
Community Empaneled Team (ex. ChARM)	**	☐ Currently Receiving ☐ Discussed ☐ New referral placed ☐ Not applicable
Recovery Supports (ex. Recovery coaching, 12-step group)		☐ Currently Receiving ☐ Discussed ☐ New referral placed ☐ Not applicable
Case Management		☐ Currently Receiving ☐ Discussed ☐ New referral placed ☐ Not applicable
Smoking Cessation		☐ Currently Receiving ☐ Discussed ☐ New referral placed ☐ Not applicable
Parenting Supports		☐ Currently Receiving ☐ Discussed ☐ New referral placed ☐ Not applicable
Financial Supports (WIC, Fuel, Reach Up)		☐ Currently Receiving ☐ Discussed ☐ New referral placed ☐ Not applicable
Housing Supports		☐ Currently Receiving ☐ Discussed ☐ New referral placed ☐ Not applicable
Childcare Resources (Children's Integrated Services: Specialized Child Care)		☐ Currently Receiving ☐ Discussed ☐ New referral placed ☐ Not applicable
Transportation		☐ Currently Receiving ☐ Discussed ☐ New referral placed ☐ Not applicable
Legal Assistance		☐ Currently Receiving ☐ Discussed ☐ New referral placed ☐ Not applicable
Other		☐ Currently Receiving ☐ Discussed ☐ New referral placed ☐ Not applicable

**confidentiality must be protected, parent/caregiver may choose to disclose contact information or leave blank

PARENT/CAREGIVER PARTICIPATION

I participated in the development of this Plan of Safe Care, have received a copy, and understand it will be shared with my baby's primary care provider.

Parent/Caregiver Signature: _____ **Date:** _____ ☐ Parent/caregiver declined participation

Staff Signature: _____ **Date:** _____

NOTES/FOLLOW-UP NEEDED

TRACKING

Date POSC initiated: _____ Date(s) Revised: _____ Date Completed: _____

☐ Sent to infant's PCP ☐ Copy in infant's chart ☐ Copy given to family ☐ CAPTA notification completed

VT POSC: What happens after discharge?

- Infant's PCP office should follow-up on any new referrals made for the infant (home visits, CIS, etc.)

- The family should be encouraged to follow-up on new referrals made for caregivers in conjunction with their PCP or other providers

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Summary: Vermont POSC

The POSC IS:	The POSC is NOT:
✓ A living document created with the pregnant individual.	✓ A form just for hospitals and providers.
✓ Document of current supports and strengths, needs, and new referrals.	✓ Punitive.
✓ Shared with the infant's primary care provider after birth and given to the caregiver.	✓ Shared with DCF unless they are involved for child safety concerns.

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Requirement 4: Data Reporting

Required data to Children's Bureau:

- # of substance exposed infants
- # of infants with plan of safe care developed
- # mothers already engaged in services
- # of infants for whom a referral was made for appropriate services

How data is collected is up to the State to determine

- Vermont opted to use the CAPTA notification form in combination with DCF reports
- All VT data is sent as an aggregate without identifying information

