



# Implementing Plans of Safe Care in Massachusetts: A Federal Mandate and Statewide Opportunity

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# **Implementing Plans of Safe Care in Massachusetts:** *A Federal Mandate and Statewide Opportunity*

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This PAE reflects the views of the authors and should not be viewed as representing the views of the PAE's external clients, nor those of Harvard University or any of its faculty.

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## Glossary of Acronyms:

BMC: Boston Medical Center

CARA: Comprehensive Addiction and Recovery Act

CAPTA: Child Abuse and Protection Treatment Act

CHARM: Children and Recovering Mothers

CHIP: Children's Health Insurance Program

DCF: Department of Children and Families

HIPAA: Health Insurance Portability and Accountability Act

MAT: Medication-Assisted Treatment

NeoQIC: Neonatal Quality Improvement Collaborative

NICU: Neonatal Intensive Care Unit

OUD: Opiate Use Disorder

OB: Obstetrician

NeoQIC: Neonatal Quality Improvement Collaborative

RESPECT: Recovery, Empowerment, Social Services, Prenatal care, Education, Community and Treatment

SAMHSA: Substance Abuse and Mental Health Services Administration

SEN: Substance Exposed Newborn

SOFAR: Supporting Our Families through Addiction and Recovery

SUD: Substance Use Disorder

WIC: Women, Infants, and Children

# Executive Summary

## Plans of Safe Care

The Comprehensive Addiction and Recovery Act (CARA), signed into law by President Obama on July 22nd, 2016, required that all states receiving Child Abuse and Protection Treatment Act (CAPTA) grants implement Plans of Safe Care for substance-exposed newborns (SEN). A Plan of Safe Care must address the health and substance use disorder (SUD) treatment needs of substance-exposed infants and their family members. The CARA amendment to CAPTA also mandates that States create a plan for which agency will be responsible for Plans of Safe Care as well as develop systems to monitor the implementation of these plans to ensure that local entities are complying with state requirements for service provision.

This report seeks to build on the Commonwealth's existing efforts in order to comply with the federal mandate for Plans of Safe Care and leverage this as an opportunity to coordinate care and services for families of substance-exposed newborns.

## Methodology

Our recommendations are based primarily on 31 interviews with care providers at 12 hospitals across the state. We sampled hospitals from each region of the Commonwealth, with a spectrum of socioeconomic diversity among patients, and neonatal units ranging from level IA (newborn nursery) to level III (full service neonatal intensive care unit (NICU)). Whenever possible, we interviewed an obstetrician, pediatric hospitalist or neonatologist, community pediatrician, and social worker at each hospital. In addition, our recommendations draw on rigorous review of the academic literature in this field and original analysis of survey data obtained through NeoQIC. We also offer two case studies from diverse geographic regions - Boston and Cape Cod - to highlight how Plans of Safe Care can be used in practice in Massachusetts.

## Key Findings

- *Spectrum of Practice Variation:* There is considerable practice variation clinically in terms of care pathways for pregnant and postpartum women with opioid use disorder (OUD) and their newborn children.
- *Health of Baby Depends on Mother:* Interviewees corroborated a robust literature demonstrating that the health of infants depends on the health of their mothers, both during and after pregnancy. This is particularly true for pregnant women with OUD, for whom relapses during pregnancy or in the postpartum period can have dramatic effects on the health and safety of their child.
- *The Earlier the Better:* In theory, there is no time too early to initiate a Plan of Safe Care; several interviewees even advocated starting these plans before conception. It is critical

to craft these plans early in pregnancy and involve all key providers in the conversation in order to optimize chances for infants to be born into a safe home.

- *Providers to Involve in Plans of Safe Care:* In order for Plans of Safe Care to be effective, a diversity of providers must be at the table:
  - *Obstetricians:* Often the first point of contact for pregnant women with OUD, obstetricians play a central role for patients throughout pregnancy and are best positioned to involve other providers.
  - *Obstetric social workers:* All obstetric practices interviewed have access to social workers who support patients with SUDs. These clinicians are essential for meeting patients' social service needs and often serve as the bridge to pediatrics.
  - *Hospitalist pediatricians:* Increasingly, NAS is managed on pediatric hospital floors rather than in the NICU. As such, pediatric hospitalists manage the vital first days of care for SEN.
  - *Primary care pediatricians:* After a newborn is discharged from the hospital, their community primary care pediatrician becomes the point person for the baby's care and the optimal person to coordinate the plan of safe care.
  - *Addiction treatment providers:* Mother's retention in addiction treatment is arguably the most important factor affecting the baby's health during pregnancy and after birth. As such, addiction treatment providers who offer evidence-based medication-assisted treatment (MAT) are essential collaborators.
  - *Adult primary care physicians:* As the longitudinal medical care providers for pregnant and postpartum women with SUDs, primary care physicians bring an essential perspective on the patient's care and offer continuity over time.
  - *Obstetric nurses:* Obstetric nurses often perform initial screening for SUDs and are a key point of continuity for patients and providers.
  - *Emergency department (ED) providers:* For some pregnant women with OUD, the ED may be their main point of care. In such cases, ED providers have an opportunity to work with the patient to improve the safety of the home.
  - *Mental health providers:* 30% of women with SUDs have co-occurring psychiatric illness, and treatment of their mental illness is essential for the health and safety of the baby.

- *Department of Children and Families (DCF):* Under state law, DCF must be notified of every case of SEN, playing an important role in assessing the safety of the home at the time of delivery and sometimes implementing their own plans for the safety of the infant.
- *Early Intervention:* Early intervention providers are key to assuring healthy childhood development and should be included in the postnatal aspects of Plans of Safe Care.

## **Recommendations**

### *Expand access to care*

1. Expand MCPAP for Moms to guarantee accelerated access to psychiatric care for pregnant women with SUD
2. Ensure access to MAT providers across the Commonwealth
3. Support emergency department induction of buprenorphine
4. Help obstetric practices set up in-office MAT programs
5. Address gaps in care of incarcerated pregnant women with substance use

### *Increase availability of social programs for mother-infant dyad*

6. Increase available housing for homeless pregnant and postpartum women
7. Support expansion of obstetric social work

### *Provide financial resources*

8. Reimburse providers for time spent developing Plans of Safe Care
9. Allocate funding towards full spectrum of care for mother-infant dyad

### *Facilitate communication across providers*

10. Initiate DCF involvement prenatally
11. Obtain early release of patient information from MAT treatment providers prior to birth

### *Improve evidence-based practices*

12. Use NIDA Quick Screen to screen all expectant mothers for substance use disorder
13. Need inpatient SUD treatment centers that will take mom with baby
14. Strengthen evidence-based guidelines for filing 51a



## The Opioid Epidemic and Substance-Exposed Newborns in Massachusetts

Amidst a nationwide epidemic of opioid use disorder (OUD) and opioid overdoses, Massachusetts remains among the hardest-hit states. In 2017, 1,977 people died of opioid overdoses in Massachusetts.<sup>1</sup> OUD is widely regarded in the medical community as a chronic, relapsing illness that can often be managed with medication-assisted treatment (MAT) using either buprenorphine or methadone. Further background information on OUD is available in the appendix.

Unfortunately, the rise in OUD has not spared women of childbearing age, including during pregnancy. Nationally, maternal opiate use in pregnancy has also increased from 1.19 per 1000 births in 2000 to 5.63 in 2009, with 60% of these mothers covered by Medicaid.<sup>2</sup> Chronic opioid use during pregnancy increases risk for multiple obstetric complications. These risks are substantially increased in women using nonprescribed opioids, and treatment of OUD with MAT is considered the standard of care during pregnancy.<sup>3</sup>

Neonatal abstinence syndrome (NAS), a syndrome of withdrawal from either prescribed opioids (e.g. for MAT or pain management) or nonprescribed opioids (e.g. heroin, fentanyl, or oxycodone), is an expected complication in newborns chronically exposed to opioids during pregnancy. The rate of NAS in Massachusetts has risen from 169 cases in January 2015 to 211 in September 2017.<sup>4</sup> Of note, all infants born with NAS - and, in fact, all SEN in general - must be reported to DCF by filing a "51A" report.

Infants born with NAS are at increased risk for neurodevelopmental issues in early childhood.<sup>5</sup> Notably, rigorous study has demonstrated that the gap between children born with NAS and non-SEN children can be entirely explained by home environment in early childhood - it appears there are no meaningful effects due solely to opioids themselves. *This presence of this identifiable risk factor (OUD) that signals potential for preventable harm (unsafe home environment) presents a significant opportunity for intervention.*

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<sup>1</sup> "Current opioid statistics." *Commonwealth of Massachusetts*, Feb. 2018, <https://www.mass.gov/lists/current-opioid-statistics>. Accessed: March 26, 2018.

<sup>2</sup> Patrick, Stephen W., et al. "Neonatal abstinence syndrome and associated health care expenditures: United States, 2000-2009." *Jama* 307.18 (2012): 1934-1940.

<sup>3</sup> Committee on Obstetric Practice. "Committee Opinion No. 711: Opioid Use and Opioid Use Disorder in Pregnancy." *Obstetrics and gynecology* 130.2 (2017): e81.

<sup>4</sup> "Governor's Working Group on Opioids Update: Action Items" *Commonwealth of Massachusetts*, Nov. 14, 2017, <https://www.mass.gov/files/documents/2017/11/15/2017-annual-update-action-items-gov-working-group.pdf>. Accessed: February 20, 2018.

<sup>5</sup> Hunt, Rod W., et al. "Adverse neurodevelopmental outcome of infants exposed to opiate in-utero." *Early human development* 84.1 (2008): 29-35.

## **Interagency Task Force on Neonatal Abstinence Syndrome**

Massachusetts has responded to the rising rate of NAS with multiple efforts. Through the fiscal year 2017 budget<sup>6</sup>, the legislature created the Interagency Task Force on Neonatal Abstinence Syndrome. This group was tasked with creating a State Plan for coordination of care and services for newborns with NAS and SEN, with strategies for collecting data, developing outcome goals, and ensuring quality service delivery to those newborns. In pursuit of this goal, the Task Force chronicled in its March 2017 report<sup>7</sup> an inventory of over 75 existing services for families with SEN, made over 60 recommendations for the Commonwealth, and published the aforementioned plan for the state.

## **SAMHSA Policy Academy on Improving Outcomes for Pregnant and Postpartum Women with SUD**

Massachusetts was also one of ten states selected to participate in a 6-month Policy Academy through the Substance Abuse and Mental Health Services Administration (SAMHSA). This team developed an action plan encompassing the development of Plans of Safe Care as well as operationalizing the Task Force's report.

## **Neonatal Quality Improvement Collaborative (NeoQIC)**

The Commonwealth is also fortunate to have a voluntary organization of newborn providers, the Neonatal Quality Improvement Collaborative (NeoQIC), which has dedicated part of its efforts to improving care for SEN. NeoQIC issued a survey to hospitals across the Commonwealth regarding care for SEN. Key results from this survey are summarized on the following page.

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<sup>6</sup> Fiscal Year 2017 Budget, Outside Section 171: <https://malegislature.gov/Budget/FY2017/FinalBudget>

<sup>7</sup> Interagency Task Force on Neonatal Abstinence Syndrome Final Report, Commonwealth of Massachusetts, March 17, 2017.

## NeoQIC Survey Results

The Neonatal Quality Care Improvement Collaborative of Massachusetts (NeoQIC) administered a survey to hospitals across the Commonwealth to assess practice patterns related to the care of pregnant women and new mothers with substance use disorder and substance-exposed newborns. Representatives of 29 hospitals completed the survey; responses have been de-identified to preserve the anonymity of responding hospitals.

We conducted original analysis of the survey data, which revealed the following:

### **1. Screening practices vary widely and few prenatal providers use standardized, validated tools**

Less than half (45%) of respondents indicated that the primary obstetrics practice affiliated with their hospital has written policies or guidelines regarding verbal screening for substance abuse during pregnancy. Even fewer (35%) indicated that the aforementioned practices use a standard validated screening tool for verbal screening of pregnant women. A similar fraction (38%) of hospitals indicate having a standardized tool for screening pregnant women for substance abuse around the time of delivery.

These findings suggest that there may be important gaps in screening of pregnant women for substance use issues and that screening can be improved by adoption of validated, standardized screening tools.

### **2. Patients may benefit from increased access to MAT services in prenatal practices**

55% of respondents indicate that affiliated obstetrics providers find it “very easy” or “fairly easy” to find available services for referral to a medication-assisted treatment program. More than half of these providers refer mothers with MAT needs to outside providers, either to an off-site MAT provider (45%) or to a provider directly associated with the OB provider’s prenatal practice (7%). However, 21% of prenatal providers have no MAT options readily available. Just 14% of respondents indicate that OB or non-OB providers trained in MAT are available within affiliated prenatal care practices.

These findings demonstrate that when pregnant women screen positive for opioid use, some prenatal providers may struggle to connect them with medication-assisted treatment (MAT) resources. Given that so few prenatal providers have MAT services directly associated with their practices or available within their practices, one important strategy may be to increase the availability of providers trained in MAT within prenatal care practices.

### **3. Few hospitals provide induction of MAT services for hospitalized women**

For hospitalized pregnant women or new mothers with documented substance use, 52% of hospitals indicate that they “almost always” or “often” provide referral to a medication-assisted treatment (MAT) program. Most hospitals (59%) find it “very easy” or “fairly easy” to refer hospitalized women to MAT services; no hospitals reported finding it “very difficult”. However, just 17% of hospitals report “almost always” or “often” providing induction of medication-assisted treatment for pregnant women with illicit drug use while the mother is hospitalized; 52% of hospitals report “rarely” providing induction of MAT.

Hospitals may consider increasing their capacity to provide induction of MAT for hospitalized women near the time of discharge.

#### **4. Referral to behavioral health providers and peer support services is challenging**

Compared with 55% of respondents indicating that affiliated obstetrics providers find it “very easy” or “fairly easy” to refer patients to medication-assisted treatment services, just 34% report that it is similarly easy for prenatal providers to refer such patients to behavioral health providers. Even fewer (31%) report that it is similarly easy for prenatal providers to refer such patients to recovery coaches/peer support services. Hospitals themselves also find it challenging to refer inpatient pregnant women or new mothers for these services. While about half (48%) of hospitals report that it is “very easy” or “fairly easy” to find available services for referral to a behavioral health provider while the mother is hospitalized, just 28% of hospitals reported finding it “very easy” or “fairly easy” to identify services for referral to a recovery coach.

These findings suggest that while prenatal providers and hospitals have some success referring patients to medication-assisted therapy services, they find it more challenging to refer patients to the behavioral health and peer support services that are also critical for recovery.

#### **5. Hospitals may benefit from standardized assessment tools for 51A report filing**

41% of hospitals report using a standardized tool or assessment for used to determine need for completion of a 51A report to the Department of Children and Families. Given the sensitivity of this issue for providers and families and the ambiguity that often faces providers who must determine whether or not to submit a 51A report, all parties involved may benefit from employment of a standardized assessment tool.

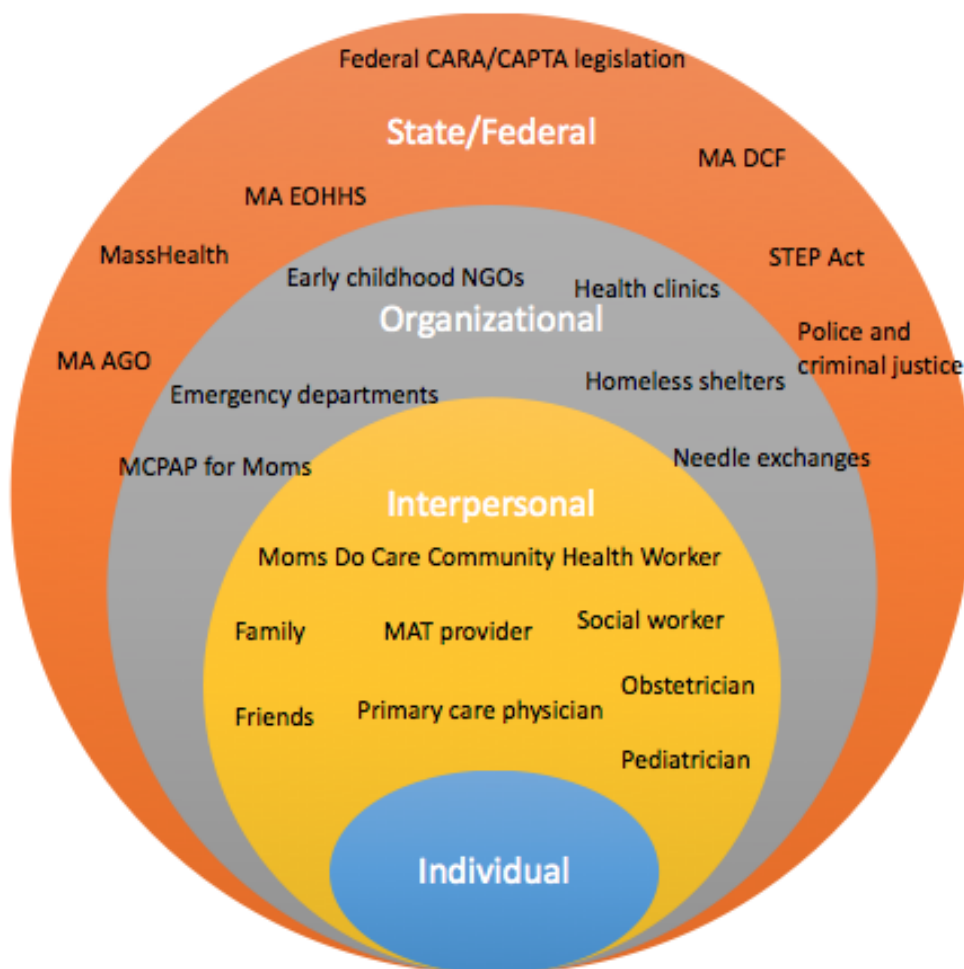
#### **Limitations**

One important limitation is that these data are self-reported and therefore may be less reliable than objective measures such as chart reviews. Further, the data regarding prenatal practices is reported on a second-hand basis, as hospital providers reported practices of their affiliated prenatal providers. As such, the reported data may not accurately reflect those practices. Nonetheless, we believe these findings provide an important view of practices across the Commonwealth regarding the care of pregnant women and new mothers with SUD.

