Implementation of the Plan of Care Act: Two generation care for mothers and infants affected by substance use disorders

CARA PLANS OF CARE FOR SUBSTANCE-EXPOSED NEWBORNS AND THEIR FAMILIES

Presenters: Cynthia Chavers, LMSW and Andy Hsi, MD

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Disclosure

Cynthia Chavers, LMSW, State of NM CYFD/Protective Services Division

Dr. Andy Hsi, UNM Institute for Resilience, Health and Justice

We do not have any financial arrangements or affiliations with any corporate organizations which might constitute a conflict of interest with regard to this continuing education activity.

Agenda

- Background – where we've been
- Best Practices – where we want to go
- Implementation and Planning - how are we going to get there
- Roles of Prenatal Care Providers, Primary Care Physicians, Discharge Planners, Insurance Care Coordinators and other professionals.
- Plan of Care Portal and Forms
- More Best Practices
- Resources

A Collaboration of Stakeholders

- Medicaid managed care organizations
- Advocacy Groups
- NM CYFD
- NM Department of Health
- NM Human Services Department
- Hospitals
- Other Medical Providers
- Indian Health Services
- The Brindle Foundation
- Families

CARA Work Group

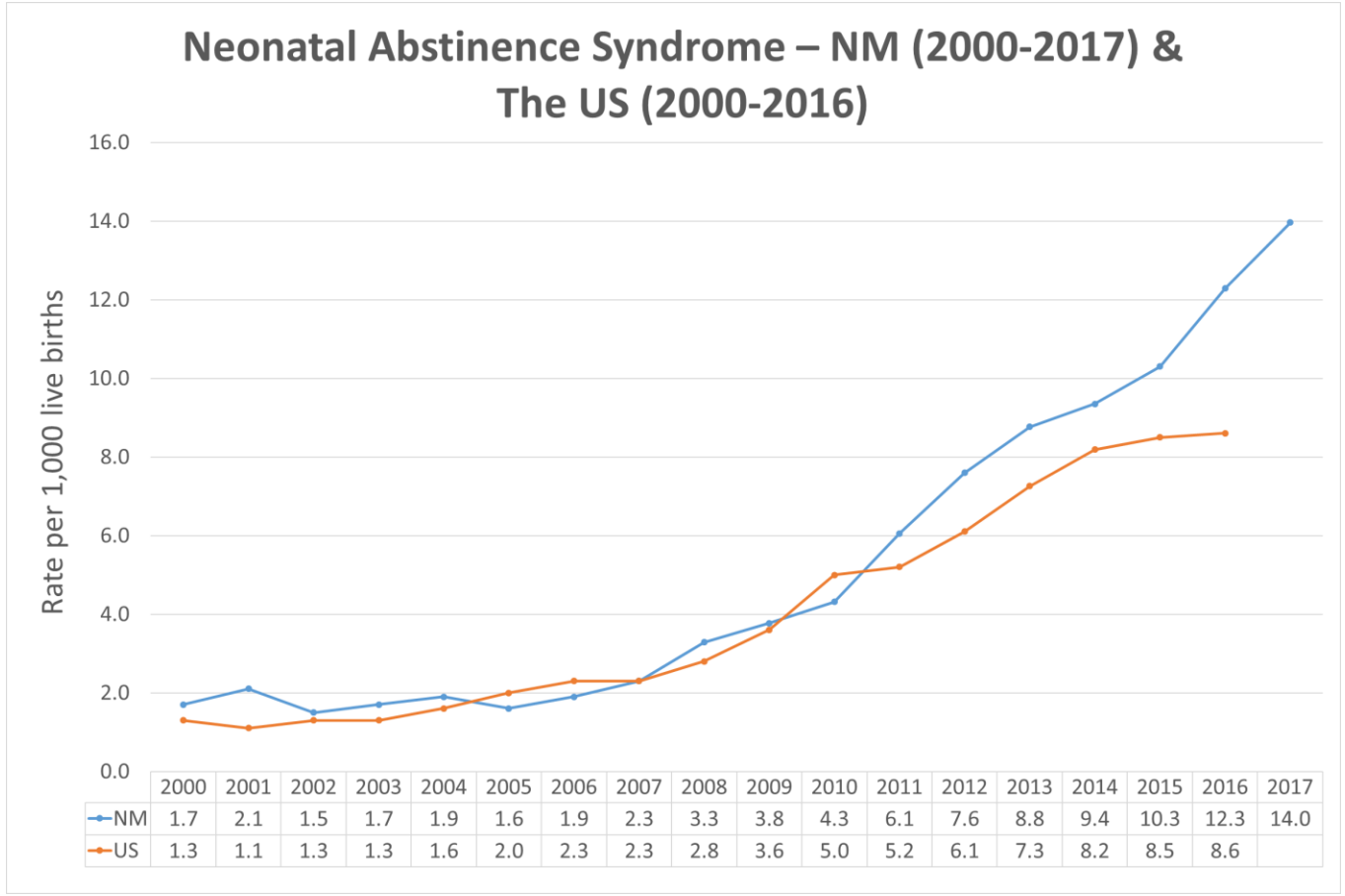
The CARA Work Group is co-chaired by Cynthia Chavers (CYFD) and Dr. Andy Hsi (UNM). The group, consisting of approximately 160 public- and private-sector stakeholders, has been working since 2017 to bring the State of New Mexico into compliance with federal law regarding substance-exposed newborns and their families.