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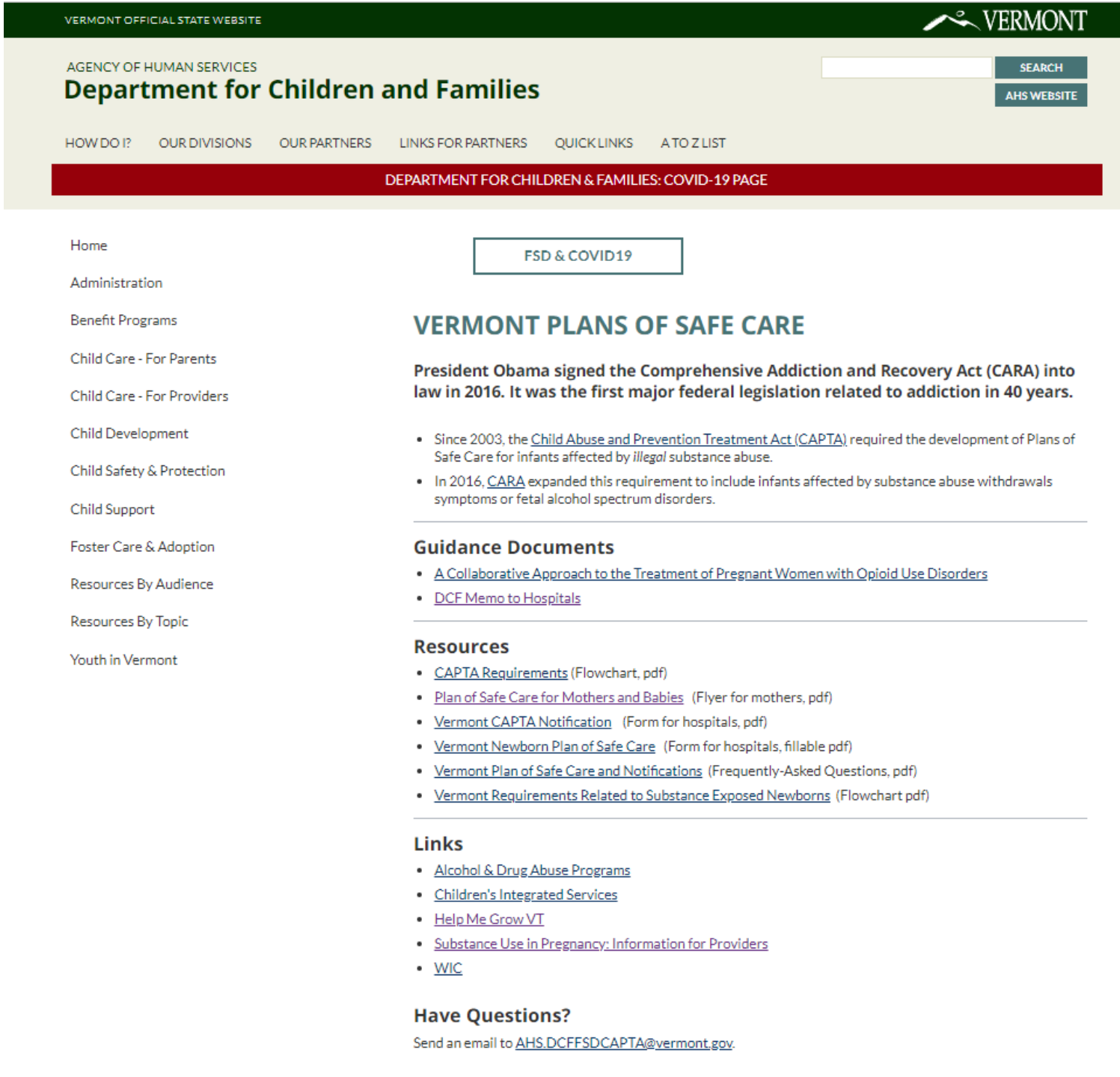
Recently Updated!

- POSC form for hospitals
- CAPTA notification form
- Frequently Asked Questions:
  - CAPTA notification
  - Vermont POSC
  - THC use in pregnancy
- POSC handout for families



VERMONT OFFICIAL STATE WEBSITE

VERMONT

AGENCY OF HUMAN SERVICES

Department for Children and Families

SEARCH

AHS WEBSITE

HOW DO I? OUR DIVISIONS OUR PARTNERS LINKS FOR PARTNERS QUICK LINKS A TO Z LIST

DEPARTMENT FOR CHILDREN & FAMILIES: COVID-19 PAGE

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Child Care - For Providers
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Resources By Topic
Youth in Vermont

FSD & COVID19

VERMONT PLANS OF SAFE CARE

President Obama signed the Comprehensive Addiction and Recovery Act (CARA) into law in 2016. It was the first major federal legislation related to addiction in 40 years.