## Theoretical Framework

The complexity of the Plans of Safe Care process necessitates a theoretical framework to ensure effective utilization and coordination of resources. Specifically, mothers with opioid use disorder and their infants are connected to a variety of actors who must be involved in the Plan of Safe Care. Beyond these individual and institutional actors are legislative forces, such as CARA and CAPTA, that dictate the general direction that interactions with these actors must take.

We choose to map this network of forces using the ecological model. The ecological model is a staple in social science for representing tiers of forces influencing an individual. In this case, the model is helpful in representing the layers of influences on pregnant and postpartum women with SUDs and their infants. In crafting Plans of Safe Care, many of these people and institutions can serve as resources, comprising integral components of the plan.



At the center of the diagram is the **individual**, who in this model represents both pregnant and postpartum women with SUDs as well as well as their newborn children.

The most proximate level of influence is **interpersonal**, with many of these individuals having relationships not only with family and friends but also with physicians, social workers, and peer health workers such as the peer coaches offered by Moms Do Care. We have deliberately selected the interpersonal level as the level at which Plans of Safe Care are developed, as these are the providers closest to and most trusted by patients with substance use disorders. Communication among providers at this level is essential for successful Plans of Safe Care implementation.

At the **organizational** level, a variety of institutions are listed that are integral to our recommendations for implementing Plans of Safe Care. MCPAP for Moms, which connects pregnant and postpartum women with SUDs to mental health care, is key to recommendation #1. Emergency departments are core to recommendation #3. And, early childhood services organizations are necessary for recommendation #9.

Finally, at the **state and federal** level, various institutions and policies touch these families, including the federal legislation (CARA and CAPTA) that mandate Plans of Safe Care, the Commonwealth's Substance Use Treatment, Education and Prevention (STEP) Act, and state-level entities including the Executive Office of Health and Human Services (EOHHS), the Attorney General's Office (AGO), the Department of Children and Families (DCF), and MassHealth, the Massachusetts Medicaid program. Coordination with these entities is essential for effective Plans of Safe Care implementation. For instance, MassHealth is integral to recommendation #8, DCF is part of #10 and #14, and the Department of Corrections and state police are key to recommendation #5.

## Federal Mandate

In response to the growing opioid epidemic, President Obama signed into law the Comprehensive Addiction and Recovery Act (CARA) on July 22nd, 2016. This legislation aimed to address the opioid crisis in America by organizing a response across agencies that concentrates on prevention, treatment, recovery, law enforcement, criminal justice reform, and overdose reversal. Title V of this legislation focuses on addiction and treatment services for women and families. Specifically, this title aims to improve treatment for pregnant and postpartum women, requires the Government Accountability Office to report on Neonatal Abstinence Syndrome (NAS) in regards to prevalence, treatment, costs, and recommendations for improvements, and develop infant Plans of Safe Care.

The CARA act amended the key federal legislation covering child abuse and neglect, Child Abuse and Protection Treatment Act (CAPTA). These amendments require that all states receiving funding through CAPTA grants develop a Plan of Safe Care for infants born and identified as being affected by substance use or withdrawal or fetal alcohol disorder. The plan of safe care needs to address the health and wellbeing of the infant as well as the affected family/caregiver. The plan of safe care recognizes that in order to support infants with substance exposure, services must be directed not only for the infant at the point of delivery but at the mother as well. Such services include mental health, parenting services, substance use prevention and treatment, and counseling, and referral to early intervention. The plan of safe care functions to provide services to the mother/infant dyad rather than assume abuse or neglect.

The Commonwealth is tasked to develop monitoring systems of the implementation of these plans to ensure that local agencies are providing necessary services for the infant and caregiver. It must also describe which agency or entity is responsible for developing a Plan of Safe Care and how follow up is conducted to guarantee safety of these infants. The U.S. Department of Health and Human Services (HHS) will be monitoring State's compliance with the development of Plans of Safe Care.

## Policy Question

The key policy question our report seeks to answer is:

*How can the Commonwealth meet the federal mandate and best develop a Plan of Safe Care that supports substance exposed infants and their families?*

In order to properly address this question, the following sub-questions were examined, and they are addressed through the the findings and recommendations of this report:

- Which hospitals are currently implementing best practice models to support women with substance use disorders and their infants?
- What are the barriers for other hospitals preventing implementation of best practices?
  - What is the role of the Commonwealth in overcoming these barriers?
- What are the roles of other state agencies within the development of Plans of Safe Care, and how can they best be integrated?
- What policies can promote the creation and integration of best practices across the Commonwealth?

To evaluate these questions, we obtained qualitative data from clinical leadership and frontline providers across the state in order to better understand the current landscape surrounding institutional policies and state resources to support these mothers and infants.



## Methodology

### Literature Review

We conducted an in-depth review of scientific literature related to issues of substance use disorder and neonatal abstinence syndrome. These materials provided insights on risks and outcomes for mothers and infants, and best practices for screening and treatment. We also reviewed state and federal legislation to understand the legal and policy issues relevant to the problem.

### In-Depth Interviews

We conducted in-depth qualitative interviews with providers across the spectrum of pre- and postnatal care at 12 hospitals across the Commonwealth of Massachusetts. 4 were academic hospitals and 8 were community hospitals. We sampled hospitals from each of seven geographic regions previously defined by the Commonwealth's Interagency Task Force on Newborns with Neonatal Abstinence Syndrome. Hospitals were chosen to obtain a representative sample across multiple axes, including socioeconomic diversity among patients (approximated using Medicaid payer mix by hospital), acuity of neonatal care units, and geographic region. In total we interviewed 31 providers. There were 8 social workers, 6 pediatricians, 3 nurse coordinators, 7 neonatologists, 2 NICU department chairs, and 5 obstetricians interviewed.

### Qualitative Interview Analysis

After compiling interview data, we analyzed them for common themes. Several major themes emerged, including issues related to screening, availability of resources, coordination of services, key stakeholders, and recommendations. We incorporated each of these themes into key findings and policy recommendations as well as into the development of a proposed Plan of Safe Care.

### NeoQIC Data Analysis

The Neonatal Quality Improvement Collaborative of Massachusetts (NeoQIC) is a voluntary organization of newborn health care providers in Massachusetts working to improve outcomes for mothers and infants in Massachusetts through the open sharing of practices and data. In September 2017, NeoQIC administered a practice survey to hospitals across the state assessing their practices related to mothers with substance use disorder and substance-exposed newborns. We were provided access to the raw survey data and conducted an original analysis thereof.

## **Case Studies: Boston-area and Cape/Islands**

We compiled two case studies that model existing supports in a given region of the state and how a Plan of Safe care might be implemented. We chose the greater Boston metro area and the Cape to illustrate how a Plan of Safe care implementation might look in an urban area as well as in a rural area. These case studies are available in the Appendix.

## Key Findings

Prior to making recommendations based on our investigation, it is important to review some key findings that underpin the recommendations. Through interviews with diverse providers at hospitals across the state, we developed an understanding of the **spectrum of clinical practice variation** in caring for mothers with SUD and infants with SEN. Some clearly identifiable best practices emerged that are important to highlight. We also identified areas of **breakdown in care pathways** in practice with respect to MAT, mental health care, and DCF involvement. Additionally, our research revealed **key principles** - that the health of the baby depends on the health of the mother, and that earlier intervention is better - that will become the platform for our PSC recommendations. Finally, we defined the spectrum of **providers to involve in crafting and implementing PSC** for these patients.

### Spectrum of practice variation

There is considerable practice variation clinically in terms of care pathways for pregnant and postpartum women with opioid use disorder (OUD) and their newborn children. In broad strokes, all hospitals interviewed have the following components: (1) intake with obstetric nurse, (2) prenatal visits with obstetrician, (3) referral to obstetric social work for all patients with SUD, (4) a mechanism for pediatricians to view the obstetricians' health records, (5) in-house treatment of NAS with most babies ultimately cared for on the pediatrics unit with mother rooming-in after she is discharged from the obstetrics unit, (6) DCF referral and evaluation of all families prior to hospital discharge, (6) primary care pediatrician (PCP) appointment set up prior to discharge with a discharge summary sent to the PCP.

Some hospitals notably went beyond this process with additional measures for these patients. In general, hospitals in regions most affected by the opioid epidemic had more robust programs in place. Additional features offered by some hospitals included:

- Enrolling patients in a specialized program based at the hospital for pregnant women with SUDs that pairs them with a peer coach and offers more robust social service support, integrated MAT, and routine drug screening throughout pregnancy. This is exemplified in Project RESPECT at Boston Medical Center, The Empower Project at Baystate, and the Green Clinic at UMass Memorial. More information on these programs is available in the appendix.
- Linking patients to Moms Do Care, a program which offers a peer coach (a mother in recovery whose child had NAS; many of whom lost and later regained custody of their children), increased social support and social services for women with OUD throughout pregnancy and for several months after delivery. Moms Do Care is available for patients delivering at Cape Cod Hospital, UMass Memorial Hospital, Lowell General Hospital, and Beverly Hospital.
- Arranging a prenatal tour of the labor and pediatrics units to meet with social workers and hospitalist pediatricians about the process of delivering a baby with NAS and preparing the mother for next steps

- Providing information about NAS, DCF referral, and other aspects of pregnancy with OUD through a patient education app available to all obstetric patients of the hospital
- A postnatal clinic tailored specifically to families with SEN. This clinic cares for the mother-baby dyad and offers integrated MAT and social work services.

Among hospitals interviewed, we identified best practices at Boston Medical Center, where pregnant women with OUD are immediately enrolled in Project RESPECT, which offers a peer coach, early social work involvement, and connection with pediatricians during pregnancy. After delivery, the mother-baby dyad is enrolled in SOFAR clinic, a specialized clinic with continued social service involvement.

### **Breakdown in Care Pathways**

#### *Varied access to MAT, with inpatient services universally lacking*

Interview respondents varied in their concern about access to MAT as a barrier to care for pregnant and postpartum women with SUD. In general, areas with higher prevalence of OUD had easier access to MAT, such as on Cape Cod, in the Boston area, and in certain parts of central and western Massachusetts. Other areas reported more difficulty accessing MAT, particularly on the south shore. Additionally, there was variation in the quality of MAT services, from providers that only prescribed medication without ensuring access to counseling, to organizations such as the Duffy Center on Cape Cod, which offers a spectrum of wraparound services and communicates closely with obstetric and other care providers.

Across the Commonwealth, respondents expressed concern about lack of access to inpatient treatment services for postpartum women with their child. As part of their care plan with DCF, some women agree to undergo inpatient treatment for their SUD in the immediate postpartum period. However, very few facilities allow those patients to remain with their children while inpatient, meaning that they are separated from their child for up to a month (or more) in the immediate postpartum period. This is destabilizing both for mother and child and reduces chances of a positive outcome.

#### *Uniform lack of access to mental health resources*

Hospitals across the Commonwealth also reported inadequate access to mental health resources, particularly psychiatry. Studies have reported that the prevalence of depression may be over 30% in patients with SUDs, and postpartum depression occurs in 40% of women with OUD. Robust literature highlights the importance of treating co-occurring mental illness with SUD in order to achieve stable recovery. However, many providers' top concern was difficulty finding psychiatrists and other mental health professionals to care for these patients. Some reported several months' wait in order to get a psychiatric appointment for a pregnant patient with an SUD.

Of note, MCPAP for Moms is a statewide initiative which attempts to fill this gap. However, providers note that the volume of patients is too great to meet the capacity of psychiatric providers in the Commonwealth, despite this service.

#### Integrated communication, except with DCF

Providers in general reported excellent communication within medical care teams, from obstetrics to social work, hospital pediatrics, *community pediatrics*, and *MAT providers*. However, many expressed concern about a breakdown communication with DCF when they became involved after delivery. There was concern about opacity in DCF's decision-making about a patient, insufficient communication with the care team about custody decisions, and norms about patient privacy that conflicted with medical ethics. In particular, providers were concerned that MAT providers sometimes did not comply quickly enough with DCF's request for information about a patient's treatment within 24 hours, leaving DCF with the impression that a patient was not in treatment even if they were stable on MAT.

### **Key Principles**

#### The health of the baby depends on the health of the mother

Interviewees corroborated a robust literature demonstrating that the health of infants depends on the health of their mothers, both during and after pregnancy. This is particularly true for pregnant women with OUD, for whom relapses during pregnancy or in the postpartum period can have dramatic effects on the health and safety of their child.

#### The earlier the better

Universally, interviewees felt that the time of delivery was too late to initiate a Plan of Safe Care. The earliest time suggested by a provider was pre-conception - essentially, that all women of childbearing age with OUD should routinely be having conversations with providers about the possibility of pregnancy and their goals of care. From the social work perspective, the more time that they have to identify and address patients' psychosocial needs, the better. Additionally, the sooner that primary care and obstetric providers can start working toward stable recovery for their SUD, the greater the chances of a healthy pregnancy and delivery of the child into a safe home.

### **Providers to Involve in Plans of Safe Care**

In order for Plans of Safe Care to be effective, a diversity of providers must be at the table. Some clinicians are fundamental, whereas others' involvement varies on a case by case basis. The Plans of Safe Care document must be crafted in a way that facilitates the incorporation of each of these providers, as needed.

## Essential providers:

- *Obstetricians:* Often the first point of contact for pregnant women with OUD, obstetricians play a central role for patients throughout pregnancy and are best positioned to involve other providers.
- *Obstetric social workers:* All obstetric practices interviewed have access to social workers who support patients with SUDs. These clinicians are essential for meeting patients' social service needs and often serve as the bridge to pediatrics.
- *Hospitalist pediatricians:* Increasingly, NAS is managed on pediatric hospital floors rather than in the NICU. As such, pediatric hospitalists manage the vital first days of care for SEN.
- *Primary care pediatricians:* After a newborn is discharged from the hospital, their community primary care pediatrician becomes the point person for the baby's care and the optimal person to coordinate the plan of safe care.
- *Adult primary care physicians:* As the longitudinal [WJB3] medical care providers for pregnant and postpartum women with SUDs, primary care physicians bring an essential perspective on the patient's care and offer continuity over time.
- *Department of Children and Families (DCF):* Under state law, DCF must be notified of every case of SEN, playing an important role in assessing the safety of the home at the time of delivery and sometimes implementing their own plans for the safety of the infant.

## Case by case basis:

- *Addiction treatment providers:* Mothers' retention in addiction treatment is arguably the most important factor affecting the baby's health during pregnancy and after birth. As such, addiction treatment providers who offer evidence-based medication-assisted treatment (MAT) are essential collaborators for patients with treatable substance use disorders.
- *Obstetric nurses:* Obstetric nurses often perform initial screening for SUDs and are a key point of continuity for patients and providers.
- *Mental health providers:* 30% of women with SUDs have co-occurring psychiatric illness, and treatment of their mental illness is essential for the health and safety of the baby.
- *Emergency department (ED) providers:* For some pregnant women with OUD, the ED may be their main point of care. In such cases, ED providers have an opportunity to work with the patient to improve the safety of the home.

## Recommendations

### Core Components of a Plan of Safe Care

We recommend that a Plan of Safe Care be developed based on five evidence-based functional goals. If each of the goals is achieved, the infant will have the best possible chance at health and safety. In each functional category, we detail the evidence in support of this goal, based on interviews and review of the medical literature. We also specify plans that should be developed to meet this goal and the relevant providers to involve.

#### Maternal addiction recovery

*Goal:* Every pregnant and postpartum woman with an SUD has the best possible chance of being in recovery during pregnancy and after delivery.

*Evidence:*

- Untreated OUD during pregnancy is associated with increased risk of poor engagement in prenatal care, poor fetal growth, fetal death, and preterm labor, among other obstetric complications.<sup>8</sup>
- Untreated SUD is also associated with high-risk activities such as prostitution and criminal activities which can expose women to sexually transmitted illnesses, violence, and legal consequences which may include loss of child custody or incarceration<sup>9</sup>.
- For patients with OUD, MAT with either methadone or buprenorphine has been demonstrated to reduce obstetric complications<sup>10</sup>. This is recommended by the American College of Obstetrics and Gynecology instead of opioid detoxification during pregnancy.
- Importantly, relapse is more common in the postpartum period than during pregnancy, so recovery must be prioritized both before and after delivery in a longitudinal plan<sup>11</sup>.
- For the >30% of patients with co-occurring SUD and mental illness, addiction recovery depends on addressing the patient's mental health as well<sup>12</sup>.

*Plans:*

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<sup>8</sup> Center for Substance Abuse Treatment. Medication-assisted treatment for opioid addiction during pregnancy. In: Medication-assisted treatment for opioid addiction in opioid treatment programs. Treatment Improvement Protocol (TIP) Series, No. 43. Rockville (MD): Substance Abuse and Mental Health Services Administration; 2005. p. 211–24.

<sup>9</sup> Committee on Obstetric Practice. "Committee Opinion No. 711: Opioid Use and Opioid Use Disorder in Pregnancy." *Obstetrics and gynecology* 130.2 (2017): e81.

<sup>10</sup> Jones HE, Martin PR, Heil SH, Kaltenbach K, Selby P, Coyle MG, et al. Treatment of opioid-dependent pregnant women: clinical and research issues. *J Subst Abuse Treat* 2008;35:245–59

<sup>11</sup> Gopman S. Prenatal and postpartum care of women with substance use disorders. *Obstet Gynecol Clin North Am* 2014;41:213–28.

<sup>12</sup> Holbrook A, Kaltenbach K. Co-occurring psychiatric symptoms in opioid-dependent women: the prevalence of antenatal and postnatal depression. *Am J Drug Alcohol Abuse* 2012;38:575–9.