Opioid Use in Pregnancy

The estimated cost of the epidemic nationwide between 2001 and 2017 exceeded $1 trillion from lost productivity and increased spending on health care, social services, education, and criminal justice.

- 1 in 12 pregnant women used an illicit drug in 2017
- Opioids contribute to 10-20% of all maternal deaths during pregnancy nationally
- In NM, multidrug use is common

NAS in NM



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
NM	1.7	2.1	1.5	1.7	1.9	1.6	1.9	2.3	3.3	3.8	4.3	6.1	7.6	8.8	9.4	10.3	12.3	14.0
US	1.3	1.1	1.3	1.3	1.6	2.0	2.3	2.3	2.8	3.6	5.0	5.2	6.1	7.3	8.2	8.5	8.6	

More than opioids…

JAMA Network | Open

Invited Commentary | Substance Use and Addiction

Is Increasing Frequency of Marijuana Use Among Women of Reproductive Age a Cause for Alarm?

Torri D. Metz, MD, MS; Elaine H. Stickrath, MD

Young-Wolff and colleagues[1] evaluated whether the frequency of marijuana use has increased among reproductive-aged women in the year before and during pregnancy from 2009 to 2017. Using Kaiser Permanente Northern California data from 367 403 pregnancies, the authors[1] found that marijuana use increased over time, with the largest proportional increase in women who used marijuana daily both before (1.17% vs 3.05%) and during (0.28% vs 0.69%) pregnancy.

With expanding legalization and increased perception of safety of marijuana use in pregnancy, it is not surprising that Young-Wolff and colleagues[1] observed increased use among reproductive-aged women over time. The question is whether these data are a cause for alarm. To make that determination, we need to evaluate what we know about the potential consequences of frequency of marijuana use on maternal-infant health. In addition, we need to determine if these data are robust enough to support the claim that reproductive-age women are using marijuana with increased frequency now compared with a decade ago.

+ Related article

Author affiliations and article information are listed at the end of this article.