- Since 2003, the Child Abuse and Prevention Treatment Act (CAPTA) required the development of Plans of Safe Care for infants affected by *illegal* substance abuse.
- In 2016, CARA expanded this requirement to include infants affected by substance abuse withdrawals symptoms or fetal alcohol spectrum disorders.

Guidance Documents

- A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders
- DCF Memo to Hospitals

Resources

- CAPTA Requirements (Flowchart, pdf)
- Plan of Safe Care for Mothers and Babies (Flyer for mothers, pdf)
- Vermont CAPTA Notification (Form for hospitals, pdf)
- Vermont Newborn Plan of Safe Care (Form for hospitals, fillable pdf)
- Vermont Plan of Safe Care and Notifications (Frequently-Asked Questions, pdf)
- Vermont Requirements Related to Substance Exposed Newborns (Flowchart pdf)

Links

- Alcohol & Drug Abuse Programs
- Children's Integrated Services
- Help Me Grow VT
- Substance Use in Pregnancy: Information for Providers
- WIC

Have Questions?

Send an email to AHS.DCFFSDCAPTA@vermont.gov.

Updated for 2021!

*Contains details about the differences between CAPTA notifications and DCF reports

Frequently Asked Questions: Vermont CAPTA Notifications

Q: What is the purpose of the CAPTA notification?

Under the federal Child Abuse Prevention and Treatment Act (CAPTA), each state must provide the Children's Bureau with certain data regarding substance-exposed newborns. In Vermont the de-identified CAPTA notification form was developed to allow the Vermont Department for Children and Families (DCF) to compile de-identified data for this annual reporting.

Q: What is the difference between a DCF report and a CAPTA notification?

- A report to DCF is made by calling the child protection hotline, which includes identifying information to allow investigation into whether an assessment should be opened.
- A notification is made via secure fax or email and does not contain any identifying information as they are used for reporting purposes only.

Q: In what situations is a CAPTA notification made based on substance use during pregnancy?

When there are no child safety concerns, a notification is required if a pregnant individual:

- Was treated by a healthcare provider with any of the following: medications for addiction treatment (MAT), prescribed opioids for chronic pain, or prescribed benzodiazepines.
- And/or used prescribed or recreational marijuana after the first trimester.

Q: Who is responsible for making CAPTA notifications?

In Vermont, birth hospital staff complete CAPTA notifications. Each birth hospital should develop a protocol and work-flow for completing and sending CAPTA notification forms to DCF in a timely fashion.

Q: Should hospitals inform the family they are sending a CAPTA notification to DCF?

Hospital staff should be transparent and should emphasize that the notification does not contain any identifying information. Give a copy of the "Vermont Plan of Safe Care for Families" handout to the family to review.

Q: When should CAPTA notifications be made?

Notifications must be made after the infant is born, submitted at hospital discharge.

Q: How do hospitals submit a CAPTA notification?

Hospital staff can either fax the notification form to (802) 241-9060 or email a scanned copy to: AHS.DCFFSDCaptaNotification@vermont.gov An electronic system is currently under development.

Frequently Asked Questions: Vermont Newborn Plan of Safe Care

Q: What is the purpose of the Plan of Safe Care (POSC)?

Under the federal Child Abuse Prevention and Treatment Act (CAPTA), a POSC should be developed for all infants exposed to substances during pregnancy. Each state had to create their own POSC document and process for completion. In Vermont, the goal of the POSC is to ensure that substance exposed infants and their families are connected to appropriate resources and services in their communities.

Q: In what situations is a POSC required based on substance use during pregnancy?

In Vermont, a POSC is required for infants when the pregnant individual:

- Was treated by a healthcare provider with any of the following: medications for addiction treatment (MAT), prescribed opioids for chronic pain, or prescribed benzodiazepines.
- And/or used prescribed or recreational marijuana after the first trimester.

Give a copy of the "Vermont Plan of Safe Care for Families" handout to the family to review.