- Obstetricians should ensure that patients with SUDs who present for prenatal care are engaged in evidence-based treatment (i.e. with MAT in the case of OUD). If not, a referral should be made as soon as possible.
- Addiction treatment providers should document the plan for addiction treatment during and after pregnancy in the Plan of Safe Care.
- Any providers who come in contact with patients who are not engaged in addiction treatment or prenatal care - including emergency department providers, mental health providers, and primary care physicians - should make every effort to engage the patient in addiction treatment and document this in the Plan of Safe Care.
- Primary care, obstetrics, and social work providers should screen all patients for mental illness. Those requiring referral to specialized mental health resources such as psychiatry should have those providers document a plan for treatment integrated with addiction recovery in the Plan of Safe Care.

### **Social stability for the family**

*Goal:* The social needs of pregnant and postpartum women and primary caregivers are met as early in pregnancy as possible, including both basic needs such as housing and transportation, as well as core support systems.

#### *Evidence:*

- Despite the proven benefits of MAT and other evidence-based addiction treatment, patients with unstable social situations have been demonstrated to face risk of relapse due to the anxiety of unemployment, homelessness, criminal justice involvement, or family instability.<sup>13</sup>
- Addressing patients' social needs has been shown to improve rates of successful recovery.<sup>1415</sup>
- The American College of Obstetrics and Gynecology states that patients should be given "access to adequate postpartum psychosocial support services," and that "preventive interventions that focus on supporting the woman and other caregivers in the early and ongoing parenting years, enriching the early experiences of children and improving the quality of the home environment are likely to be beneficial."<sup>16</sup>
- Numerous scientific studies have demonstrated that developmental outcomes in children of mothers with OUD are attributable entirely to environment, not intrinsic biological factors.<sup>17</sup>

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<sup>13</sup> Laudet, A., & White, W. L. (2010). What are your priorities right now? Identifying service needs across recovery stages to inform service development. *Journal of Substance Abuse Treatment*, 38, 51-59.

<sup>14</sup> United Nations, Office on Drugs and Crime. (2002). *Contemporary drug abuse treatment: A review of the evidence base*. Retrieved from <https://www.unodc.org>.

<sup>15</sup> The National Center on Addiction and Substance Abuse at Columbia University. (2012). *Addiction medicine: Closing the gap between science and practice*. New York

<sup>16</sup> Committee on Obstetric Practice. "Committee Opinion No. 711: Opioid Use and Opioid Use Disorder in Pregnancy." *Obstetrics and gynecology* 130.2 (2017): e81.

<sup>17</sup> Ornoy, A. "The impact of intrauterine exposure versus postnatal environment in neurodevelopmental toxicity: long-term neurobehavioral studies in children at risk for developmental disorders." *Toxicology letters* 140 (2003): 171-181.



- Collaborative social service provision entities, such as the CHARM (Children and Recovering Mothers) Collaborative in Burlington, Vermont, have increased maternal engagement in MAT, improved children’s developmental outcomes, and increased retention of children in maternal custody.<sup>18</sup>
- Specifically, housing and transportation are major barriers to stable recovery for patients in Massachusetts. Several interviewees expressed concern about unstable transportation impairing pregnant and postpartum women’s ability to attend prenatal visits and get to the methadone clinic each day. Additionally, homeless women with OUD who are pregnant or have a newborn face additional barriers to attaining safe housing.

*Plans:*

- Social workers should be involved in the pregnant patient’s care as early as possible and document detailed plans and linkages to community-based resources.
- Patients should be supported in engaging with social work, particularly during pregnancy, including offering transportation support and more intensive outreach if possible
- Housing and transportation pose particular barriers that must be addressed specifically in the Plan of Safe Care. Pregnant and postpartum women would benefit from additional state resources and innovative interventions in this area.
- The Plan of Safe Care should help prepare pregnant women for the eventual DCF case by documenting the domains that DCF is interested in and a plan to achieve a positive outcome. DCF should be provided with the Plan of Safe Care document at the time it makes its judgment and offered to participate in constructing the Plan of Safe Care.

## **Healthy fetal development and delivery**

*Goal:* Substance-exposed fetuses will develop in the healthiest *in utero* environment possible and undergo the appropriate screenings and treatments to facilitate a healthy delivery.

*Evidence:*

- Interviewees stated that engagement in prenatal care is essential for the baby’s health after birth.

*Plans:*

- The Plan of Safe Care should include documentation from obstetric providers on shared goals with the patient to achieve a healthy pregnancy.
- Obstetric social workers should document plans made with the patient to address potential barriers to achieving these goals for healthy pregnancy.

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<sup>18</sup> Substance Abuse and Mental Health Services Administration. *A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders*. HHS Publication No. (SMA) 16-4978. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016. Available at: <http://store.samhsa.gov/>.

- Emergency department providers should be attentive to pregnant women with SUD who are not engaged in prenatal care and involve social work resources in order to support the patient in initiating prenatal care.

### **Healthy infant development**

*Goal:* Substance-exposed newborns have a smooth transition from hospital care into care at home, with attentive care providers at home, close medical follow-up, and appropriate social services for development support.

*Evidence:*

- Interviewees emphasized the importance of a prenatal visit between the patient, social work, and hospitalist pediatricians to build rapport with the pediatric team and prepare the family for challenges at the time of delivery, including DCF intervention and NAS.
- Interviewees identified the transition from hospital to home as a high-risk time for neonates with close medical surveillance being an important part of ensuring the baby's health.

*Plans:*

- A prenatal visit should be arranged for the pregnant patient with an obstetric social worker and a hospitalist pediatrician, at which each of those providers should discuss plans for hospital care and the transition to care at home. Goals from this conversation should be documented in the Plan of Safe Care.
- Hospitalist pediatricians should specifically document in the Plan of Safe Care a conversation with the community pediatrician, transmission of the hospital discharge summary to the community pediatrician, and consideration of home visiting nursing services to support the initial transition to home.
- Community pediatricians should be comfortable with the Plan of Safe Care prior to the infant's hospital discharge and add details about planning for medical and social service care coordination for the infant early in the infant's care.
- Obstetric social workers should either document a plan for connecting the infant to appropriate social services, such as early intervention, or transition care to a pediatric social worker who can assume responsibility for these components.

## **Recommendations for Resources and Programming**

If each of the Plans of Safe Care goals outlined above is achieved, a substance-exposed newborn should have a strong chance at having a safe and healthy beginning to its life. Unfortunately, patients are not always able to achieve these goals due to resource constraints. Additionally, we have identified ways to achieve these goals more successfully through innovative state programming. In this section we offer recommendations for those resources and programs, rooted in evidence and often in comparison to programs in other states. Our recommendations are organized according to five themes: (1) Expand access to care; (2)

Increase availability of social programs for mother-infant dyad; (3) Provide financial resources; (4) Facilitate communication across providers; (5) Improve evidence-based practices.

### *Expand access to care*

#### **1. Expand MCPAP for Moms to guarantee accelerated access to psychiatric care for pregnant women with substance use disorders**

##### *Problem:*

- Patients with psychiatric comorbidities will not be able to fulfill the “addiction recovery” goal in the Plan of Safe Care without access to appropriate mental health services.
- MCPAP for Moms was created to fill this gap, but capacity is limited and many patients are not being served fully.

##### *Evidence:*

- A major theme among interview responses was lack of access to mental health services. Some respondents specifically cited that they had attempted to work with MCPAP for Moms but were not able to achieve the desired results.
- According to the Massachusetts Department of Health, 82% of mothers with an opioid-related overdose during pregnancy or the first year postpartum had a diagnosis of depression during the study period.

##### *Recommendation:*

- Double the annual budget for MCPAP for Moms in order to meet a statewide need for increased mental health services in pregnancy.

#### **2. Ensure access to medication-assisted treatment providers across the Commonwealth**

##### *Problem:*

- Access to MAT is inconsistent across the state, especially in areas with *lower* incidence of opioid use disorder. High-incidence areas such as the Cape and Islands are typically well-resourced, but mothers in low incidence areas may paradoxically be under-resourced.
- Expectant mothers/new mothers in areas with insufficient access to trained MAT providers are less able to obtain needed services.

##### *Evidence:*

- Providers in high-incidence areas such as the Cape and Islands report good availability to MAT providers, while providers in areas such as the South Shore recommend increasing the supply of MAT providers.

##### *Recommendation:*

1. Identify areas across the state with low access to MAT providers.
2. Develop a statewide plan for improving access to MAT providers in lower-resourced areas.
3. Maintain a centralized repository of training opportunities for MAT providers.

### **3. Support emergency department induction of buprenorphine**

*Problem:*

- Getting more patients into addiction treatment, particularly MAT for OUD, would facilitate engagement with prenatal care and is a vital part of Plans of Safe Care. However, the resources are often not available at the time when the patient is ready.

*Evidence:*

- Several providers interviewed expressed concern about patients' unwillingness to start MAT during pregnancy if they were not already in treatment for OUD.
- Interviewees also noted that patients who do not engage in prenatal care do often get care in emergency departments for other issues, presenting an opportunity to engage them in Plans of Safe Care.

*Recommendation:*

- Work with MassHealth to incentivize emergency department physicians to offer a first dose of buprenorphine in the emergency department with a next-day appointment in an MAT clinic.

### **4. Help obstetric practices set up in-office medication-assisted treatment programs**

*Problem:*

- Certain parts of the state do not have easy, consistent access to MAT, making it difficult for pregnant and postpartum women with OUD to achieve stable recovery.

*Evidence:*

- Several providers interviewed noted that MAT is difficult to access in their geographic region. Notably, this was not across the state [WJB5], but tended to be reported more in areas less severely affected by the opioid epidemic.
- Some practices interviewed are in the process of setting up in-office MAT programs, training an obstetrician or midwife in buprenorphine prescribing so that they can start patients on MAT in the clinic.

*Recommendation:*

- Support obstetric practices in developing in-office MAT programs by helping practices with such programs serve as mentors for those that are interested, and by making buprenorphine training available to obstetric practitioners.

### **5. Address gaps in care of incarcerated pregnant women with substance use**

*Problem:*

- Pregnant women with substance use disorder are a vulnerable population that is currently underserved

*Evidence:*

- Incarcerated women are placed on methadone while they are pregnant. However, once they deliver, women no longer receive MAT. Research has shown that MAT combined with counseling is an effective way of treating substance use disorder.

- Interviewees have noted that pregnant incarcerated women with substance use disorder are at a high risk of relapse upon leaving prison. These women need to be seen by outpatient providers upon their release. However outpatient providers are unaware of their release and often do not have slots available to accommodate these patients in the timely manner they are needed to be seen.
- Incarcerated women are not allowed to breastfeed. Breastfeeding is beneficial for both mother and baby, it promotes mother-infant attachment and improved newborn immunity. Research has also shown that women on MAT that breastfeed is associated with a decrease in severity of NAS and reduced amounts of pharmacotherapy<sup>19</sup>.
- Approximately half of prison and jail inmates in the United States meet criteria for substance use disorder or dependence and at any given time roughly 10% of the women incarcerated are pregnant.<sup>20</sup> The period of incarceration presents an opportunity to treat an often difficult to reach population in a stable environment.

*Recommendation:*

- Close gaps in care for incarcerated women by:
  - Continuing MAT after delivery
  - Facilitating communication with community providers prior to release
  - Allowing incarcerated women to breastfeed if not medically contraindicated

*Increase availability of social programs for mother-infant dyad*

**6. Increase available housing for homeless pregnant and postpartum women**

*Problem:*

- Many women become pregnant while temporarily or permanently homeless; some of these women also suffer from substance use disorders
- Homelessness increases the risk for poor adherence to treatment and poor health outcomes

*Evidence:*

- Homelessness has been shown to independently exacerbate social instability
- Many interviewees express concern that homelessness may potentially increase the likelihood of noncompliance with MAT and relapse and increase barriers to consistent prenatal care

*Recommendation:*

- Boston Housing Authority should establish/expand supporting housing for homeless populations with priority for pregnant and postpartum women

**7. Support expansion of obstetric social work**

*Problem:*

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<sup>19</sup> Bagley SM, Wachman EM, Holland E, Brogly SB. Review of the assessment and management of neonatal abstinence syndrome. [Addict Sci Clin Pract 2014;9:19.](#)

<sup>20</sup> "Incarceration, Substance Abuse, and Addiction." The Center for Prisoner Health and Human Rights, [www.prisonerhealth.org/educational-resources/factsheets-2/incarceration-substance-abuse-and-addiction/](http://www.prisonerhealth.org/educational-resources/factsheets-2/incarceration-substance-abuse-and-addiction/).

- Obstetric social workers are integral to ensuring social stability in families with SEN. However, these resources tend to be limited, and the potential is not being fully realized.

*Evidence:*

- Several practices interviewed reported a no-show rate over 50% at prenatal hospital tours with social workers and pediatric hospitalists.
- At least one hospital reported a 42% rate of any engagement prenatally for pregnant patients with SUD.
- Most hospitals interviewed only have one obstetric social worker. This person tends to focus on the patients on the labor floor and has less time to spend with patients in the obstetric office.
- Interviewees also expressed concern that emergency department social workers tend to be unfamiliar with the needs of pregnant patients, meaning that there is a missed opportunity to engage with patients who are not participating in prenatal care.

*Recommendation:*

- Identify opportunities to support expansion of obstetric social work programs to have obstetric social workers located in obstetric practices and on-call for emergency department consultation. Such support could come in the form of a new grant program as a pilot, or new reimbursement levels in coordination with MassHealth.

*Provide financial resources*

**8. Reimburse providers for time spent developing Plans of Safe Care**

*Problem:*

- MassHealth does not currently incorporate a billing code that enables reimbursement specifically for Plans of Safe Care
- This disincentivizes providers from spending time on these critical activities; many providers will be unable to spend the time necessary to develop a PSC

*Evidence:*

- Providers discussed the challenge of incorporating non-reimbursed preventive health measures in general and the likelihood that the inability to bill for PSC would be a barrier to uptake by providers.

*Recommendation:*

- Advocate for an addition to MassHealth reimbursement policy that specifically allows providers to bill for PSC visits, during which most or all of the visit time will be spent on developing a PSC.

**9. Allocate funding towards full spectrum of care for mother-infant dyad**

*Problem:*

- Women with substance use disorders need a wide array of resources and supports to assist in recovery.

- There are limited resources that integrate all the pathways of care such as behavioral health, MAT providers, primary care, and peer to peer support all the way from pregnancy to the year after delivery.
- Projects such as Moms Do Care who provide full spectrum of care are grant dependent. Moms Do Care Funding expires in July 2018.

*Evidence:*

- Interviewees have emphasized the importance of the full spectrum of care from pregnancy to 12-18 months after delivery. There are more comprehensive programs for women through OB offices. However, the obstetrician often stops caring for mom six weeks after delivery, leaving mom at a vulnerable time.
- Interviewees expressed grave concerns over the lack of services and follow up provided to mom and baby after delivery due to the high risk of relapse in the 12-18 months after giving birth.
- Research has shown that women with substance use disorders relapse far more often during the postpartum period than during pregnancy.<sup>21</sup> This is a time of high stress and women are particularly vulnerable, especially if there is concerns over lack of access to health care while experiencing the demands of caring for a child.
- Treatment for substance use disorders that supports the family as a unit has been shown to promote child well-being and help prevent maternal relapse.<sup>22</sup>

*Recommendation:*

- Allocate more funding to programs that provide full spectrum of care such as Moms Do Care, Project Respect/SoFAR clinic, and Hope clinic.
- Look to expand these programs throughout the state

*Facilitate communication across providers*

**10. Initiate Department of Children and Families involvement prenatally**

*Problem:*

- DCF cannot act on a report of prenatal substance exposure until the infant is born. This misses a critical window to provide resources to mom and reduce fear of child removal from mother.

*Evidence:*

- Women are informed a 51a will be filed but do not meet DCF until after birth of child. Interviewees emphasized the stress DCF involvement causes all women throughout pregnancy.
- Research has shown that Punitive approaches for women may also have the unintended consequence of further alienating such women from seeking both obstetrical care and SUD treatment.<sup>23</sup>

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<sup>21</sup> Gopman S. Prenatal and postpartum care of women with substance use disorders. *Obstet Gynecol Clin North Am* 2014;41:213–28.

<sup>22</sup> Johnson RE, Jones HE, Jasinski DR, Sviki DS, Haug NA, Jansson LM, et al. Buprenorphine treatment of pregnant opioid-dependent women: maternal and neonatal outcomes. *Drug Alcohol Depend* 2001;63:97–103.

- Vermont, through work with the Charm Collaborative, has been able to change policies regarding timing and role of DCF involvement. Vermont Child Welfare performs a safety and risk assessment 30 days prior to a woman's due date and if indicated can begin providing supportive services to the family.
  - "CHARM Collaborative members consider provision of services by the child welfare system 30 days prior to the birth of the child to be one of the most significant and beneficial system level changes the collaborative has made"<sup>24</sup>

*Recommendation:*

- Initiate child welfare involvement prenatally - Vermont child welfare involvement can serve as a potential practice model.

## **11. Obtain early release of patient information from medication-assisted treatment providers prior to birth**

*Problem:*

- DCF requires treatment information from MAT providers in order to fully process a case. If there is a delay in receiving this information, cases can be prolonged and escalated.

*Evidence:*

- The inability to get timely information from MAT providers to DCF regarding patient's treatment adherence presented itself as a common barrier by our interviewees
- Protecting patient confidentiality is critical in substance abuse treatment and all patient information is protected under 42 C.F.R. Part 2 and all patient health information is protected under the Health Insurance Portability and Accountability Act (HIPAA).

*Recommendation:*

- Ensure all plans of safe care have written consent of release of patient information prior to birth in order to facilitate care across agencies.