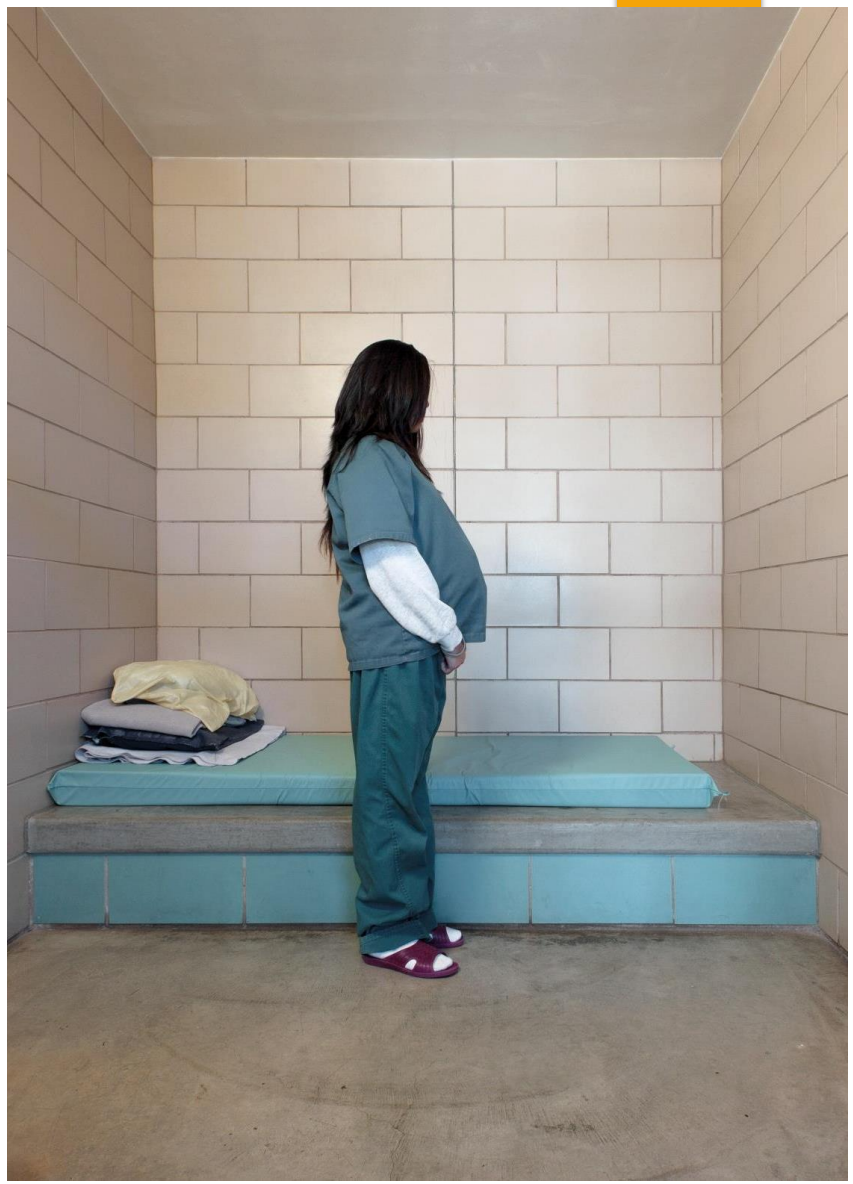
State Responses

Tennessee-
"Fetal Assault Law"

Alabama-
"Chemical Endangerment Law"