In addition, a Vermont CAPTA notification should be completed. See "Frequently Asked Questions: Vermont CAPTA Notifications" for more details.

Q: Who completes the POSC?

The POSC should be developed with the pregnant individual and other involved caregivers. Ideally the POSC should be started prenatally at the obstetric/midwifery office or by MAT providers. The POSC would then be shared with the birth hospital staff for completion after the infant is born. Each birth hospital should identify a work-flow for POSC completion. This includes identifying care managers, social work, and/or nursing staff who will work with families to review and complete the POSC.

Q: When is the POSC completed?

In Vermont, birth hospital staff must complete a POSC after birth for newborns exposed to prescribed medications (MAT, opioids, or benzodiazepines) or marijuana (after the first trimester). Ideally the POSC should be started prenatally and must be completed prior to hospital discharge.
*Note: If a DCF report has been made and an assessment is opened, DCF will complete the POSC.

Q: Who should receive a copy of the POSC?

The completed POSC should be sent to the infant's primary care provider at hospital discharge to facilitate communication and follow-up of new referrals. It should be stored in the infant's medical record and the family should also receive a copy that they may choose to share with other providers.
*Note: the completed POSC forms should not be shared with DCF.

Q: What if the pregnant individual/caretakers decline to participate in POSC development?

The goal is to involve families in the POSC process; however, they may decline. In these instances, hospital staff should complete the POSC with available information and share it with the infant's primary care provider at discharge. The refusal to develop a POSC does not warrant a DCF child protection report if no child safety concerns are present.

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Q: What about other drug or alcohol use during pregnancy? Is a POSC required?
A POSC should be completed prior to hospital discharge for newborns exposed to prescribed medications (MAT, opioids, or benzodiazepines) or marijuana (after the first trimester). In other situations, a DCF report may be indicated and if accepted DCF would complete the POSC.

The following situations meet DCF's report acceptance criteria for substance use during pregnancy:

- A pregnant individual reports (or a healthcare provider certifies) the use of an illegal substance, use of non-prescribed prescription medication, or misuse of prescription medication during the last trimester of pregnancy.
- Concern that the pregnant individual's substance use constitutes a significant threat to an infant's health or safety (with the goal to address the safety concerns prior to birth).
- A newborn has a positive confirmed toxicology result (urine, meconium or cord) for an illegal substance or non-prescribed medication.
- A newborn develops signs or symptoms of withdrawal (neonatal abstinence syndrome) as the result of exposure to an illegal substance, use of non-prescribed medications, misuse of prescribed medication, or due to undetermined exposure.
- A newborn is suspected to have fetal alcohol spectrum disorder (FASD), or the pregnant individual had active alcohol use disorder during the last trimester of pregnancy.

Q: What if a pregnant individual resides in another state but delivers in Vermont?

A Vermont POSC should be completed prior to hospital discharge for all infants born in Vermont if there are no child safety concerns and the substance exposure consists of prescribed medications (MAT, opioids, or benzodiazepines) or marijuana (after the first trimester). The completed POSC is sent to the infant's primary care provider, regardless of the state they practice. In addition, a de-identified Vermont CAPTA notification form should be sent to Vermont DCF for tracking.
*Note: If an assessment has been opened by Vermont DCF or the child protective services agency in the state of residence, that office will complete the POSC as part of the infant discharge planning process.

Q: What if a newborn is transferred to another hospital, who is responsible for completing the POSC?

The hospital discharging the infant is responsible for the completing the POSC.

Q: Can hospitals make modifications to the POSC form?

Hospitals can make modifications to the Plan of Safe Care template as long as no content is removed. In addition, hospitals may choose to incorporate the POSC into their electronic health record system.

Q: Where can hospital staff find the POSC form?

The DCF Family Services Division website has the most updated version of the POSC and supporting documents.
https://dcf.vermont.gov/fsd/partners/POSC

Q: Who can hospital staff contact if they have questions?

Questions can be emailed to AHS.DCFFSDCAPTA@vermont.gov or call 802-760-0476 and ask to speak with DCF's Policy and Planning Manager.