### *Improve evidence-based practices*

## **12. Use NIDA Quick Screen to screen all expectant mothers for substance use disorder.**

*Problem:*

- Many women are not screened for substance use disorder at all or are not screened with evidence-based screening tools.
- As a result, many at-risk women go unidentified and do not receive the appropriate supports.

*Evidence:*

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<sup>23</sup> Mishka Terplan, Alene Kennedy-Hendricks, Margaret S Chisolm (2015), Prenatal Substance Use: Exploring Assumptions of Maternal Unfitness: Subst Abuse. 2015; 9(Suppl 2): 1–4. Published online 2015 Sep 20.

<sup>24</sup> Charm Collaborative (2014), The Children and Recovering Mothers (CHARM) Collaborative in Burlington, Vermont: A Case Study.



- Many professional obstetrics and pediatrics organizations, as well as the AMA and CDC, recommend screening for substance use disorder at the first prenatal visit and every trimester if pregnant women screen positive for past use<sup>25</sup>.
- NIDA Quick Screen is considered by experts to be sufficiently sensitive and specific for use in the prenatal setting.<sup>26</sup>
- NIDA asks about use in the past year, which patients may be more likely to respond honestly to than questions about use during pregnancy.

*Recommendation:*

- Encourage obstetric providers to incorporate substance use disorder screening into routine prenatal care.

### **13. Increase the availability of inpatient SUD treatment centers that will take mom with baby**

*Problem:*

- Inpatient substance use disorder treatment centers are not equipped to care for neonates. As a result, new mothers who require inpatient treatment soon after delivery are dislocated from their newborns for extended periods.
- This can have a destabilizing effect on mothers and compromise their recovery.
- Extended separation from mothers has also been shown to have negative impacts on newborn development.

*Evidence:*

- Many interviewees expressed concern about the absence of inpatient treatment options that can accommodate mothers with their babies.
- Interviewees expressed particular concern about the implications of separation from infants on mothers' psychological well-being and addiction recovery.

*Recommendation:*

- Develop capacity for newborn care at inpatient substance use disorder centers, potentially by providing support for centers to hire nurses trained in newborn care

### **14. Strengthen evidence-based guidelines for filing 51a**

*Problem:*

- All women who have substance use whether illegal or legal, even women stable and compliant on MAT for years, have a mandatory 51a filed on them.

*Evidence:*

- Interviewees believe that it is punitive to file a 51a on women who are established on MAT for substance use disorder for many years and consistently seeking prenatal care

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<sup>25</sup> Wright, T. E., Terplan, M., Ondersma, S. J., Boyce, C., Yonkers, K., Chang, G., & Creanga, A. A. (2016). The role of screening, brief intervention, and referral to treatment in the perinatal period. *American Journal of Obstetrics & Gynecology*, 215(5), 539-547.

<sup>26</sup> *Ibid.*

- Research regarding substance use disorder has shown that the presumption that prenatal substance use equates to poor parenting fitness is detrimental to the health of mom and baby by deterring pregnant women from seeking both prenatal care and treatment for their substance use.<sup>27</sup>
- Interviewees also expressed concern over mandated filing for positive marijuana use and expressed desire for guidance from the State regarding marijuana use as legalization has occurred.

*Recommendation:*

- Develop an evidence based decision point for who gets a 51a filed as reports of substance use (both legal and illegal) are treated the same at point of screening

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<sup>27</sup> Mishka Terplan, Alene Kennedy-Hendricks, Margaret S Chisolm (2015), Prenatal Substance Use: Exploring Assumptions of Maternal Unfitness: Subst Abuse. 2015; 9(Suppl 2): 1–4. Published online 2015 Sep 20.

## Process for Implementing Plans of Safe Care

Having detailed the providers who should be involved in creating Plans of Safe Care, the functional goals that these plans should address, and recommendations for new initiatives to achieve those goals, we now turn to implementation process. We will outline a process for finalizing the document, key principles for its use, and highlight more specific ways we anticipate the plans being used in practice.

### Finalizing the Plans of Safe Care Document

A draft Plans of Safe Care document is included in the appendix. It addresses the four functional goals specified above and incorporates the relevant providers in each section. This document should next be shared with providers across the Commonwealth to solicit their feedback. An ideal Plans of Safe Care document would have widespread support from providers across the Commonwealth and fit neatly within providers' existing practice patterns. The document should also be shared with a sample of pregnant and postpartum patients with SUD to evaluate whether the document will appropriately address their needs. After soliciting such feedback, the document should be finalized by EOHHS and the Attorney General's Office.

### Key principles for using Plans of Safe Care

As the document proceeds into implementation, four key principles should be followed:

1. The patient must be at the center of the process. Providers should only complete the document after participating in shared decision-making with patients.
2. Plans of Safe Care should not place additional burdens on patients, but rather offer additional resources. This means that Plans of Safe Care will require substantial coordination on the provider side, rather than asking patients to track down the relevant stakeholders.
3. Similarly, Plans of Safe Care should not overburden already-strained providers. MassHealth should be involved in developing reimbursement codes to compensate providers for time spent crafting Plans of Safe Care.
4. As envisioned, the Plans of Safe Care document should look very different for a person on MAT versus not, and for a patient who is engaged in prenatal care versus not. These are two major branch points in care planning and the use of the document should reflect that.

### The Plans of Safe Care document in use

We envision the Plans of Safe Care document digitized, with the relevant providers across the Commonwealth granted editing privileges to contribute to their relevant portion and view the contributions of other providers on the care team. A paper document would be substantially less effective at fulfilling the care coordination objectives of Plans of Safe Care. However, we acknowledge that there are considerable patient privacy issues to be addressed, and we

recommend that the legal teams of the Attorney General's Office (AGO) and EOHHS be involved in making sure that privacy is protected.

Providers will need to be informed of the new mandate to contribute to Plans of Safe Care. We encourage EOHHS and AGO to send a notification to all the relevant providers statewide about this mandate. We also encourage communication specifically with obstetric and pediatric department chairs at all hospitals with labor and delivery wards in the Commonwealth regarding expectations for these documents. Online resources could be developed at low cost to demonstrate usage of the digital platform.

A Plan of Safe Care should be initiated by the first provider to come in contact with a pregnant woman with an SUD. That provider should initiate communication with the relevant other providers who should contribute to the document. The plan should remain in effect until 6 months after the delivery of the newborn.

## Case Studies: Boston Metro Area, Cape and Islands

We have conducted two case studies to evaluate how Plans of Safe Care will be utilized in different regions of Massachusetts. Case study 1 is conducted in Boston, a region that has numerous hospitals and community resources, as well as programs that are implementing best practices in the care of mothers with substance use disorder and substance-exposed infants. Case study 2 is conducted in the Cape and Islands, a region that has limited resources and fewer hospitals, also with a high burden of opioid use disorder. Each case study follows a patient from prenatal care through 3 months post delivery. These case studies allow us to evaluate how a Plan of Safe Care could be utilized in order to coordinate care and services across the spectrum of care to address the needs of our patient. *The completed Plan of Safe Care for each case can be found in the Appendix.*

### **Case Example: Boston Metro Area**

#### **Low Risk Case:**

Case Study 1 follows a 27-year female who is 10 weeks pregnant. She has a history of opiate use disorder for 5 years but has been stable on buprenorphine for the past 3 years. She presents to Boston Medical Center (BMC) for prenatal care. She is seen at Project RESPECT, a clinic specifically for mothers with substance use disorders. This patient was referred to Project RESPECT by her primary care physician at BMC. As BMC is one of the leaders in the care of substance use disorder, they have well established programs for individuals with OUD and her primary care physician prescribes her buprenorphine. This patient is considered low risk as she is stable on MAT therapy and seeking prenatal care.

At the patient's first prenatal visit with project RESPECT, the PoSC is filled out by her OB, she is referred to social work, and asked to make an appointment with her MAT provider. Her social worker evaluates her needs, informs her of DCF involvement, and helps schedule a tour of the hospital for delivery.

At her appointment with her MAT provider, they discuss the plan regarding her medications throughout pregnancy and a disclosure of medical information is signed regarding treatment information to ensure DCF has access to her MAT treatment records.

Throughout pregnancy, she meets with her social worker to ensure she has stable housing, transportation, and social support and develops goals of care with her OB. She works with her to help her apply for WIC and ensure the child receives CHIP. When the patient arrives for her hospital tour, she meets with the pediatric hospitalist who completes their aspect of the PoSC after speaking with OB. The pediatrician explains NAS and sets goals of care for mom and baby.

By the time of delivery, Mom's social needs have been addressed and all of her paperwork has been sent to DCF. DCF is able to quickly evaluate her case and her baby stays within the patient's custody. A warm hand off between the hospital social workers is performed with the outpatient pediatric social workers. Both community pediatrician and social work fill out PoSC and goals for the mom and baby are established for at least 3 months after delivery.

### **High Risk Case:**

Case Study 2 follows a 27-year-old female who is 10 weeks pregnant and still using opiates. She arrives at the BMC emergency department hoping to get on maintenance therapy for this pregnancy. She comes to BMC because of the reputation established around care of pregnant women with OUD. The patient gets evaluated in the emergency department and admitted inpatient in order to be titrated on maintenance therapy. While inpatient, the patient is evaluated by an OB and a social worker from Project RESPECT. Both providers fill out the PoSC document and begin establishing care. The patient is captured on methadone while inpatient and made a next day appointment with Boston Comprehensive Treatment Center to continue methadone treatment and assigned a MAT provider. She is scheduled with a follow up appointment with the Project RESPECT clinic before being discharged.

At the follow-up clinic, the patient is found to have co-existing depression and linked with a mental health provider. This mental health provider fills out the PoSC and develops a mental health plan for pregnancy. Social work continues to evaluate patient needs and refers the patient to the Mom's Project, pairs her with a recovery coach, and begins to address social needs such as filing for housing due to unstable living conditions. The patient is informed of DCF involvement and also schedules a hospital tour.

The patient attends the Mom's Project throughout pregnancy. The Mom's Project is through Boston Public Health Commission and is an outpatient treatment program where she receives services such as counseling and psychotherapeutic groups. The patient is aware of the need to consistently attend prenatal visits and the Mom's Project if she wants to keep her child. She sets goals with her OB and social work in order to achieve this and a healthy pregnancy, all of which are explained in the PoSC document.

The patient meets with the pediatric hospitalist during the hospital tour and is informed of NAS and the increased needs of her new child. She works with social work to establish VNA services after discharge, which is noted in the PoSC document by the pediatrician.

After delivery, mom's case is evaluated by DCF. Due to her compliance with her programs and increased social supports through the help of social workers she is able to keep her child. Inpatient pediatric social notes that the patient is still at high risk within recovery and refers mom and baby to the SOFAR clinic at BMC. This clinic specializes on the treatment of children of mothers with OUD.

The SOFAR clinic receives a warm handoff from the pediatric hospitalist team and develops a plan for mom and child which is documented within the PoSC. Mom continues to meet with addiction specialists through this clinic and her child receives weekly visits with the infant for the first month of life. The child is also referred to early intervention and is evaluated by developmental/behavioral pediatricians at the SOFAR clinic.

### **Case Example: Cape and Islands**

#### **Low Risk Case:**

Case Study 3 follows a 27-year-old female who is 8 weeks pregnant. She has a history of opioid use disorder (OUD) for 3 years and is not currently stable on medication-assisted treatment. She presents to Cape Cod Hospital (CCH) for prenatal care. CCH has considerable experience treating patients with OUD during pregnancy, with streamlined pathways for addiction treatment and social services. This patient is considered relatively low risk, as she has a stable social situation, relatively mild OUD, and is eager to engage in treatment.

At the patient's first prenatal visit at CCH, the Plan of Safe Care is completed by her OB provider. She is found to have mild OUD as well as generalized anxiety disorder. CCH has close connections with addiction treatment providers at the Duffy Center, which has expertise in treating co-occurring mental illness. She is referred to addiction and mental health treatment providers there. An appointment is also set up for her to meet with the obstetric social worker, and she is encouraged to see her primary care physician for routine follow-up as well.

At her appointment at Duffy, she is informed about medication-assisted treatment and initiated on buprenorphine (Subutex), a standard-of-care medication for women in pregnancy. She also sees a psychiatrist who starts her on sertraline for generalized anxiety disorder and refers her to

counseling. They confirm that she is able to use public transit to attend her visits at Duffy and emphasize the importance of engaging with those prenatal visits.

Throughout pregnancy, she also meets with her obstetric social worker, who attends to the psychosocial needs identified by the patient. She is concerned about her housing situation, reliance on public transit, and preparation to care nutritionally for the baby. The social worker helps her apply for WIC and refers her to a nutritionist.

After delivering the baby, the newborn's pediatric hospitalist coordinates with the mother, DCF, and the baby's outpatient provider to ensure that the baby is going to a safe home. Ideally, documentation from the mother's MAT program has already been sent to DCF and DCF has been made aware of the patient well before delivery. As such, a streamlined process occurs and the baby goes home with mother. Both the community pediatrician and the obstetric social worker, who stays involved with the case, establish goals for the mom and baby for at least 3 months after delivery.

### **High Risk Case:**

Case Study 4 follows a 21-year-old female who is 16 weeks pregnant. She started using opioids when she was 16 years old and is not currently on MAT. She initially presents to the Cape Cod Hospital (CCH) emergency department (ED) for a leg injury. She is determined to be pregnant and have uncontrolled OUD. She is given an initial dose of buprenorphine for MAT in the ED and referred for a next-day appointment with an obstetric MAT provider at CCH. Several hospitals are currently exploring buprenorphine licensing for obstetricians, and it is recommended that the Commonwealth support practices in doing this.

The next day, with her OUD momentarily under treatment, she presents to CCH for her obstetrics appointment. She is written for an ongoing prescription of buprenorphine and caught up on her prenatal screening. She declines psychiatric screening, so she is not referred for mental health treatment.

At her appointment with her social worker, she discusses her personal goals. She is currently experiencing homelessness and would like to get into stable housing. She has some ambivalence about MAT but strives to stay engaged in treatment during her pregnancy. She mostly walks to get around the area and worries about her ability to get to appointments. Given these significant barriers and her high risk of relapse, the social worker prioritizes finding a community health worker for the patient through Moms Do Care, a service available at Cape Cod Hospital and a few other hospitals across the Commonwealth. This community health worker would help the patient get to her visits and support her in engaging in care.

Prior to delivery, the Department of Children and Families is notified that this patient may not be able to provide a safe home for her baby after delivery. The patient is made aware of this likelihood and offered counseling, as well as resources to try to make her home safer. After delivering the baby, the newborn's pediatric hospitalist coordinates with the mother, DCF, and

the baby's outpatient provider to ensure that the baby is going to a safe home. DCF assumes custody for the child and coordinates with the obstetric social worker, a pediatric social worker who is brought onto the team, and the pediatricians. Both the community pediatrician and pediatric social worker establish goals for the mom and baby for at least 3 months after delivery.



## Appendix

- A. Background on Substance Use Disorders
- B. About NeoQIC
- C. Summary of NeoQIC survey results
- D. DCF Legislation Pertaining to Plans of Safe Care
- E. Interview Questions
- F. Proposed Plans of Safe Care document
- G. Plans of Safe Care Case Studies
- H. Overview of Programs with Best Practices
- I. Release of Patient Information Example

## A. Background on Substance Use Disorders

Substance Use disorder occurs when an individual's use of drugs or alcohol lead to impairment that impacts daily life. These individuals may experience health problems, interference with their ability to perform work, school, or family obligations, or even disability. Substance use disorder is a disease that results from chemical changes in the brain due to recurrent drug use. Clinically it is diagnosed using the American Psychiatric Association (APA) DSM 5 (Diagnostic and Statistical Manual of Mental Disorders) criteria. Under the DSM 5, an individual with substance use disorder exhibits at least 2-3 of the following criteria within a 12 month period:<sup>28</sup>

1. Using the substance in larger amounts and for longer time than intended
2. Desire to reduce or stop the substance but unable to
3. A large amount of time is spent trying to obtain the substance, use the substance, or recover from the substance
4. Cravings or strong urge to use the substance
5. Recurrent inability to fulfill major obligations at home, school, or work due to substance use
6. Despite social problems caused or made worse by the substance recurrent use
7. Decreasing or termination of important social, recreational, or occupational activities due to substance use
8. Recurrent use of the substance in physically hazardous situations
9. Persistent use of the substance despite knowledge of physical or psychological harm that is likely caused or worsened by the use of the substance
10. Tolerance as defined by either
  1. a need for markedly increased amounts to achieve intoxication or desired effect
  2. markedly diminished effect with continued use of the same amount. (Does not apply for diminished effect when used appropriately under medical supervision)
11. Withdrawal manifesting as either
  1. characteristic syndrome
  2. the substance is used to avoid withdrawal

It is important to note that the DSM 5 in 2013 changed the language regarding substance use disorder. Prior to 2013, substance use disorder was labelled as substance *abuse* disorder. The term *abuse* conveys a negative connotation and infers that the individual with this disease is intentionally acting badly. Individuals with substance use disorder are physiologically dependent on their substance much like individuals with diabetes are dependent on insulin. Physiologic dependence does not equate to misconduct. Substance use disorder is a chronic disease and the shift away from using the term abuse is critical to destigmatize this medical disease.

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<sup>28</sup> "DSM 5 Criteria for Substance Use Disorder." *DSM 5 Criteria for Substance Use Disorder* | *BupPractice*, [www.buppractice.com/node/12351](http://www.buppractice.com/node/12351).

## B. About NeoQIC

For more information, go to: <https://www.neoqicma.org/substance-exposed-newborns>

The Massachusetts Neonatal Quality Improvement Collaborative (NeoQIC) is a voluntary organization of newborn health care providers in Massachusetts, committed to improving the outcomes of mothers and newborns throughout the state through the open sharing of practices and data.