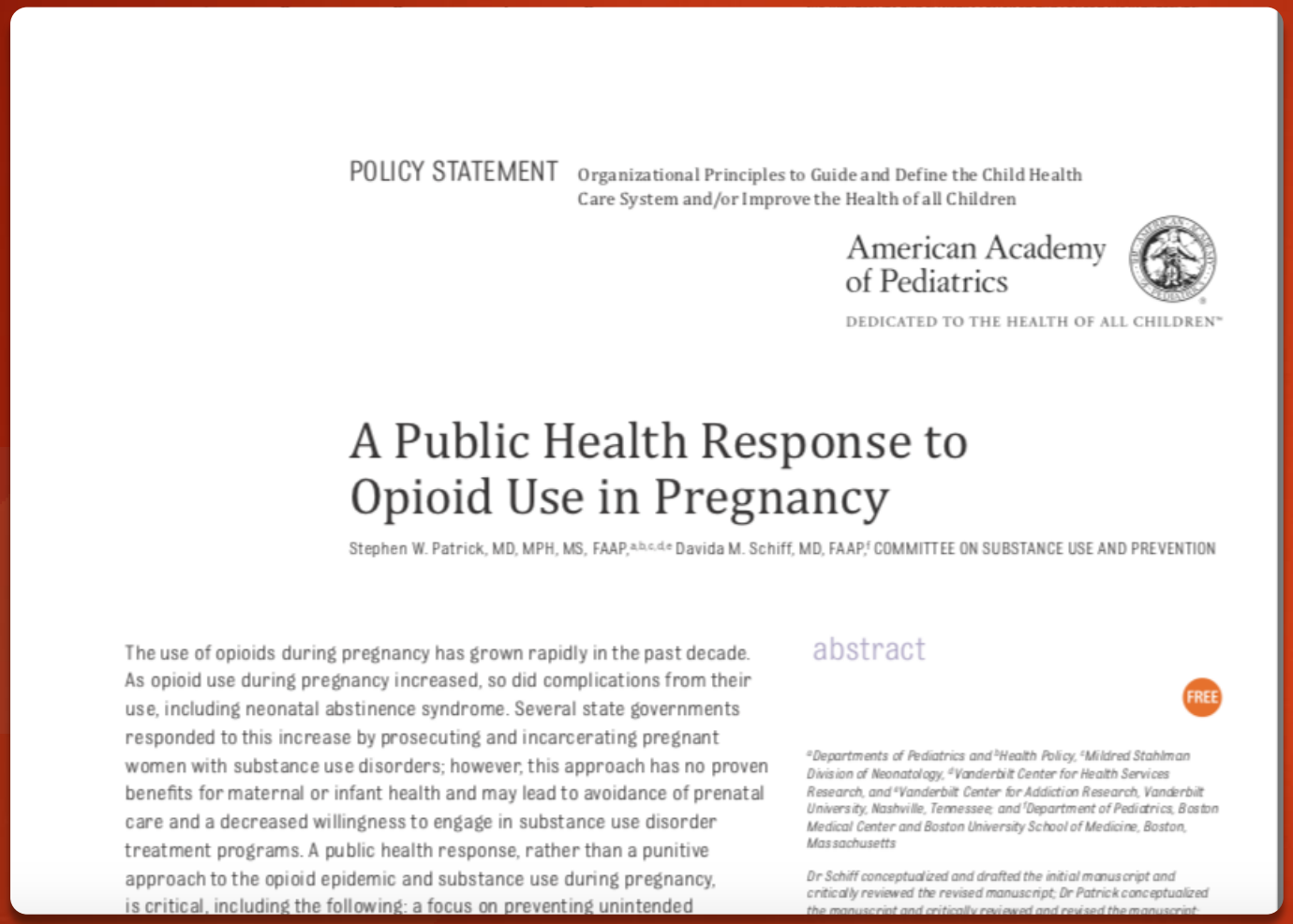
Driving Forces: Racism, Discrimination, Emphasis on criminalization and punishment over public health

Result? Barriers to accessing care; erosion of trust.



Result of Punitive policies

- Barriers to accessing care
- Erosion of trust between patients and providers
- Increased rates of NAS (JAMA, Nov. 2019)



POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

A Public Health Response to Opioid Use in Pregnancy

Stephen W. Patrick, MD, MPH, MS, FAAP,[a,b,c,d,e] Davida M. Schiff, MD, FAAP,[f] COMMITTEE ON SUBSTANCE USE AND PREVENTION

abstract

FREE

The use of opioids during pregnancy has grown rapidly in the past decade. As opioid use during pregnancy increased, so did complications from their use, including neonatal abstinence syndrome. Several state governments responded to this increase by prosecuting and incarcerating pregnant women with substance use disorders; however, this approach has no proven benefits for maternal or infant health and may lead to avoidance of prenatal care and a decreased willingness to engage in substance use disorder treatment programs. A public health response, rather than a punitive approach to the opioid epidemic and substance use during pregnancy, is critical, including the following: a focus on preventing unintended