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Frequently Asked Questions: Marijuana Use in Pregnancy

Q: When should healthcare providers ask pregnant individuals about marijuana use?

Conversations about substance use including marijuana, alcohol, tobacco, and other drugs should occur at every prenatal visit in an open, non-judgmental fashion.

Q: How should healthcare providers ask about marijuana use?

Prenatal providers should develop a work-flow for universal screening of pregnant individuals for substance use using questionnaires or verbally. Results should be documented to allow follow-up at subsequent visits.
For more information and resources, visit the Vermont Department of Health's One More Conversation campaign website: https://www.healthvermont.gov/family/pregnancy/substance-use-pregnancy-information-providers

Q: What should I do if a pregnant individual discloses marijuana or other substance use?

First, thank them for their honesty. Then ask about reasons for using and whether they have interest in cutting back or stopping use. Discuss any concerns they have around effects on their baby and provide both verbal and written information about the impact of substance use on development. Consider referring for substance use counseling or treatment if indicated.

Q: How are infants affected by marijuana use during pregnancy and breastfeeding?

Current data suggests marijuana use during pregnancy may impact fetal growth and development. Some studies also show long-term effects on attention and behaviors in school age children exposed to marijuana during pregnancy. Tetrahydrocannabinol (THC), the active ingredient in marijuana is concentrated in fat cells, easily passing into breastmilk and may cause sedation, poor feeding and problems with weight gain of infants who are breastfed.

Q: Marijuana use is legal in Vermont, what about federal laws regarding marijuana use in pregnancy?

Under federal law, each state must provide the Children's Bureau with certain data regarding substance-exposed newborns. In addition, this legislation states a Plan of Safe Care (POSC) should be developed for all infants exposed to substances during pregnancy. Each state created their own process, in Vermont the de-identified Child Abuse Prevention and Treatment Act (CAPTA) notification form was developed. Please see "Frequently Asked Questions: Vermont Plan of Safe Care" and "Frequently Asked Questions: Vermont CAPTA Notifications" for more information.

Q: When is a Plan of Safe Care (POSC) and CAPTA notification required?
When there are no child safety concerns, a POSC and CAPTA notification form is required if a pregnant individual:

- Was treated by a healthcare provider with any of the following: medications for addiction treatment (MAT), prescribed opioids for chronic pain, or prescribed benzodiazepines.
- And/or used prescribed or recreational marijuana after the first trimester.

Q: What if a pregnant individual stopped using marijuana after discovering they are pregnant?

If a pregnant individual stops using marijuana in the first trimester a POSC and CAPTA notification are not required. If use continues into the second or third trimester of pregnancy a POSC and CAPTA notification should be completed.

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FAQs: Marijuana Use in Pregnancy (continued)

Q: In what situations is a DCF report made based on substance use during pregnancy?

The following situations meet Vermont's report acceptance criteria:

- A pregnant individual reports (or a healthcare provider certifies) the use of an illegal substance, use of non-prescribed prescription medication, or misuse of prescription medication during the last trimester of pregnancy.
- Concern that the pregnant individual's substance use constitutes a significant threat to an infant's health or safety (with the goal to address the safety concerns prior to birth).
- A newborn has a positive confirmed toxicology result (urine, meconium or cord) for an illegal substance or non-prescribed medication.
- A newborn develops signs or symptoms of withdrawal (neonatal abstinence syndrome) as the result of exposure to an illegal substance, use of non-prescribed medications, misuse of prescribed medication, or due to undetermined exposure.
- A newborn is suspected to have fetal alcohol spectrum disorder, or the pregnant individual had active alcohol use disorder during the last trimester of pregnancy.

Q: Why isn't the use of marijuana during pregnancy a DCF report?

Effective November 1, 2017, DCF no longer accepts reports where the sole concern is regarding marijuana use during pregnancy. While some studies have suggested that prenatal exposure to marijuana may be harmful, there is lack of sufficient evidence to warrant a child protection intervention.