### **Active Improvement Initiatives:**

NeoQIC is proud to support three ongoing collaborative quality improvement initiatives:

1. Increasing the use of mother's own milk in very low birth weight infants;
2. Increasing safe sleep practices in high risk infants; and
3. Improving the care of infants and families impacted by perinatal opioid use and neonatal abstinence syndrome (substance exposed newborns).

A fourth initiative is being launched focused on nosocomial infections and antibiotic utilization in neonatal intensive care units. This is a re-launch of the earlier NeoQIC NICU CLABSI initiative.

**The Neonatal Quality Improvement Collaborative of Massachusetts (NeoQIC)** and the **Massachusetts Perinatal Quality Collaborative (MPQC)** are excited to launch a joint statewide quality improvement initiative focused on improving the care of infants and families impacted by perinatal opioid use and neonatal abstinence syndrome. This initiative builds upon years of past improvement work by NeoQIC, MPQC, and hospitals throughout the state, and relies on close collaborations with many state organizations, including the Department of Public Health, the Bureau of Substance Abuse Services, the Department of Children and Families, Early Intervention, and the Health Policy Commission.

This initiative was formally launched in January 2017. It will be built around multi-disciplinary hospital-based improvement teams, and will rely on the open sharing of practices and data to improve care throughout the state. All hospitals that care for mothers or newborns are invited to participate.

## C. NeoQIC survey results summary

### **1. Screening practices vary widely and few practices use standardize tools.**

Our findings suggest that there may be important gaps in screening of pregnant women for substance use issues and that screening can be improved by adoption of validated, standardized screening tools.

### **2. Patients may benefit from increased access to MAT services in prenatal practices.**

Our findings demonstrate that when pregnant women screen positive for opioid use, some prenatal providers struggle to connect them with medication-assisted treatment (MAT) resources. One important strategy may be to increase the availability of providers trained in MAT within prenatal care practices.

### **3. Few hospitals provide induction of MAT services for hospitalized women.**

Just 17% of hospitals report “almost always” or “often” providing induction of medication-assisted treatment for pregnant women with illicit drug use while the mother is hospitalized; 52% of hospitals report “rarely” providing induction of MAT. Hospitals may consider increasing their capacity to provide induction of MAT for hospitalized women near the time of discharge.

### **4. Referral to behavioral health providers and peer support services is challenging.**

Our findings suggest that while prenatal providers and hospitals have some success referring patients to medication-assisted therapy services, they find it more challenging to refer patients to the behavioral health and peer support services that are also critical for recovery.

### **5. Hospitals may benefit from standardized assessment tools for 51A report filing.**

Just 41% of hospitals report using a standardized tool or assessment for used to determine need for completion of a 51A report to the Department of Children and Families.

## D. DCF Legislation Pertaining to Plans of Safe Care

### Massachusetts General Laws Chapter 119 § 51A

Section 51A. (a) A mandated reporter who, in his professional capacity, has reasonable cause to believe that a child is suffering physical or emotional injury resulting from: (i) abuse inflicted upon him which causes harm or substantial risk of harm to the child's health or welfare, including sexual abuse; (ii) neglect, including malnutrition; **(iii) physical dependence upon an addictive drug at birth**, shall immediately communicate with the department orally and, within 48 hours, shall file a written report with the department detailing the suspected abuse or neglect; or (iv) being a sexually exploited child; or (v) being a human trafficking victim as defined by section 20M of chapter 233.

If a mandated reporter is a member of the staff of a medical or other public or private institution, school or facility, the mandated reporter may instead notify the person or designated agent in charge of such institution, school or facility who shall become responsible for notifying the department in the manner required by this section.

A mandated reporter may, in addition to filing a report under this section, contact local law enforcement authorities or the child advocate about the suspected abuse or neglect.

(b) For the purpose of reporting under this section, hospital personnel may have photographs taken of the areas of trauma visible on the child without the consent of the child's parents or guardians. These photographs or copies thereof shall be sent to the department with the report.

If hospital personnel collect physical evidence of abuse or neglect of the child, the local district attorney, local law enforcement authorities, and the department shall be immediately notified. The physical evidence shall be processed immediately so that the department may make an informed determination within the time limits in section 51B. If there is a delay in processing, the department shall seek a waiver under subsection (d) of section 51B.

(c) Notwithstanding subsection (g), whoever violates this section shall be punished by a fine of not more than \$1,000. Whoever knowingly and willfully files a frivolous report of child abuse or neglect under this section shall be punished by: (i) a fine of not more than \$2,000 for the first offense; (ii) imprisonment in a house of correction for not more than 6 months and a fine of not more than \$2,000 for the second offense; and (iii) imprisonment in a house of correction for not more than 2 1/2 years and a fine of not more than \$2,000 for the third and subsequent offenses.

Any mandated reporter who has knowledge of child abuse or neglect that resulted in serious bodily injury to or death of a child and willfully fails to report such abuse or neglect shall be punished by a fine of up to \$5,000 or imprisonment in the house of correction for not more than 2 1/2 years or by both such fine and imprisonment; and, upon a guilty finding or a continuance without a finding, the court shall notify any appropriate professional licensing authority of the mandated reporter's violation of this paragraph.

(d) A report filed under this section shall contain: (i) the names and addresses of the child and the child's parents or other person responsible for the child's care, if known; (ii) the child's age; (iii) the child's sex; (iv) the nature and extent of the child's injuries, abuse, maltreatment or neglect, including any evidence of prior injuries, abuse, maltreatment or neglect; (v) the circumstances under which the person required to report first became aware of the child's injuries, abuse, maltreatment or neglect; (vi) whatever action, if any, was taken to treat, shelter or otherwise assist the child; (vii) the name of the person or persons making the report; (viii) any other information that the person reporting believes might be helpful in

establishing the cause of the injuries; (ix) the identity of the person or persons responsible for the neglect or injuries; and (x) other information required by the department.

(e) A mandated reporter who has reasonable cause to believe that a child has died as a result of any of the conditions listed in subsection (a) shall report the death to the district attorney for the county in which the death occurred and the office of the chief medical examiner as required by clause (16) of section 3 of chapter 38. Any person who fails to file a report under this subsection shall be punished by a fine of not more than \$1,000.

(f) Any person may file a report under this section if that person has reasonable cause to believe that a child is suffering from or has died as a result of abuse or neglect.

(g) No mandated reporter shall be liable in any civil or criminal action for filing a report under this section or for contacting local law enforcement authorities or the child advocate, if the report or contact was made in good faith, was not frivolous, and the reporter did not cause the abuse or neglect. No other person filing a report under this section shall be liable in any civil or criminal action by reason of the report if it was made in good faith and if that person did not perpetrate or inflict the reported abuse or cause the reported neglect. Any person filing a report under this section may be liable in a civil or criminal action if the department or a district attorney determines that the person filing the report may have perpetrated or inflicted the abuse or caused the neglect.

(h) No employer shall discharge, discriminate or retaliate against a mandated reporter who, in good faith, files a report under this section, testifies or is about to testify in any proceeding involving child abuse or neglect. Any employer who discharges, discriminates or retaliates against that mandated reporter shall be liable to the mandated reporter for treble damages, costs and attorney's fees.

(i) Within 30 days of receiving a report from a mandated reporter, the department shall notify the mandated reporter, in writing, of its determination of the nature, extent and cause or causes of the injuries to the child and the services that the department intends to provide to the child or the child's family.

(j) Any privilege relating to confidential communications, established by sections 135 to 135B, inclusive, of chapter 112 or by sections 20A and 20B of chapter 233, shall not prohibit the filing of a report under this section or a care and protection petition under section 24, except that a priest, rabbi, clergy member, ordained or licensed minister, leader of a church or religious body or accredited Christian Science practitioner need not report information solely gained in a confession or similarly confidential communication in other religious faiths. Nothing in the general laws shall modify or limit the duty of a priest, rabbi, clergy member, ordained or licensed minister, leader of a church or religious body or accredited Christian Science practitioner to report suspected child abuse or neglect under this section when the priest, rabbi, clergy member, ordained or licensed minister, leader of a church or religious body or accredited Christian Science practitioner is acting in some other capacity that would otherwise make him a mandated reporter.

(k) A mandated reporter who is professionally licensed by the commonwealth shall complete training to recognize and report suspected child abuse or neglect.

## E. Interview questions

### For NICU department chairs:

1. What are your institution's policies with respect to screening and risk stratification for SEN and NAS?
2. To what extent do you believe providers in your department are aware of and implementing these policies?
3. Which cases of NAS/SEN are referred to DCF?
4. Are there common cases in which DCF referral is mandated but not indicated from your perspective?
5. What resources are offered to support families with SEN and NAS, and do these resources vary depending on whether a DCF referral is made?
6. Are there resources you would like to offer families with SEN or NAS that are not available? Where do you feel most squeezed and unable to do what you want to be doing?
7. Which staff member(s) are the final decision makers regarding referrals to DCF or other social services? Which staff member(s) are responsible for coordinating any such referrals?
8. What is the triage process for newborns with known substance exposure in utero? i.e. are they automatically admitted to the NICU for observation?
9. For newborns with potential substance exposure but who show no evidence of physical dependence upon addictive drugs at birth, which circumstances (if any) would trigger DCF referral or referral to other social services?
10. What is the process by which neonatologists at this institution communicate with obstetricians who provide prenatal care regarding infants who are potentially substance-exposed?
11. How is care coordinated for infants as they are discharged from the hospital, including medical care and social services? How is that integrated with care coordination for mother, including her medical care, addiction treatment, and social services?
12. What follow up do mothers and infants get after hospital discharge? How are needs regarding social services addressed at those visits?

13. Who should be involved in developing a Plan of Safe Care for families with SEN, and at what point before, during, or after delivery should that happen? Such a plan would determine plans for medical care for mother and baby, childcare, parenting support, safe sleep, safe housing, crisis planning, service referrals, and referral to resources.

**For OB/Gyn physicians:**

1. What is your understanding of your institution's policies with respect to screening and risk stratification for substance use disorders?
2. To what extent do you believe providers in your department are aware of and implementing these policies?
3. During prenatal care, what are typical practices around referring women with substance use disorders to addiction treatment and social services? What resources are offered to those patients? What preparations are put in place for the time of delivery, such as for potential DCF involvement, referral to addiction treatment, and preparation for caring for a baby that may have NAS?
4. How do you evaluate patients' and families' needs regarding social services in the case of SEN?
5. What is your understanding of DCF's role in supporting substance-exposed newborns and their families? What are the steps taken and potential outcomes when a DCF referral is made?
6. Are there common cases in which DCF referral is mandated but not indicated from your perspective?
7. How do you communicate with neonatologists, pediatricians, and social workers with respect to SEN? What are barriers to such communication?
8. In general, how are social services coordinated for families with SEN after delivery?
9. Are there things you wish you could do to support families with SEN that you are unable to, whether due to institutional policy or resource constraints?
10. Who should be involved in developing a Plan of Safe Care for families with SEN, and at what point before, during, or after delivery should that happen? Such a plan would determine plans for childcare, parenting support, safe sleep, safe housing, crisis planning, service referrals, and referral to resources.

**For neonatologists:**



1. What is your understanding of your institution's policies with respect to screening and risk stratification for SEN?
2. To what extent do you believe providers in your department are aware of and implementing these policies?
3. What resources are offered to support families with SEN?
4. How do you evaluate patients' and families' needs regarding social services in the case of SEN?
5. What is your understanding of DCF's role in supporting substance-exposed newborns and their families? What are the steps taken and potential outcomes when a DCF referral is made?
6. Are there common cases in which DCF referral is mandated but not indicated from your perspective?
7. How do you communicate with obstetricians, community pediatricians, and social workers with respect to SEN? What are barriers to such communication?
8. In general, how are social services coordinated for families with SEN after delivery and at the point of NICU discharge?
9. Are there things you wish you could do to support families with SEN that you are unable to, whether due to institutional policy or resource constraints?
10. Who should be involved in developing a Plan of Safe Care for families with SEN, and at what point before, during, or after delivery should that happen? Such a plan would determine plans for childcare, parenting support, safe sleep, safe housing, crisis planning, service referrals, and referral to resources.

**For pediatricians:**

1. What is your understanding of your institution's policies with respect to screening and risk stratification for SEN or infants with history of NAS?
2. To what extent do you believe providers in your department are aware of and implementing these policies?
3. What resources are offered to support families with SEN or infants with history of NAS?
4. How do you evaluate patients' and families' needs regarding social services in the case of SEN or infants with history of NAS?

5. What is your understanding of DCF's role in supporting substance-exposed newborns and their families? What are the steps taken and potential outcomes when a DCF referral is made?
6. Are there common cases in which DCF referral is mandated but not indicated from your perspective?
7. How do you communicate with obstetricians, neonatologists, and social workers with respect to SEN and infants with history of NAS? What are barriers to such communication?
8. How do you communicate with community pediatricians with respect to SEN and infants with history of NAS? What are barriers to such communication?
9. In general, how are social services coordinated for families with SEN as they transition from hospital to community pediatric care?
10. Are there things you wish you could do to support families with SEN that you are unable to, whether due to institutional policy or resource constraints?
11. Who should be involved in developing a Plan of Safe Care for families with SEN, and at what point before, during, or after delivery should that happen? Such a plan would determine plans for childcare, parenting support, safe sleep, safe housing, crisis planning, service referrals, and referral to resources.

**For NICU/ OB social workers:**

1. What is your understanding of your institution's policies with respect to screening and risk stratification substance use disorders?
2. Which of those patients are you involved with?
3. During prenatal care, what are typical practices around referring women with substance use disorders to addiction treatment and social services? What resources are offered to those patients? What preparations are put in place for the time of delivery, such as for potential DCF involvement, referral to addiction treatment, and preparation for caring for a baby that may have NAS?
4. What resources are offered to support patients with substance use disorders?
5. How do you evaluate patients' and families' needs regarding social services in the case of SEN? Specifically what tools do you use to identify need for WIC, financial assistance, and other social services?
6. What is your understanding of DCF's role in supporting substance-exposed newborns and their families? What are the steps taken and potential outcomes when a DCF referral is made?

7. Are there common cases in which DCF referral is mandated but not indicated from your perspective?
8. How do you communicate with obstetricians, neonatologists, and community pediatricians with respect to SEN? What are barriers to such communication?
9. In general, how are social services coordinated for families with SEN as they transition from hospital to community care?
10. Are there things you wish you could do to support families with SEN that you are unable to, whether due to institutional policy or resource constraints?
11. Who should be involved in developing a Plan of Safe Care for families with SEN, and at what point before, during, or after delivery should that happen? Such a plan would determine plans for childcare, parenting support, safe sleep, safe housing, crisis planning, service referrals, and referral to resources.

## F. Proposed Plan of Safe Care

### Massachusetts Plans of Safe Care

**DRAFT TEMPLATE**

**Functional Goal 1: Maternal addiction recovery**

*Goal: Every pregnant and postpartum woman with an SUD has the best possible chance of being in recovery during pregnancy and after delivery.*

**Obstetrics, Primary Care, and Emergency Department Providers**

Screened for substance use disorders and screened positive

for: \_\_\_\_\_

If above box checked:  Referred to SUD treatment at \_\_\_\_\_ (clinic) with \_\_\_\_\_

(provider)

Patient already in evidence-based treatment

Patient declined treatment referral

Other: \_\_\_\_\_

Screened for psychiatric comorbidity and screened positive

for: \_\_\_\_\_

If above box checked:  Made referral to treatment at \_\_\_\_\_ (clinic) with \_\_\_\_\_ (provider)

Patient already in evidence-based treatment

Patient declined treatment referral

Other: \_\_\_\_\_

Screened for psychiatric comorbidity and screened negative

If patient was not screened for SUD and/or psychiatric comorbidity, please explain:

\_\_\_\_\_

*For cases of opioid use disorder:*

Patient is already participating in medication-assisted treatment, at \_\_\_\_\_ (clinic) with \_\_\_\_\_  
(provider)

Patient declines medication-assisted treatment at this time

Other (please explain): \_\_\_\_\_

\_\_\_\_\_  
Signature of obstetric provider

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of primary care provider

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of emergency dept. provider

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Date

### Functional Goal 1: **Maternal addiction recovery**

*Goal: Every pregnant and postpartum woman with an SUD has the best possible chance of being in recovery during pregnancy and after delivery.*

### **Addiction and mental health providers:**

Patient is being treated for the following substance use disorders:

\_\_\_\_\_

Patient is being treated for the following psychiatric comorbidities:

\_\_\_\_\_

If patient was not screened for SUD and/or psychiatric comorbidity, please explain:

\_\_\_\_\_

*Treatment plan:*

MAT during pregnancy: \_\_\_\_\_

MAT after pregnancy: \_\_\_\_\_

MAT not indicated in this patient (explain): \_\_\_\_\_  Patient declines medication

Psychiatric medication during pregnancy:  
\_\_\_\_\_

Psychiatric medication after pregnancy:  
\_\_\_\_\_

Psychiatric medication not indicated in this patient (explain): \_\_\_\_\_  Patient declines

medication  Plan for therapy and other psychosocial support (counseling, therapy, AA, NA, etc.):

\_\_\_\_\_  
\_\_\_\_\_

Potential barriers to treatment adherence (e.g. lack of transportation to methadone clinic) and plan to address them:

\_\_\_\_\_

\_\_\_\_\_  
Signature of addiction treatment provider      Print name      Date

\_\_\_\_\_  
Signature of mental health provider      Print name      Date

**Functional Goal 2: Social stability for the family**

*Goal:* The social needs of pregnant and postpartum women and primary caregivers are met as early in pregnancy as possible, including both basic needs such as housing and transportation, as well as core support systems.

**Social worker:**

Patient offered a prenatal tour with social work and pediatrics

Tour scheduled for \_\_\_\_\_  Patient declined tour  Patient missed tour, rescheduled for: \_\_\_\_\_

The patient lives \_\_\_\_\_ (location) with \_\_\_\_\_ (other people).