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Dr Schiff conceptualized and drafted the initial manuscript and critically reviewed the revised manuscript; Dr Patrick conceptualized the manuscript and critically reviewed and revised the manuscript;

Best Practices: Public Health Approach

Best Practices: Collaborative, Nonjudgmental Approach

- A coordinated, multisystem approach best serves the needs of pregnant women with opioid use disorders and their infants.
- Substance abuse is viewed as a medical condition with social, economic, and cultural roots. Favor behavioral health service providers who have demonstrated a nonjudgmental approach.
- Support client/patient efforts at harm reduction.
- Interventions should be provided in ways that prevent stigmatization, discrimination, criminalization, and marginalization of women seeking treatment.
- Prevention and treatment should promote and facilitate family, community and social support as well as social inclusion by fostering strong links with available childcare, economic supports, education, housing, and relevant services.

Innovative Strategies

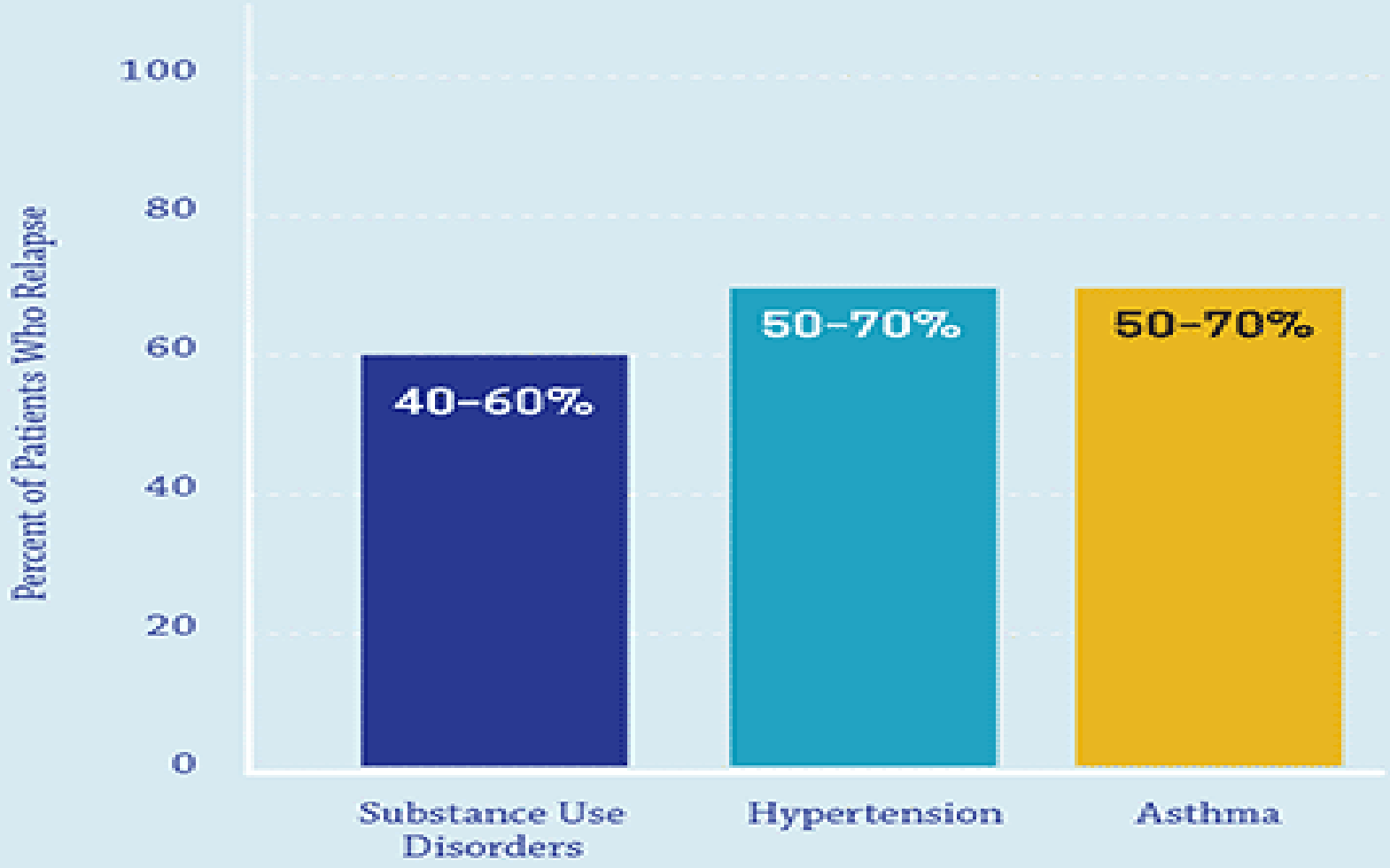
Individualized, comprehensive and multidisciplinary treatment is needed since no single agency has the resources or the information base to address the full range of needs of all substance-exposed infants and their families.