Q: What if hospital staff believe a pregnant individual's use of marijuana is impacting their ability to safely parent their newborn?

A report to DCF should be made via the child protection hotline at 1-800-649-5285 in any situation where there is a concern for infant safety.

Q: Where can prenatal providers go for more information and educational materials on marijuana use during pregnancy?

- The Vermont Department of Health Substance Use in Pregnancy Information for Providers:
  One More Conversation https://www.healthvermont.gov/family/pregnancy/substance-use-pregnancy-information-providers
- Centers for Disease Control and Prevention: https://www.cdc.gov/marijuana/factsheets/pregnancy.htm

Q: Where can hospital staff find the POSC and CAPTA notification forms?

The DCF Family Services Division website has the most updated version of these forms and supporting documents.
https://dcf.vermont.gov/fsd/partners/POSC

Q: Who can hospital staff contact if they have questions?

Questions can be emailed to AHS.DCFFSDCAPTA@vermont.gov or call 802-760-0476 and ask to speak with DCF's Policy and Planning Manager.

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Vermont POSC Parent Handout- revised for 2021

Vermont Plan of Safe Care for Families

What is a Plan of Safe Care?

The Plan of Safe Care is a document created with your help listing current supports and strengths your family has and any new community resources or referrals you may need after your baby is born. This plan will help your family and the infant's primary care provider communicate and be sure you have all the supports and services you need.

Who needs a Plan of Safe Care?

In Vermont, a Plan of Safe Care is developed when certain prescription medications or substances are used during pregnancy including:

- Prescribed medications for addiction treatment (MAT)
- Prescribed opioids for chronic pain
- Prescribed benzodiazepines
- Prescribed or recreational marijuana use continuing after the first trimester

What will be in your plan?

- Information about your current supports and services
- Information about new resources or referrals placed after the baby is born.
  Examples include: home health/nurse home visiting, parenting and recovery supports, financial or housing supports, and medical or developmental referrals.

Who keeps the plan?