This situation is (stable / unstable) and (will meet / will not meet) the patient and her child’s needs during pregnancy and postnatally. Plan to address (if relevant): \_\_\_\_\_

The patient uses \_\_\_\_\_ for transportation, which (will meet / will not meet) the patient’s needs during pregnancy and postnatally, including her ability to engage in medical care and addiction treatment. Plan to address (if relevant): \_\_\_\_\_

Through shared decision-making, the patient and I have also prioritized the following psychosocial needs and plan for addressing them:

- 1) \_\_\_\_\_



Plan to address: \_\_\_\_\_

\_\_\_\_\_

Service referral: \_\_\_\_\_

2) \_\_\_\_\_

Plan to address: \_\_\_\_\_

\_\_\_\_\_

Service referral: \_\_\_\_\_

\_\_\_\_\_

3) \_\_\_\_\_

Plan to address: \_\_\_\_\_

\_\_\_\_\_

Service referral: \_\_\_\_\_

The patient and I have discussed that the Department of Children and Families will be involved at the time of delivery and may also be concerned about the following issues. We plan to address them as follows:

1) \_\_\_\_\_

Plan to address: \_\_\_\_\_

\_\_\_\_\_

Service referral: \_\_\_\_\_

2) \_\_\_\_\_

Plan to address: \_\_\_\_\_

\_\_\_\_\_

Service referral: \_\_\_\_\_

3) \_\_\_\_\_

Plan to address: \_\_\_\_\_

\_\_\_\_\_

Service referral: \_\_\_\_\_

\_\_\_\_\_  
Signature of social worker

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Date

**Functional Goal 3: Healthy fetal development and delivery**

*Goal:* Substance-exposed fetuses will develop in the healthiest *in utero* environment possible and undergo the appropriate screenings and treatments to facilitate a healthy delivery.

**Obstetrics:**

*The patient and I have discussed shared goals to achieve a healthy pregnancy, and together we have decided to*

*prioritize:*

1) \_\_\_\_\_

Plan to achieve this goal: \_\_\_\_\_

\_\_\_\_\_

2) \_\_\_\_\_

Plan to achieve this goal: \_\_\_\_\_

\_\_\_\_\_

3) \_\_\_\_\_

Plan to achieve this goal: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of obstetric provider

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Date

**Social worker:**

*The patient and I have discussed potential barriers to achieving the goals listed above and plans to meet them. They*

*include:*

1) \_\_\_\_\_

Plan to overcome this barrier: \_\_\_\_\_

\_\_\_\_\_

2) \_\_\_\_\_

Plan to overcome this barrier: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of social worker

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Date

**Functional Goal 4: Healthy infant development**

*Goal: Substance-exposed newborns have a smooth transition from hospital care into care at home, with attentive care providers at home, close medical follow-up, and appropriate social services for development support.*

**Pediatric hospitalist:**

The family had a prenatal visit with a hospitalist to prepare her for hospital care of the newborn, including management of neonatal abstinence syndrome and involvement of the Department of Children and Families

*Prior to hospital discharge:*

The family feels comfortable feeding the newborn by \_\_\_\_\_ (method)       Breastfeeding was encouraged

The family feels comfortable caring for the newborn at home and has the following social supports: \_\_\_\_\_

\_\_\_\_\_  The family knows the date and location for the patient’s first community pediatrics appointment

The patient will have VNA services after discharge       VNA is not indicated for this patient because: \_\_\_\_\_

The above questions do not apply as the family is not retaining custody of the patient

I spoke with the community pediatrician about the care of this patient, including a plan for ensuring the patient’s safety at home

\_\_\_\_\_  
Signature of pediatric hospitalist

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Date

**Functional Goal 4: Healthy infant development**

*Goal: Substance-exposed newborns have a smooth transition from hospital care into care at home, with attentive care providers at home, close medical follow-up, and appropriate social services for development support.*

**Social Worker:**

[ ] I am the family’s obstetric worker and will be assuming care for the infant’s social needs as well

[ ] I am a pediatric social worker, and I (have / have not) spoken with the obstetric social worker regarding the family’s care plan

Through shared decision-making, the patient and I have prioritized the following psychosocial needs for the infant and plan for addressing them:

1) \_\_\_\_\_

Plan to address: \_\_\_\_\_

\_\_\_\_\_

Service referral: \_\_\_\_\_

2) \_\_\_\_\_

Plan to address: \_\_\_\_\_

\_\_\_\_\_

Service referral: \_\_\_\_\_

3) \_\_\_\_\_

Plan to address: \_\_\_\_\_

\_\_\_\_\_

Service referral: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of social worker

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Date

### **Community Pediatrician:**

*After communicating with hospital-based care providers and the patient's family, we have set the following goals for the patient's healthy development and plans to meet them:*

1) \_\_\_\_\_

Plan to achieve this goal: \_\_\_\_\_

\_\_\_\_\_

2) \_\_\_\_\_

Plan to achieve this goal: \_\_\_\_\_

\_\_\_\_\_

3) \_\_\_\_\_

Plan to achieve this goal: \_\_\_\_\_

\_\_\_\_\_

*Social work coordination:*

I have reviewed the social worker's plan for addressing the family's psychosocial needs

I have communicated with the social worker regarding the plan to continue to meet the patient's developmental needs and the family's psychosocial needs and am comfortable with my role in the plan.

\_\_\_\_\_  
Signature of pediatrician

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Date



## G. Plans of Safe Care Case Studies

### Massachusetts Plans of Safe Care

#### Boston Case Study 1: Low Risk Patient

27F 10 weeks pregnant with OUD x 5 years, stable on buprenorphine presents to OB for prenatal care

**Functional Goal 1: Maternal addiction recovery**

*Goal: Every pregnant and postpartum woman with an SUD has the best possible chance of being in recovery during pregnancy and after delivery.*

**Obstetrics, Primary Care, and Emergency Department Providers**

Screened for substance use disorders and screened positive for: opiates, 5-year history of opioid use disorder

If above box checked:  Referred to SUD treatment at \_\_\_\_\_ (clinic) with \_\_\_\_\_

(provider)

Patient already in evidence-based treatment  Patient declined treatment referral  Other: \_\_\_\_\_

Screened for psychiatric comorbidity and screened positive for: \_\_\_\_\_

If above box checked:  Made referral to treatment at \_\_\_\_\_ (clinic) with \_\_\_\_\_ (provider)

Patient already in evidence-based treatment  Patient declined treatment referral  Other: \_\_\_\_\_

Screened for psychiatric comorbidity and screened negative

If patient was not screened for SUD and/or psychiatric comorbidity, please explain: \_\_\_\_\_

*For cases of opioid use disorder:*

Patient is already participating in medication-assisted treatment, at BMC Primary Care (clinic) with Dr. Primary Care (provider)

Patient declines medication-assisted treatment at this time

Other (please explain): \_\_\_\_\_

Dr. Project Respect

Dr. Project Respect

3/22/18

Signature of obstetric provider

Print name

Date

Dr. Primary Care

Dr. Primary Care, BMC

4/1/18

Signature of primary care provider

Print name

Date

\_\_\_\_\_  
Signature of emergency dept. provider

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Date

### Functional Goal 1: **Maternal addiction recovery**

*Goal: Every pregnant and postpartum woman with an SUD has the best possible chance of being in recovery during pregnancy and after delivery.*

### **Addiction and mental health providers:**

Patient is being treated for the following substance use disorders: opiate use disorder

Patient is being treated for the following psychiatric comorbidities: none

[ ] If patient was not screened for SUD and/or psychiatric comorbidity, please explain: \_\_\_\_\_

#### *Treatment plan:*

[x] MAT during pregnancy: Buprenorphine 8 mg/day

[x] MAT after pregnancy: Buprenorphine 12 mg/day

[ ] MAT not indicated in this patient (explain): \_\_\_\_\_

[ ] Patient declines

medication

[ ] Psychiatric medication during pregnancy: none

[ ] Psychiatric medication after pregnancy: none



to address (if relevant): \_\_\_\_\_

\_\_\_\_\_

[x] The patient uses personal vehicle for transportation, which (will meet / will not meet) the patient's needs during pregnancy and postnatally, including her ability to engage in medical care and addiction treatment. Plan to address (if relevant): \_\_\_\_\_

\_\_\_\_\_

Through shared decision-making, the patient and I have also prioritized the following psychosocial needs and plan for addressing them:

4) Needs nutritional support

Plan to address: apply to WIC

Service referral: WIC

5) Medical insurance for infant

Plan to address: Patient enrolled in Medicaid, will enroll child to CHIP

Service referral: Massachusetts's Medicaid Agency

6) Patient would like to breastfeed but is concerned about difficulty

Plan to address: would like her to see a lactation specialist

Service referral: Boston Baby Cafes at BMC: free drop in-sessions about breastfeeding

The patient and I have discussed that the Department of Children and Families will be involved at the time of delivery and may also be concerned about the following issues. We plan to address them as follows:

4) Continued treatment on Methadone

Plan to address: Patient has signed release of MAT information and Dr. MAT is aware clinic may be contacted

Service referral: \_\_\_\_\_

5) \_\_\_\_\_

Plan to address: \_\_\_\_\_

\_\_\_\_\_

Service referral: \_\_\_\_\_

6) \_\_\_\_\_

Plan to address: \_\_\_\_\_

\_\_\_\_\_

Service referral: \_\_\_\_\_

Social Worker

Social Worker

3/29/18

Signature of social worker

Print name

Date

**Functional Goal 3: Healthy fetal development and delivery**

*Goal:* Substance-exposed fetuses will develop in the healthiest *in utero* environment possible and undergo the appropriate screenings and treatments to facilitate a healthy delivery.

**Obstetrics:**

*The patient and I have discussed shared goals to achieve a healthy pregnancy, and together we have decided to prioritize:*

4) maintain methadone compliance and stable recovery

Plan to achieve this goal: continue attending NA meetings and methadone treatment

5) \_\_\_\_\_

Plan to achieve this goal: \_\_\_\_\_

\_\_\_\_\_

6) \_\_\_\_\_

7) Plan to achieve this goal: \_\_\_\_\_

\_\_\_\_\_

Dr. Obstetrician

Dr. Obstetrician

03/29/18

Signature of obstetric provider

Print name

Date

**Social worker:**

*The patient and I have discussed potential barriers to achieving the goals listed above and plans to meet them. They include:*

3) Fear of attending NA meetings while obviously pregnant

Plan to overcome this barrier: will begin working with recovery coach to develop strategies to ensure compliance

4) \_\_\_\_\_

Plan to overcome this barrier: \_\_\_\_\_

\_\_\_\_\_

*Social Worker*  
\_\_\_\_\_  
Signature of social worker

Social Worker  
\_\_\_\_\_  
Print name

03/29/18  
\_\_\_\_\_  
Date

**Functional Goal 4: Healthy infant development**

*Goal: Substance-exposed newborns have a smooth transition from hospital care into care at home, with attentive care providers at home, close medical follow-up, and appropriate social services for development support.*

**Pediatric hospitalist:**

[x] The family had a prenatal visit with a hospitalist to prepare her for hospital care of the newborn, including management of neonatal abstinence syndrome and involvement of the Department of Children and Families

[x] The family received a referral to early intervention

*Prior to hospital discharge:*



- The family feels comfortable feeding the newborn by breastfeeding (method)     Breastfeeding was encouraged
- The family feels comfortable caring for the newborn at home and has the following social supports: Patient's mother will be living at home to help support newborn, father has ensured to watch child so mom can attend weekly NA meetings.
- The family knows the date and location for the patient's first community pediatrics appointment
- The patient will have VNA services after discharge             VNA is not indicated for this patient because \_\_\_\_\_
- The above questions do not apply as the family is not retaining custody of the patient
- I spoke with the community pediatrician about the care of this patient, including a plan for ensuring the patient's safety at home

*Dr. Pediatrics*

Dr. Pediatrics

08/18/18

\_\_\_\_\_  
Signature of pediatric hospitalist

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Date

**Functional Goal 4: Healthy infant development**

*Goal: Substance-exposed newborns have a smooth transition from hospital care into care at home, with attentive care providers at home, close medical follow-up, and appropriate social services for development support.*

**Social Worker:**

- I am the family's obstetric worker and will be assuming care for the infant's social needs as well

[x] I am a pediatric social worker, and I (have / have not) spoken with the obstetric social worker regarding the family's care plan

Through shared decision-making, the patient and I have also prioritized the following psychosocial needs for the infant and plan for addressing them:

4) Adjustment to home with a baby with NAS and increased needs

Plan to address: Patient would like VNA

Service referral: VNA services

5) \_\_\_\_\_

Plan to address: \_\_\_\_\_

Service referral: \_\_\_\_\_

6) \_\_\_\_\_

Plan to address: \_\_\_\_\_

Service referral: \_\_\_\_\_

Pediatric Social work  
Signature of Pediatric social worker

Pediatric Social work  
Print name

10/4/18  
Date

## Community Pediatrician:

*After communicating with hospital-based care providers and the patient's family, we have set the following goals for the patient's healthy development and plans to meet them:*

4) Mom really wants to breastfeed her child

Plan to achieve this goal: Patient X is going to go to Boston Baby Café's and will see lactation specialist in clinic if concerns continue after Boston Baby Café

5) Wants to ensure her child starts off on the right foot

Plan to achieve this goal: has been referred to early intervention, will follow progress and give recommendations as needed

6) \_\_\_\_\_

Plan to achieve this goal: \_\_\_\_\_

### *Social work coordination:*

I have reviewed the social worker's plan for addressing the family's psychosocial needs

I have communicated with the social worker regarding the plan to continue to meet the patient's developmental needs and the family's psychosocial needs and am comfortable with my role in the plan.

Dr. Community Pediatrician

Dr. Community Pediatrician

10/15/18

Signature of pediatrician

Print name

Date

## Massachusetts Plans of Safe Care

### Boston Case Study 2: High Risk Patient

27F 10 weeks pregnant and currently using opiates presents to Emergency Department seeking to get on maintenance therapy

**Functional Goal 1: Maternal addiction recovery**

*Goal: Every pregnant and postpartum woman with an SUD has the best possible chance of being in recovery during pregnancy and after delivery.*

**Obstetrics, Primary Care, and Emergency Department Providers**

Screened for substance use disorders and screened positive for: opiate use disorder

If above box checked:  Referred to SUD treatment at Boston Comprehensive Treatment Center (clinic) with Dr. MAT (provider)

Patient already in evidence-based treatment

Patient declined treatment referral  Other: \_\_\_\_\_

Screened for psychiatric comorbidity and screened positive for depression

If above box checked:  Made referral to treatment at \_\_\_\_\_ (clinic) with \_\_\_\_\_ (provider)

Patient already in evidence-based treatment

Patient declined treatment referral  Other: \_\_\_\_\_

Screened for psychiatric comorbidity and screened negative

If patient was not screened for SUD and/or psychiatric comorbidity, please explain: \_\_\_\_\_

*For cases of opioid use disorder:*

Patient is already participating in medication-assisted treatment, at \_\_\_\_\_ (clinic) with \_\_\_\_\_

(provider)

Patient declines medication-assisted treatment at this time

Other (please explain): \_\_\_\_\_

*Dr. Project Respect OB*

Dr. Project Respect OB

03/22/18

\_\_\_\_\_  
Signature of obstetric provider

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of primary care provider

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Date

Dr. Emergency Medicine

Signature of emergency dept. provider

Dr. Emergency Medicine

Print name

03/28/18

Date

### Functional Goal 1: **Maternal addiction recovery**

*Goal: Every pregnant and postpartum woman with an SUD has the best possible chance of being in recovery during pregnancy and after delivery.*

### **Addiction and mental health providers:**

Patient is being treated for the following substance use disorders: opiate use disorder

Patient is being treated for the following psychiatric comorbidities: depression

[ ] If patient was not screened for SUD and/or psychiatric comorbidity, please explain: \_\_\_\_\_

#### *Treatment plan:*

[X] MAT during pregnancy: methadone 40 mg/day

[X] MAT after pregnancy: methadone 50 mg/day

[ ] MAT not indicated in this patient (explain): \_\_\_\_\_

[ ] Patient declines

medication

[X] Psychiatric medication during pregnancy: Fluoxetine

[X] Psychiatric medication after pregnancy: Fluoxetine

Psychiatric medication not indicated in this patient (explain): \_\_\_\_\_  Patient declines

medication  Plan for therapy and other psychosocial support (counseling, therapy, AA, NA, etc.): referred to the Mom's Project  
which provides individual substance use disorder counseling and psychotherapeutic groups

Potential barriers to treatment adherence (e.g. lack of transportation to methadone clinic) and plan to address them:

Lacks transportation, applied for transportation assistance through Mom's Project

---

signed release of substance use treatment and health information

<u>Dr. MAT</u>	Dr. MAT	03/19/18
Signature of addiction treatment provider	Print name	Date

<u>Dr. Psychiatrist</u>	Dr. Psychiatrist	<u>04/15/18</u>
Signature of mental health provider	Print name	Date

## Functional Goal 2: **Social stability for the family**

*Goal:* The social needs of pregnant and postpartum women and primary caregivers are met as early in pregnancy as possible, including both basic needs such as housing and transportation, as well as core support systems.