"The consequences of prenatal drug exposure and significant adversity early in life REQUIRE innovative strategies to reduce toxic stress within a coordinated system of policies and services guided by an integrated science of early childhood and early brain development."

Jack Shonkoff, 2016

Center on the Developing Child

Comparison of Relapse Rates Between Substance Use Disorders and Other Chronic Illnesses



What does relapse mean?

Like other chronic diseases such as heart disease or asthma, treatment for drug addiction usually isn't a cure. But addiction ***can*** be managed successfully. Treatment enables people to counteract addiction's disruptive effects on their brain and behavior and regain control of their lives.

Treatment of chronic diseases involves changing deeply rooted behaviors, and relapse doesn't mean treatment has failed. When a person recovering from an addiction relapses, it indicates that the person needs to speak with their doctor to resume treatment, modify it, or try another treatment.

The chronic nature of addiction means that for some people *relapse*, or a return to drug use after an attempt to stop, can be part of the process, but newer treatments are designed to help with relapse prevention. Relapse rates for drug use are similar to rates for other chronic medical illnesses. If people stop following their medical treatment plan, they are likely to relapse.

https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery

Best Practices: Prenatal Screening

Lovelace
Medical Group

Name_____Date_____

Please answer each question below.

Have you ever used drugs, alcohol or tobacco during this pregnancy?

Have you had a problem with drugs, alcohol or tobacco in the past?

Does your partner have a problem with drugs, alcohol or tobacco?

Do you consider one of your parents to be an addict, an alcoholic, or unable to stop smoking?

SCREENING QUESTIONNAIRE FOR SUBSTANCE USE IN PRENATAL CARE

1) When did you know of your pregnancy?
   a) How did you find out you are pregnant?
   b) Have you started prenatal care?
   c) How are you doing?

2) Before you knew of your pregnancy what was your use of alcohol?
   a) No use
   b) 1 to 2 drinks in a month
   c) 1 to 2 drinks in a week
   d) 1 to 2 drinks in a day
   e) 3 or more drinks in a day

3) Since learning of your pregnancy what is your use of alcohol?
   a) No use
   b) 1 to 2 drinks in a month
   c) 1 to 2 drinks in a week
   d) 1 to 2 drinks in a day
   e) 3 or more drinks in a day

4) Before you knew of your pregnancy what was your use of cigarettes/tobacco products?
   a) No smoking
   b) 1 to 2 cigarettes/tobacco products in a month
   c) 1 to 2 cigarettes/tobacco products in a week
   d) 1 to 2 cigarettes/tobacco products in a day
   e) 3 or more cigarettes/tobacco products in a day

Substance Use Disorder: *Original Research*

OPEN

Accuracy of Three Screening Tools for Prenatal Substance Use

Victoria H. Coleman-Cowger, PhD, Emmanuel A. Oga, MD, MPH, Erica N. Peters, PhD, Kathleen E. Trocin, MPH, Bartosz Koszowski, PharmD, PhD, and Katrina Mark, MD

OBJECTIVE: To compare and evaluate the accuracy of three screening tools in identifying illicit drug use and prescription drug misuse among a diverse sample of pregnant women.