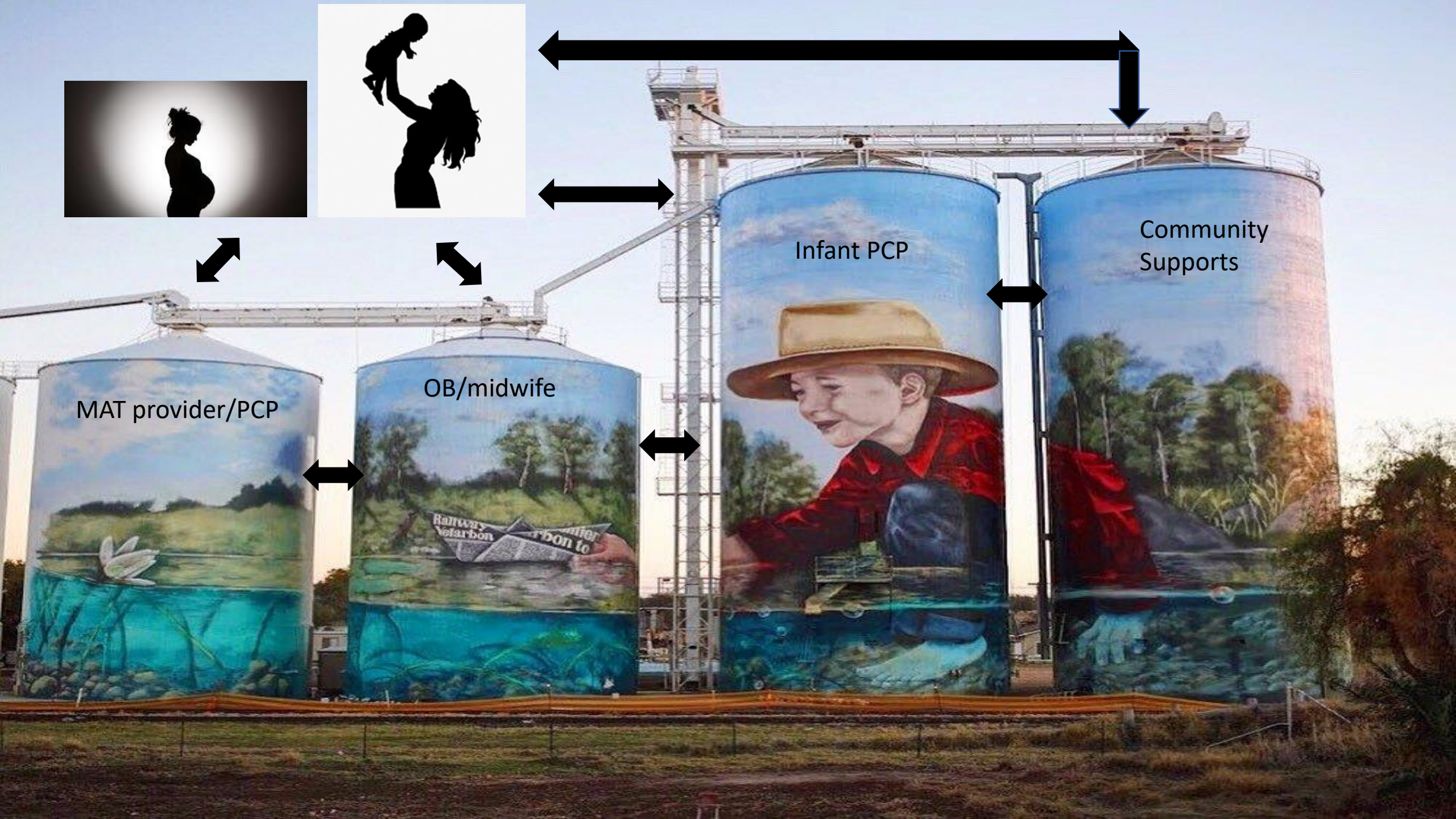
You'll get a copy and one will be sent to your baby's primary care provider. A copy will also be stored in your baby's medical record.

Will the hospital provide information about me or my newborn to DCF?

- The use of prescribed MAT, opioids, or benzodiazepines as directed by a health care provider and/or marijuana use during pregnancy are not reported to DCF when there are no child safety concerns.
- The federal government requires states to track the number of babies exposed to substances. In Vermont, a de-identified notification form was made. This form has no names, birth dates, or other identifying information and is sent to the Family Services Division for tracking purposes only.
- A report containing information is made to the Vermont Department for Children and Families (DCF) only if:
  - There are concerns for your infant's safety.
  - There was use of illegal substances, non-prescribed medications, or misuse of prescribed medications during the third trimester of pregnancy (reported, found on screening tests, or infant has withdrawal)
  - Your baby is suspected of having Fetal Alcohol Spectrum Disorder or there was active alcohol use disorder in the third trimester of pregnancy.

Where can I get more information?

Talk to your obstetrical care provider if you have any questions about the Plan of Safe Care.


MAT provider/PCP
OB/midwife
Infant PCP
Community Supports

Early communication and clear messaging is key!

Combat fear with facts:

- Reinforce that MAT is the best treatment for OUD in pregnancy and is SAFE for mom and baby. Stopping MAT puts both at risk.
- In VT DCF does not get involved unless there are child safety concerns- MAT or THC use alone do NOT trigger involvement

Empower women to ask questions and seek answers:

- What will it be like in the hospital after the baby is born?
- Will my baby have withdrawal? What are the symptoms? How long does it last? How is it treated?

Fight stigma with TRUTH:

- Encourage women to be open and honest with all their providers.
- Help women feel pride in their recovery!

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VERMONT DEPARTMENT OF HEALTH
VCHIP Vermont Child Health Improvement Program UNIVERSITY OF VERMONT LARNER COLLEGE OF MEDICINE
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KidSafe Collaborative

Prepare families: What happens after birth?