### **Social worker:**

Patient offered a prenatal tour with social work and pediatrics

Tour scheduled for 08/18/18  Patient declined tour  Patient missed tour, rescheduled for \_\_\_\_\_

The patient lives in Dorchester (location) with mom, brother, and two sisters (other people). This situation is (stable / unstable) and (will meet / will not meet) the patient and her child's needs during pregnancy and postnatally. Plan to

address (if relevant): Patient is currently living with family members without stable housing. Referred to Department of Housing and Community Development

[x] The patient uses public transportation/borrows car for transportation, which (will meet / will not meet) the patient's needs during pregnancy and postnatally, including her ability to engage in medical care and addiction treatment. Plan to

address (if relevant): Applying for medical transportation services through BMC and Mom's Project

Through shared decision-making, the patient and I have also prioritized the following psychosocial needs and plan for addressing them:

7) Housing

Plan to address: providing information and assistance to apply for housing through Department of Housing and Community Development

Service referral: Department of Housing and Community Development

8) Substance Use Treatment

Plan to address: referred to the Mom's Project, an outpatient treatment program, and enrolled in Project RESPECT

Service referral: Mom's Project through Boston Public Health Commission

9) Transportation

Plan to address: applying for medical transportation services through BMC

Service referral: BMC Department of Transportation



The patient and I have discussed that the Department of Children and Families will be involved at the time of delivery and may also be concerned about the following issues. We plan to address them as follows:

7) Food insecurity \_\_\_\_\_

Plan to address: enroll mom in SNAP and apply for WIC \_\_\_\_\_

Service referral: Department of Transitional Assistance \_\_\_\_\_

8) \_\_\_\_\_

Plan to address: \_\_\_\_\_

Service referral: \_\_\_\_\_

9) \_\_\_\_\_

Plan to address: \_\_\_\_\_

Service referral: \_\_\_\_\_

Social Worker

Social Worker

03/29/18

Signature of social worker

Print name

Date

**Functional Goal 3: Healthy fetal development and delivery**

*Goal:* Substance-exposed fetuses will develop in the healthiest *in utero* environment possible and undergo the appropriate screenings and treatments to facilitate a healthy delivery.

**Obstetrics:**

*The patient and I have discussed shared goals to achieve a healthy pregnancy, and together we have decided to*

*prioritize:*

8) Attend all prenatal visits and medical care

Plan to achieve this goal: writing all appointments into calendar and engaging family members in care to attend appointments

9) Commit to recovery

Plan to achieve this goal: enrollment in Mom's Project and Project Respect

10) \_\_\_\_\_

Plan to achieve this goal: \_\_\_\_\_

Dr. Project Respect OB

Dr. Project Respect OB

03/29/18

Signature of obstetric provider

Print name

Date

**Social worker:**

*The patient and I have discussed potential barriers to achieving the goals listed above and plans to meet them. They*

*include:*

5) Transportation will be primary issue

Plan to overcome this barrier: applying for transportation, scheduling appointments early so family can coordinate rides

6) Concerned about ability to stay sober

Plan to overcome this barrier: Attend as many psychotherapeutic groups at Mom's Project as possible, engage with recovery coach

*Social Worker*

Social Worker

03/29/18

\_\_\_\_\_  
Signature of social worker

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Date

**Functional Goal 4: Healthy infant development**

*Goal: Substance-exposed newborns have a smooth transition from hospital care into care at home, with attentive care providers at home, close medical follow-up, and appropriate social services for development support.*

**Pediatric hospitalist:**

The family had a prenatal visit with a hospitalist to prepare her for hospital care of the newborn, including management of neonatal abstinence syndrome and involvement of the Department of Children and Families

The family received a referral to early intervention

*Prior to hospital discharge:*

The family feels comfortable feeding the newborn by formula feeds (method)  Breastfeeding was encouraged

The family feels comfortable caring for the newborn at home and has the following social supports: Patient's mother and siblings are supporting mom, father is not in the picture

The family knows the date and location for the patient's first community pediatrics appointment

The patient will have VNA services after discharge  VNA is not indicated for this patient because:\_\_\_\_\_

The above questions do not apply as the family is not retaining custody of the patient

I spoke with the community pediatrician about the care of this patient, including a plan for ensuring the patient's safety at home

*Dr. Pediatric Hospitalist, BMC*

Dr. Pediatric Hospitalist

10/4/18

\_\_\_\_\_  
Signature of pediatric hospitalist

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Date

**Functional Goal 4: Healthy infant development**

*Goal: Substance-exposed newborns have a smooth transition from hospital care into care at home, with attentive care providers at home, close medical follow-up, and appropriate social services for development support.*

**Social Worker:**

[x] I am the family’s obstetric worker and will be assuming care for the infant’s social needs as well

[x] I am a pediatric social worker, and I (have / have not) spoken with the obstetric social worker regarding the family’s care plan

Through shared decision-making, the patient and I have also prioritized the following psychosocial needs for the infant and plan for addressing them:

7) Newborn born with NAS and mother still in recovery

Plan to address: Mother/Infant Dyad receive comprehensive pediatric care for substance exposed newborns and continued maternal support

Service referral: referred to SOFAR clinic at BMC

8) Financial assistance for food and newborn care

Plan to address: apply to WIC and Medicaid

Service referral: WIC and CHIP

9) \_\_\_\_\_

Plan to address: \_\_\_\_\_

Service referral: \_\_\_\_\_  
\_\_\_\_\_

*Pediatric Social Worker*

Pediatric Social Worker

10/4/18

\_\_\_\_\_  
Signature of pediatric social worker

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Date

### **Community Pediatrician:**

*After communicating with hospital-based care providers and the patient's family, we have set the following goals for the patient's healthy development and plans to meet them:*

7) Supporting the mother/infant dyad

Plan to achieve this goal: weekly visits with infant first month of life and adult trained addiction specialist for mom at SOFAR clinic

8) Concern for Development delays due to in utero exposure to opiates and NAS

Plan to achieve this goal: referred to early intervention and developmental/behavioral pediatricians at SOFAR clinic

9) \_\_\_\_\_

Plan to achieve this goal: \_\_\_\_\_  
\_\_\_\_\_

*Social work coordination:*

I have reviewed the social worker's plan for addressing the family's psychosocial needs

I have communicated with the social worker regarding the plan to continue to meet the patient's developmental needs and the family's psychosocial needs and am comfortable with my role in the plan.

*Dr. Community Pediatrics*

Dr. Community Pediatrics

10/15/18

\_\_\_\_\_  
Signature of pediatrician

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Date

## Massachusetts Plans of Safe Care

### Cape and Islands Case Study 1: Low Risk Patient

21F 16 weeks pregnant with OUD x 5 years (not on MAT), presents to emergency department for care for an injury.



## Functional Goal 1: **Maternal addiction recovery**

Goal: Every pregnant and postpartum woman with an SUD has the best possible chance of being in recovery during pregnancy and after delivery.

### **Obstetrics, Primary Care, and Emergency Department Providers**

Screened for substance use disorders and screened positive for opioid use disorder.

If above box checked:  Referred to SUD treatment at \_\_\_\_\_ (clinic) with \_\_\_\_\_ (provider)

Patient already in evidence-based treatment       Patient declined treatment referral  Other: initiated Subutex with starting

dose in ED, referred to obstetric MAT provider at Cape Cod Hospital

Screened for psychiatric comorbidity and screened positive for \_\_\_\_\_

If above box checked:  Made referral to treatment at \_\_\_\_\_ (clinic) with \_\_\_\_\_ (provider)

Patient already in evidence-based treatment       Patient declined treatment referral  Other: \_\_\_\_\_

Screened for psychiatric comorbidity and screened negative

If patient was not screened for SUD and/or psychiatric comorbidity, please explain: refused screening

*For cases of opioid use disorder:*

Patient is already participating in medication-assisted treatment, at CCH obstetrics (clinic) with Dr. Obstetrician (provider)

Patient declines medication-assisted treatment at this time

Dr. Obstetrician

Signature of obstetric provider

Dr. Obstetrician

Print name

3/2/19

Date

\_\_\_\_\_  
Signature of primary care provider

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Date

Dr. Emergency

Signature of emergency dept. provider

Dr. Emergency

Print name

3/1/19

Date

## Functional Goal 1: **Maternal addiction recovery**

Goal: Every pregnant and postpartum woman with an SUD has the best possible chance of being in recovery during pregnancy and after delivery.

### **Addiction and mental health providers:**

Patient is being treated for the following substance use disorders: opioid use disorder

Patient is being treated for the following psychiatric comorbidities: \_\_\_\_\_

[ ] If patient was not screened for SUD and/or psychiatric comorbidity, please explain: \_\_\_\_\_

#### *Treatment plan:*

[X] MAT during pregnancy: Subutex, initiated 3/1/19, 12mg

[X] MAT after pregnancy: Likely transition to Suboxone

[ ] MAT not indicated in this patient (explain): \_\_\_\_\_

[ ] Patient declines medication

[ ] Psychiatric medication during pregnancy: \_\_\_\_\_

[ ] Psychiatric medication after pregnancy: \_\_\_\_\_

[ ] Psychiatric medication not indicated in this patient (explain): \_\_\_\_\_

[X] Patient declines medication [ ] Plan for

therapy and other psychosocial support (counseling, therapy, AA, NA, etc.): declines at this time

[X] Potential barriers to treatment adherence (e.g. lack of transportation to methadone clinic) and plan to address them:

Pt accepts Subutex but refuses counseling or any mental health intervention. High risk for relapse. Referring to Moms Do Care.

Dr. Obstetrics

Signature of addiction treatment provider

Dr. Obstetrics

Print name

3/17/19

Date

\_\_\_\_\_  
Signature of mental health provider

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Date

## Functional Goal 2: **Social stability for the family**

*Goal:* The social needs of pregnant and postpartum women and primary caregivers are met as early in pregnancy as possible, including both basic needs such as housing and transportation, as well as core support systems.

### **Social worker:**

[X] Patient offered a prenatal tour with social work and pediatrics

[ ] Tour scheduled for \_\_\_\_\_ [X] Patient declined tour [ ] Patient missed tour, rescheduled for \_\_\_\_\_

[X] The patient lives homeless in Falmouth (location) with \_\_\_\_\_ (other people). This situation is (stable / unstable) and (will meet / will not meet) the patient and her child's needs during pregnancy and postnatally. Plan to address (if relevant): applied for housing in the office today

[X] The patient uses walking/public buses for transportation, which (will meet / will not meet) the patient's needs during pregnancy and postnatally, including her ability to engage in medical care and addiction treatment. Plan to address (if relevant):

Seeking community health worker through Moms Do Care who can take her to appointments

Through shared decision-making, the patient and I have also prioritized the following psychosocial needs and plan for addressing them:

1) Homelessness: as above

Plan to address: as above

Service referral: as above

2) Treatment engagement: Patient is at high risk of relapse and is not interested in engaging much in treatment

Plan to address: Connect with a community health worker

Service referral: Moms Do Care as above

The patient and I have discussed that the Department of Children and Families will be involved at the time of delivery and may also be concerned about the following issues. We plan to address them as follows:

1) Housing situation

Plan to address: Pursuing stable housing

Service referral: Housing application

2) Risk of relapse

Plan to address: Demonstrate stable engagement in treatment throughout remainder of prenatal period

Service referral: Moms Do Care

3) \_\_\_\_\_

Plan to address: \_\_\_\_\_

Service referral: \_\_\_\_\_

Social Worker, MSW  
Signature of social worker

Social Worker, MSW  
Print name

3/17/19  
Date

### Functional Goal 3: **Healthy fetal development and delivery**

Goal: Substance-exposed fetuses will develop in the healthiest *in utero* environment possible and undergo the appropriate screenings and treatments to facilitate a healthy delivery.

#### **Obstetrics:**

*The patient and I have discussed shared goals to achieve a healthy pregnancy, and together we have decided to prioritize:*

1) Initiate and remain stable on MAT

Plan to achieve this goal: Attend MAT appointment; work with social worker and community health worker

2) Engaging in prenatal visits

Plan to achieve this goal: Social worker and CHW will remind patient about visits

3) \_\_\_\_\_

Plan to achieve this goal: \_\_\_\_\_

Dr. Obstetrician

Signature of obstetric provider

Dr. Obstetrician

Print name

3/17/19

Date

#### **Social worker:**

*The patient and I have discussed potential barriers to achieving the goals listed above and plans to meet them. They include:*

1) Transportation issues

Plan to overcome this barrier: Transportation from community health worker

2) Treatment adherence

Plan to overcome this barrier: Frequent contact with treatment team, by phone or in person

Social Worker, MSW

Signature of social worker

Social Worker, MSW

Print name

3/17/19

Date

#### Functional Goal 4: **Healthy infant development**

*Goal: Substance-exposed newborns have a smooth transition from hospital care into care at home, with attentive care providers at home, close medical follow-up, and appropriate social services for development support.*

#### **Pediatric hospitalist:**

The family had a prenatal visit with a hospitalist to prepare her for hospital care of the newborn, including management of neonatal abstinence syndrome and involvement of the Department of Children and Families

*Prior to hospital discharge:*

The family feels comfortable feeding the newborn by \_\_\_\_\_ (method)  Breastfeeding was encouraged

The family feels comfortable caring for the newborn at home and has the following social supports: mother and sister are actively involved in caring for infant

The family knows the date and location for the patient's first community pediatrics appointment

The patient will have VNA services after discharge  VNA is not indicated for this patient because \_\_\_\_\_

The above questions do not apply as the family is not retaining custody of the patient

I spoke with the community pediatrician about the care of this patient, including a plan for ensuring the patient's safety at home

Dr. Hospitalist

Signature of pediatric hospitalist

Dr. Hospitalist

Print name

8/29

Date

**Functional Goal 4: Healthy infant development**

*Goal: Substance-exposed newborns have a smooth transition from hospital care into care at home, with attentive care providers at home, close medical follow-up, and appropriate social services for development support.*

**Social Worker:**

[ ] I am the family’s obstetric worker and will be assuming care for the infant’s social needs as well

[X] I am a pediatric social worker, and I (**have** / have not) spoken with the obstetric social worker regarding the family’s care plan

Through shared decision-making, the patient and I have prioritized the following psychosocial needs for the infant and plan for addressing them:

1) Early child development

Plan to address: refer to early intervention

Service referral: refer to EI

2) Nutritional support

Plan to address: ensure family is prepared to care for infant’s feeding needs

Service referral: WIC

3) \_\_\_\_\_

Plan to address: \_\_\_\_\_

Service referral: \_\_\_\_\_

Social Worker 2, MSW  
Signature of social worker

Social Worker 2, MSW  
Print name

3/17/19  
Date

## Community Pediatrician:

*After communicating with hospital-based care providers and the patient's family, we have set the following goals for the patient's healthy development and plans to meet them:*

1) Nutritional support

Plan to achieve this goal: meeting with pediatric nutritionist

2) Early intervention programs

Plan to achieve this goal: DCF case worker will refer to early intervention

3) \_\_\_\_\_

Plan to achieve this goal: \_\_\_\_\_

### *Social work coordination:*

I have reviewed the social worker's plan for addressing the family's psychosocial needs

I have communicated with the social worker regarding the plan to continue to meet the patient's developmental needs and the family's psychosocial needs and am comfortable with my role in the plan.

Dr. Pediatrician  
Signature of pediatrician

Dr. Pediatrician  
Print name

9/15/19  
Date



## Massachusetts Plans of Safe Care

### Cape and Islands Case Study 2: High Risk Patient

27F 8 weeks pregnant with OUD x 3 years (not on MAT), presents to OB for prenatal care, then gets referred to addiction provider and therapist.

She also gets scheduled to see her PCP shortly after initiating prenatal care.

## Functional Goal 1: **Maternal addiction recovery**

Goal: Every pregnant and postpartum woman with an SUD has the best possible chance of being in recovery during pregnancy and after delivery.

### **Obstetrics, Primary Care, and Emergency Department Providers**

Screened for substance use disorders and screened positive for opioid use disorder

If above box checked:  Referred to SUD treatment at Duffy Health Center (clinic) with Dr. MAT (provider)

Patient already in evidence-based treatment                       Patient declined treatment referral  Other: \_\_\_\_\_

Screened for psychiatric comorbidity and screened positive for generalized anxiety disorder (JS)

If above box checked:  Made referral to treatment at Duffy Health Center (clinic) with Dr. MAT (provider)

Patient already in evidence-based treatment                       Patient declined treatment referral  Other: \_\_\_\_\_

Screened for psychiatric comorbidity and screened negative

If patient was not screened for SUD and/or psychiatric comorbidity, please explain: \_\_\_\_\_

*For cases of opioid use disorder:*

Patient is already participating in medication-assisted treatment, at \_\_\_\_\_ (clinic) with \_\_\_\_\_ (provider)

Patient declines medication-assisted treatment at this time

Other (please explain): \_\_\_\_\_

<u>Dr. Obstetrician</u>	<u>Dr. Obstetrician</u>	<u>1/1/19</u>
Signature of obstetric provider	Print name	Date

<u>Dr. Primary Care</u>	<u>Dr. Primary Care</u>	<u>2/1/19</u>
Signature of primary care provider	Print name	Date

_____	_____	_____
Signature of emergency dept. provider	Print name	Date

## Functional Goal 1: **Maternal addiction recovery**

Goal: Every pregnant and postpartum woman with an SUD has the best possible chance of being in recovery during pregnancy and after delivery.

### **Addiction and mental health providers:**

Patient is being treated for the following substance use disorders: opioid use disorder

Patient is being treated for the following psychiatric comorbidities: generalized anxiety disorder

[ ] If patient was not screened for SUD and/or psychiatric comorbidity, please explain: \_\_\_\_\_

*Treatment plan:*

[X] MAT during pregnancy: Subutex, initiated 1/17/19, uptitrating dose

[X] MAT after pregnancy: TBD, likely transition to Suboxone

[ ] MAT not indicated in this patient (explain): \_\_\_\_\_ [ ] Patient declines medication

[X] Psychiatric medication during pregnancy: sertraline initiated by Dr. Maitland 1/17/19

[X] Psychiatric medication after pregnancy: TBD, likely continue sertraline

[ ] Psychiatric medication not indicated in this patient (explain): \_\_\_\_\_ [ ] Patient declines medication [ ] Plan for

therapy and other psychosocial support (counseling, therapy, AA, NA, etc.): pt goes to AA meetings weekly and will continue monthly counseling appointments with me

[X] Potential barriers to treatment adherence (e.g. lack of transportation to methadone clinic) and plan to address them:

Pt has had bad experiences with mental health providers in the past; I will focus on therapeutic alliance in initial visits

<u>Dr. MAT</u>	<u>Dr. MAT</u>	<u>1/17/19</u>
Signature of addiction treatment provider	Print name	Date

<u>Dr. Mental Health</u>	<u>Dr. Mental Health</u>	<u>2/20/19</u>
Signature of mental health provider	Print name	Date

## Functional Goal 2: **Social stability for the family**

*Goal:* The social needs of pregnant and postpartum women and primary caregivers are met as early in pregnancy as possible, including both basic needs such as housing and transportation, as well as core support systems.