METHODS: This prospective cross-sectional study enrolled a consecutive sample of 500 pregnant women, stratified by trimester, receiving care in two prenatal clinical settings in Baltimore, Maryland, from January 2017 to January 2018. All participants were administered three index tests: 4P's Plus, NIDA Quick Screen-ASSIST (Modified Alcohol, Smoking and Substance Involvement Screening Test), and the SURP-P (Substance Use Risk Profile-Pregnancy) scale, and administered reference tests (urine and hair drug testing) at the in-person baseline visit. To assess test–retest reliability of the index tests, screening tool administrations were repeated 1 week later by telephone. For each screening tool, sensitivity, specificity, positive predictive value, negative predictive value and test–retest reliability were computed. Results were stratified by age, race, and trimester of pregnancy. reference testing, and 453 underwent test–retest analysis. For the 4P's Plus, sensitivity=90.2% (84.5, 93.8), and specificity=29.6% (24.4, 35.2). For the NIDA Quick Screen-ASSIST, sensitivity=79.7% (71.2, 84.2), and specificity=82.8% (78.1, 87.1). For the SURP-P, sensitivity=92.4% (87.6, 95.8) and specificity=21.8% (17.4, 27.2). Test–retest reliability (phi correlation coefficients) was 0.84, 0.77, and 0.79 for the 4P's Plus, NIDA Quick Screen-ASSIST and the SURP-P, respectively. For all screening tools, there were differences in validity indices by age and race, but no differences by trimester.

CONCLUSION: The SURP-P and 4P's Plus had high sensitivity and negative predictive values, making them more ideal screening tests than the NIDA Quick Screen-ASSIST. A clear recommendation for a clinically useful screening tool for prenatal substance use is crucial to allow for prompt and appropriate follow-up and intervention.

(Obstet Gynecol 2019;133:952–61)

DOI: 10.1097/AOG.0000000000003230

Prenatal Drug Exposure and Adversity

Fisher et al., 2011

Feldman et al., 2018

- Children with both prenatal drug exposure and early adversity face greater risks to later developmental outcomes.
- Developmental pathway that leads to behavioral dysregulation and executive function difficulties.
- Requires evidence-based interventions and policy change.
- Requires system integration.

Pediatrics 2018 – Recent Study

- Parental ACE exposures can negatively impact child development in multiple domains.
- For each Maternal ACE, there was an 18% increase in the risk for a developmental delay. Similar for Paternal ACEs.
- High Parental ACEs signal the need for early Family-Based Interventions to mitigate developmental risks
- Folger et al., 2018

Evidence Based Practice: EARLY START

Early Start

A Cost–Beneficial Perinatal Substance Abuse Program

Nancy C. Goler, MD, Mary Anne Armstrong, MA, Veronica M. Osejo, BS, Yun-Yi Hung, PhD, Monica Haimowitz, LCSW, and Aaron B. Caughey, MD, PhD

OBJECTIVE: To conduct a cost–benefit analysis of Early Start, an integrated prenatal intervention program for stopping substance use in pregnancy.

METHODS: A retrospective cohort study was conducted of 49,261 women who had completed prenatal substance abuse screening questionnaires at obstetric clinics and who had undergone urine toxicology screening tests. Four study groups were compared: women screened and assessed positive and followed by Early Start (screened-assessed-followed, n=2,032), women screened and assessed positive without follow-up (screened-assessed, n=1,181), women screened positive only (screened-positive-only, n=149), women in the control group who screened negative (control, n=45,899). Costs associated with maternal health care (prenatal through 1 year postpartum), neonatal birth hospitalization care, and pediatric health care (through 1 year) were adjusted to 2009 dollars. Mean costs were calculated and adjusted for age, race, education, income, marital status, and amount of prenatal care.