Birth hospital staff

- Support families in caring for their infant
- Encourage and assist with breastfeeding (true contraindications very rare)
- Monitor for signs and symptoms of withdrawal (neonatal abstinence syndrome) using tools such as the Eat, Sleep, Console Care Tool
  - All infants are monitored for several days
  - Infants that have symptoms requiring medication treatment will need to stay in the hospital longer
- Complete the Plan of Safe Care with involved family/caregivers and send to the infant's PCP at hospital discharge

**Assuming no child safety concerns- if concerns are present a DCF intake is completed and they complete a POSC

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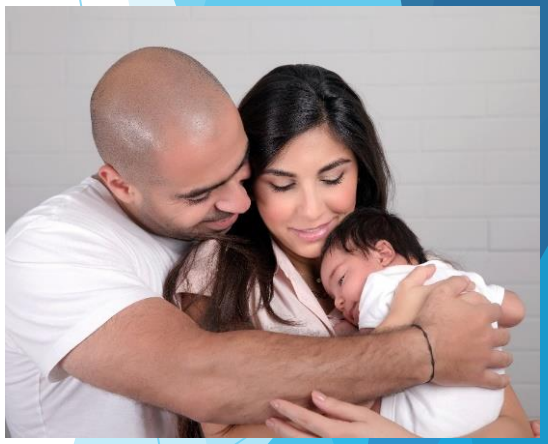
CHARM Collaborative Process Outcomes

- Improved understanding of patients/clients, opioid use disorder; minimize misunderstandings and misinformation
- Development of expertise among project partners about health and treatment of opioid-exposed newborns
- Improved understanding of each other's roles and perspectives
- Child protection decisions made based on better information from project partners about safety and risks
- Time-saver = money saver
- Have a "Go-to" contact for questions

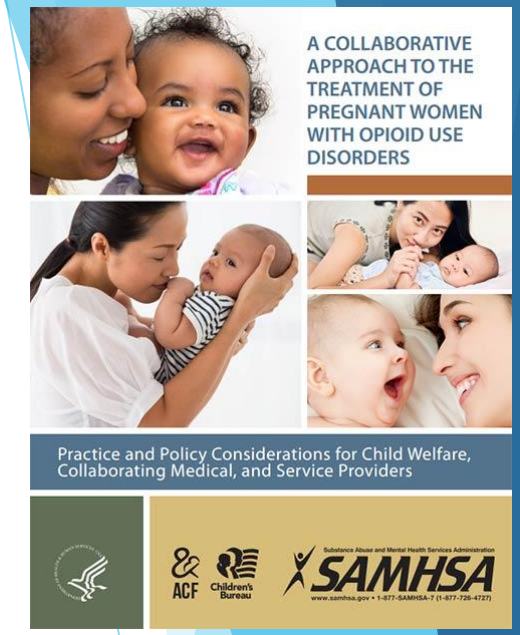
CHARM *Outcomes*

- ***Improved collaboration = safer babies***
- *"Anything that drives pregnant women with opioid use disorder from seeking treatment results in more prematurity, higher infant mortality, less probability of successful parenting"*
- ***"The health of baby depends on the mother's health, the family's health!"***

Dr. Anne Johnston, Neonatologist, UVM Children's Hospital



- **The Children and Recovering Mothers (CHARM) Collaborative in Burlington, VT: A Case Study**
  National Center on Substance Abuse and Child Welfare
  https://ncsacw.samhsa.gov/files/Collaborative_Approach_508.pdf
- **Improving Care for Opioid-exposed Newborns (ICON):**
  https://www.med.uvm.edu/vchip/icon



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POLLING QUESTIONS

1. **Overall, today's webinar was:**
   A. Very useful
   B. Somewhat useful
   C. Not very useful
   D. Not useful at all

2. **The material presented today was:**
   A. At the right level
   B. Too basic
   C. Too detailed

Questions?

CountyTouchpoints@healthmanagement.com