### **Social worker:**

[X] Patient offered a prenatal tour with social work and pediatrics

[ ] Tour scheduled for \_\_\_\_\_ [ ] Patient declined tour [X] Patient missed tour, rescheduled for 4/15/19

[X] The patient lives in Falmouth (location) with two roommates (other people). This situation is (**stable** / unstable) and (**will meet** / will not meet) the patient and her child's needs during pregnancy and postnatally. Plan to address (if relevant):

---

[X] The patient uses public buses for transportation, which (will meet / will not meet) the patient's needs during pregnancy and postnatally, including her ability to engage in medical care and addiction treatment. Plan to address (if relevant):

Will discuss additional modes of transportation for the immediate postnatal period for her to attend MAT appointments

Through shared decision-making, the patient and I have also prioritized the following psychosocial needs and plan for addressing them:

1) Family support: patient's family has not been involved in her life since her last relapse. She would like them involved.

Plan to address: Patient will reach out to her sister after starting MAT and attempt to set up a meeting with SW in the room.

Service referral: N/A

2) Difficulties with anxiety

Plan to address: Patient is initiating medical treatment for anxiety but is nervous about the medication

Service referral: Will contact PCP about making sure she has early access to counseling

3) Risk of relapse

Plan to address: Patient will continue attending AA and engaging in MAT. She has SW cell phone number and knows she can text 24/7 with acute issues. Will also enroll in Moms Do Care.

Service referral: Moms Do Care

The patient and I have discussed that the Department of Children and Families will be involved at the time of delivery and may also be concerned about the following issues. We plan to address them as follows:

1) Housing situation

Plan to address: Patient will attempt to move in with family after re-engaging with family members

Service referral: N/A

2) Nutritional support

Plan to address: Patient education on nutrition during pregnancy and for infant

Service referral: Nutritionist, WIC

3) \_\_\_\_\_

Plan to address: \_\_\_\_\_

Service referral: \_\_\_\_\_

Social Worker, MSW

Signature of social worker

Social Worker, MSW

Print name

2/19/19

Date

### Functional Goal 3: **Healthy fetal development and delivery**

Goal: Substance-exposed fetuses will develop in the healthiest *in utero* environment possible and undergo the appropriate screenings and treatments to facilitate a healthy delivery.

#### **Obstetrics:**

*The patient and I have discussed shared goals to achieve a healthy pregnancy, and together we have decided to prioritize:*

1) Initiate and remain stable on MAT

Plan to achieve this goal: Attend MAT appointment; work with social worker

2) Engaging in prenatal visits

Plan to achieve this goal: Social worker will remind patient about visits

3) \_\_\_\_\_

Plan to achieve this goal: \_\_\_\_\_

Dr. Obstetrician

Signature of obstetric provider

Dr. Obstetrician

Print name

1/1/19

Date

#### **Social worker:**

*The patient and I have discussed potential barriers to achieving the goals listed above and plans to meet them. They include:*

1) Transportation issues

Plan to overcome this barrier: If buses become a problem, will help her reach out to social supports for transportation

2) MAT adherence

Plan to overcome this barrier: As above

Social Worker, MSW

Signature of social worker

Social Worker, MSW

Print name

2/19/19

Date

#### Functional Goal 4: **Healthy infant development**

*Goal: Substance-exposed newborns have a smooth transition from hospital care into care at home, with attentive care providers at home, close medical follow-up, and appropriate social services for development support.*

#### **Pediatric hospitalist:**

The family had a prenatal visit with a hospitalist to prepare her for hospital care of the newborn, including management of neonatal abstinence syndrome and involvement of the Department of Children and Families

*Prior to hospital discharge:*

The family feels comfortable feeding the newborn by breastfeeding (method)  Breastfeeding was encouraged

The family feels comfortable caring for the newborn at home and has the following social supports: mother and sister are actively involved in caring for infant

The family knows the date and location for the patient's first community pediatrics appointment

The patient will have VNA services after discharge  VNA is not indicated for this patient because she has home support

The above questions do not apply as the family is not retaining custody of the patient

I spoke with the community pediatrician about the care of this patient, including a plan for ensuring the patient's safety at home

Dr. Hospitalist

Signature of pediatric hospitalist

Dr. Hospitalist

Print name

8/1/19

Date

**Functional Goal 4: Healthy infant development**

*Goal: Substance-exposed newborns have a smooth transition from hospital care into care at home, with attentive care providers at home, close medical follow-up, and appropriate social services for development support.*

**Social Worker:**

I am the family’s obstetric worker and will be assuming care for the infant’s social needs as well

I am a pediatric social worker, and I (have / have not) spoken with the obstetric social worker regarding the family’s care plan

Through shared decision-making, the patient and I have also prioritized the following psychosocial needs for the infant and plan for addressing them:

1) Transportation issues: harder to take the bus now that she has an infant at home

Plan to address: Temporarily getting rides from family, but this is unstable

Service referral: Considering referral to a clinic with treatment support

2) MAT adherence: uncomfortable with MAT now that she is breastfeeding

Plan to address: will speak with addiction social worker; discussed that it is safe to continue her buprenorphine

Service referral: addiction SW

3) Early intervention/developmental support

Plan to address: refer to early intervention

Service referral: EI

Social Worker, MSW  
Signature of social worker

Social Worker, MSW  
Print name

9/20/19  
Date



**Community Pediatrician:**

*After communicating with hospital-based care providers and the patient’s family, we have set the following goals for the patient’s healthy development and plans to meet them:*

- 1) Nutritional support  
Plan to achieve this goal: meeting with pediatric nutritionist
- 2) Early intervention programs  
Plan to achieve this goal: SW will refer to early intervention
- 3) \_\_\_\_\_  
Plan to achieve this goal: \_\_\_\_\_  
\_\_\_\_\_

*Social work coordination:*

I have reviewed the social worker’s plan for addressing the family’s psychosocial needs

I have communicated with the social worker regarding the plan to continue to meet the patient’s developmental needs and the family’s psychosocial needs and am comfortable with my role in the plan.

Dr. Pediatrician  
Signature of pediatrician

Dr. Pediatrician  
Print name

9/15/19  
Date

## H. Overview of Programs with Best Practices:

- **Moms Do Care**
- **Project RESPECT**
- **SOFAR**
- **Baystate Pregnancy Plan**
- **MCPAP for Moms**
- **CHARM Collaborative**
- **Mom's Project**

### **Moms Do Care**

<http://www.healthrecovery.org/projects/moms-do-care/>

#### **Biography:**

Integrated system of medical and behavioral health care for pregnant women with opiate use disorders including access to medication assisted treatment (MAT) and recovery support throughout the pregnancy and postpartum period through peer recovery coaches.

#### **Services Provided:**

1. Assistance in accessing and navigating MAT, obstetrical and other health care and substance use services
2. Recovery coaching and case management with staff who have lived experience with substance use, recovery, and motherhood
3. Specialized programming such as “Seeking Safety” and “Nurturing Families in Recovery” groups and peer support meetings for mothers in the community
4. Follow up in postpartum period when women may be at risk for postpartum depression and relapse
5. Education for community providers in trauma-informed care and medication assisted treatment

#### **Criteria for enrollment:**

1. Pregnant women, over the age of 18, with an opioid use disorder
2. Willingness to start Medication Assisted Treatment (i.e. methadone or buprenorphine)  
OR already on Medication Assisted Treatment

### **Project Respect**

<https://www.bmc.org/obstetrics/project-respect>

#### **What is Project RESPECT?**

Project RESPECT (Recovery, Empowerment, Social Services, Prenatal care, Education, Community and Treatment), is a high risk obstetrical and addiction recovery medical home at Boston Medical Center and Boston University School of Medicine. Project RESPECT provides a unique service of comprehensive obstetric and substance use disorder treatment for pregnant women and their newborns in Massachusetts.

### **How does Project RESPECT help pregnant women struggling with addiction?**

The majority of Project RESPECT patients are in recovery from opioid addiction. In-patient, monitored, acute substance withdrawal treatment and induction of opioid maintenance therapies for pregnant woman seeking addiction treatment are provided. Intensive, individualized out-patient treatment plans are outlined for each patient based on the severity of their disease and their recovery progress. The out-patient medical home model provides on site, collaborative and multidisciplinary care for pregnant and post-partum women in recovery.

### **What kind of care is provided through Project RESPECT?**

The Project RESPECT clinical team includes buprenorphine-waivered obstetric providers, a psychiatrist specializing in mood disorders in pregnancy, an addiction psychiatry nurse practitioner, and a Licensed Independent Clinical Social Worker. The team collaborates and coordinates all of the mom-to-be's care with their inpatient obstetric, pediatric, psychiatry, social work, nursing and lactation teams to provide them with supportive and informed care.

### **Besides physical health, how does the Project RESPECT team work to improve the lives of the women and babies they care for?**

Project RESPECT works in collaboration with multiple community based organizations including local methadone clinics, residential addiction treatment centers, the Department of Public Health, and the Department of Children and Families.

Project RESPECT is a regional leader in the treatment of Substance Use Disorders in pregnancy and is actively engaged with the Massachusetts Bureau of Substance Abuse Services (BSAS) and the American Society of Addiction Medicine (ASAM) in education and outreach programs for the medical community.

### **SOFAR clinic**

<https://www.bmc.org/pediatrics-primary-care/sofar>

### **SOFAR**

The goal of SOFAR (Supporting Our Families through Addiction and Recovery) is to create a medical home in the pediatric primary care clinic for mothers in recovery and their children.

SOFAR provides ongoing support for families to enhance child development as well as ongoing support for recovery, with access to specialty care and social services.

SOFAR works to coordinate infants' primary care visits with any additional care that mothers and babies need, to minimize the number of visits required.

## **Who We Are**

SOFAR is a multidisciplinary team of physicians, social workers, patient navigators, nurse practitioners, and coordinators who provide high-quality, coordinated medical and psychosocial care for families to maximize their ability to successfully navigate parenting and substance use recovery. SOFAR expands on the multidisciplinary prenatal care provided by Project RESPECT for pregnant women with opioid use disorder.

## **Services**

### For infants:

- Primary care
- Pediatric infectious disease care
- Developmental assessment and links to early intervention services
- Social work support (DCF follow up, links to other social resources)

### For mothers:

- Care coordination through Grayken Center for Addiction
- CATALYST Clinic (teens and young adults)
- OBAT (adult primary care)
- Linkage to outside resources and social services
- Peer support

## **MCPAP for Moms**

<https://www.mcpapformoms.org/Providers/HowMCPAPForMomsWorks.aspx>

MCPAP for Moms promotes maternal and child health by building the capacity of providers serving pregnant and postpartum women and their children up to one year after delivery to effectively prevent, identify, and manage mental health and substance use concerns.

### **How MCPAP for Moms Works:**

Providers can call MCPAP for Moms at 855-Mom-MCPAP (855-666-6272), Monday-Friday, 9am-5pm, and speak with a Care Coordinator who will work with the provider to determine their needs - i.e., consultation regarding psychiatric care, community care coordination, or both.

### **Psychiatric consultation:**

The MCPAP for Moms perinatal psychiatrist provides real-time consultation via the telephone. The consultation may involve diagnostic support, guidance in regards to medication treatment (when indicated), psychotherapy and community support needs, treatment planning, and medication concerns regarding preconception, pregnancy and lactation. The MCPAP for Moms psychiatrist works with the provider to assist him/her in addressing their patient's mental health concerns. The MCPAP for Moms psychiatrist is also available to see patients for face-to-face consultations, after which they will send a detailed written assessment that will include treatment recommendations to the provider.

**Resource and Referral:**

The Resource and Referral Specialist works with providers to assist them in arranging ongoing mental health support for patients including, but not limited to, psychotherapy groups, mental health treatment (including prescribers), and family based treatments that are geographically convenient for the patient. In some cases the Resource and Referral Specialist can call the patient/family and provider to ensure that patients have access to follow-up mental health care.

**CHARM collaborative:**

A full case study of the CHARM collaborative can be found here:

[http://county.milwaukee.gov/ImageLibrary/Groups/cntyHHS/BHD/CARS/Well-Baby/CHARM\\_CaseStudy.pdf](http://county.milwaukee.gov/ImageLibrary/Groups/cntyHHS/BHD/CARS/Well-Baby/CHARM_CaseStudy.pdf)

**CHARM Today:**

The CHARM Collaborative includes 10 organizations that collectively provide comprehensive care coordination for pregnant women with opioid use disorders and consultation for child welfare, medical, and addiction professionals across Vermont. Several members have been involved in CHARM since the group's inception. The following table lists the CHARM Collaborative members.

Member Organization	Services Provided
Comprehensive Obstetric and Gynecological Services (COGS), Fletcher Allen Health Care Hospital	<ul style="list-style-type: none"> <li>• Prenatal care</li> <li>• MAT assessment</li> <li>• Buprenorphine</li> <li>• Care coordination</li> </ul>
NeoMed Clinic, Vermont Children's Hospital at Fletcher Allen Health Care Hospital	<ul style="list-style-type: none"> <li>• Neonatal assessment and treatment</li> <li>• Parent education on Neonatal Abstinence Syndrome</li> <li>• Developmental assessment</li> </ul>
Howard Center/Chittenden Clinic	<ul style="list-style-type: none"> <li>• MAT assessment</li> <li>• Methadone, buprenorphine</li> <li>• Individual and Group substance abuse treatment</li> </ul>
LUND	<ul style="list-style-type: none"> <li>• Residential care for mother and baby</li> <li>• Substance abuse treatment</li> <li>• Parent and Family support</li> </ul>
Vermont Department for Children and Families	<ul style="list-style-type: none"> <li>• Child Safety Assessments</li> <li>• Child Welfare Services</li> </ul>
Vermont Department of Corrections/Correct Care Solutions	<ul style="list-style-type: none"> <li>• Healthcare for women in the corrections system</li> </ul>
Alcohol and Drug Abuse Programs, Vermont Department of Health	<ul style="list-style-type: none"> <li>• Substance abuse treatment</li> <li>• Opioid Treatment Authority</li> </ul>
Maternal and Child Health (Chittenden, Franklin and Grand Isle Counties), Vermont Department of Health	<ul style="list-style-type: none"> <li>• Public Health Services</li> <li>• Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)</li> <li>• Home Visiting referral</li> </ul>
Vermont Department of Health Access	<ul style="list-style-type: none"> <li>• Medicaid</li> </ul>
Visiting Nurse Association of Chittenden and Grand Isle	<ul style="list-style-type: none"> <li>• Nurse Home Visiting services</li> </ul>

At any given time, approximately 100 women receive coordinated care through the CHARM Collaborative. Each month, about 20 pregnant women are added to the client list and about 10 babies are born. Annually, the collaborative serves 200–250 families.

Members of the CHARM Collaborative meet once a month for 2 hours to discuss the needs of client families and how to address these needs. Decisions about solutions and follow-up tasks are made for each family before the next family is discussed. To support these discussions, the facilitator distributes a list of client families at each meeting. The lists of client families are divided into four categories: families that are new to CHARM, those with a woman expected to give birth within 30 days, those with a woman who recently gave birth, and those for whom a collaborative member has concerns. Within each category, the names are listed alphabetically, and families are discussed in that order. Typically, about 40 families are discussed at each meeting. Periodically, the first 15 minutes are used for providing cross-disciplinary training, sharing outcomes, and discussing related projects and other non case-specific process issues.

## **Mom's Project by Boston Public Health Commission**

(<http://www.bphc.org/whatwedo/Recovery-Services/roadmap-to-recovery/Programs-and-Services/Pages/MOM'S-Project.aspx>)

THE MOM'S PROJECT/WOMEN'S HEALTH & RECOVERY is an outpatient treatment program that provides recovery services (individual therapy, group therapy, and case management) for self-identified women who have substance use disorders. Our staff offer expertise in the treatment needs of those with substance use disorders provided in a caring, diverse, culturally-sensitive, and non-judgmental environment.

### **SERVICES WE PROVIDE:**

- Individual substance use disorder counseling
- Treatment planning
- Psychotherapeutic groups, including:
  - o Relapse Prevention, Mindfulness, Anger Management, Neurobiology of Addiction, Spirituality & Recovery, Family Nurturing, Pathways to Reunification, Self-Esteem and Early Recovery Evening Group (Wednesday evenings 6:00 – 7:30pm).
- Case management services
- On-site primary care services
- On-site HIV and STI testing
- Drug screening if requested by outside providers
- Care-coordination
- Transportation assistance for eligible clients
- Services provided in both English and Spanish
- Light lunch and refreshments

### **POPULATION SERVED:**

The program serves self-identifying women (18+ years old) from the Boston area and beyond, all coming from a diverse variety of backgrounds.

### **ELIGIBILITY:**

- Identify as female
- 18+ years old
- A past or present history of substance use disorder

### **IN NEED OF SERVICES OR WANT TO MAKE A REFERRAL?**

**When?** Walk-ins are welcome for enrollment (no appointment needed)

- o Intakes: Mon. – Fri., 9:00am – 3:00pm (note: Tuesdays until 12:00pm).
- o Programs: Mon. – Fri., 8:00am – 4:00pm (note: Wednesdays until 1:30pm).

**Where?** We are located at 774 Albany Street, 4rd floor, Boston, MA 02118 (directly across from the Boston Medical Center Ambulance entrance). **How?** For more information please call: 617-534-7411

## I. Release of Patient Information Example

*Consent Form used by CHARM Collaborative in Vermont to receive Substance Use information and Health information*

### CHILDREN AND RECOVERING MOTHERS (CHARM) PROGRAM 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
- KidSafe Collaborative
- Northwest Counseling and Support Services
- 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.