RESULTS: Screened-positive-only group adjusted mean maternal total costs ($10,869) were significantly higher than screened-assessed-followed, screened-assessed, and control groups ($9,430; $9,230; $8,282; all $P<.001$). Screened-positive-only group adjusted mean infant total costs ($16,943) were significantly higher than screened-assessed-followed, screened-assessed, and control groups ($11,214; $11,304; $10,416; all $P<.001$). Screened-positive-only group adjusted mean overall total costs ($27,812) were significantly higher than screened-assessed-followed, screened-assessed, and control groups ($20,644; $20,534; $18,698; all $P<.001$). Early Start implementation costs were $670,600 annually. Cost–benefit analysis showed that the net cost benefit averaged $5,946,741 per year.

CONCLUSION: Early Start is a cost-beneficial intervention for substance use in pregnancy that improves maternal–infant outcomes and leads to lower overall costs by an amount significantly greater than the costs of the program.

(Obstet Gynecol 2012;119:102–10)
DOI: 10.1097/AOG.0b013e31823d427d

LEVEL OF EVIDENCE: II

Alcohol, tobacco, and other drug use remains a paramount problem in pregnancy leading to preventable morbidity and mortality in more than 400,000 pregnancies annually.[1–3] Exposure to alcohol, tobacco, and other drugs in pregnancy leads to increased rates of placental abruption, intrauterine fetal demise, low-birth-weight neonates, neonatal abstinence syndrome, and preterm labor and birth.[1,2,4] In turn, preterm birth, associated with short-term and long-term morbidity, adds significant costs.[5] Despite multiple educational advertising campaigns, substance use during pregnancy continues to be significant. Data from the Substance Abuse and Mental Health Services Administration in 2008 revealed no significant decrease in pregnancy usage (5.1% up from 4% in 2005–2006).[6]

In 1990, Kaiser Permanente Northern California developed Early Start, an integrated prenatal intervention program for stopping alcohol, tobacco, and other drug use.[7] The program created the Early Start specialist position, a licensed clinical social worker or marriage and family therapist with expertise in substance use and pregnancy who is located within the obstetrics and gynecology department. Appointments for substance use are linked to routine prenatal care

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Financial Disclosure
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2007 James A Vohs Award for Quality Second-Place Selection

Early Start: An Integrated Model of Substance Abuse Intervention for Pregnant Women

By Cosette Taillac, LCSW, BCD
Nancy Goler, MD
Mary Anne Armstrong, MA
Kathleen Haley, MS
Veronica Osejo

Abstract

Untreated perinatal substance abuse is associated with serious adverse maternal and neonatal outcomes. Historically, many barriers have prevented pregnant women from seeking treatment. Early Start (ES) breaks new ground by sidestepping these barriers with a fully integrated service delivery model.

ES is the largest HMO-based prenatal substance-abuse program in the United States targeting all pregnant women seen at Kaiser Permanente Northern California (KPNC) prenatal clinics, currently screening more than 39,000 women each year. The program is based on the premise that substance abuse is a treatable disease and addresses it in a nonjudgmental, accepting manner. A substance-abuse counselor is located in each obstetrics clinic providing accessible one-to-one counseling to pregnant women screened at risk for alcohol, tobacco, or drug use as part of the routine prenatal care package offered to all patients.

A 2006 ES study, sponsored by the Kaiser Foundation Research Institute, evaluated program effectiveness in terms of its impact on neonatal and maternal outcomes. Preliminary results that included 49,986 KPNC patients indicate that compared with pregnant women whose results on screening for substance use were positive but who were untreated, ES-treated women had significantly lower rates on a number of outcome measures.

The originality and transferability of ES has led to both local and national recognition. Universal screening of all pregnant women with access to an integrated model of substance-abuse treatment should be the standard of care for every prenatal patient because of the significant benefits for mothers and their babies.

Introduction

In the early 1990s, two prevalence studies confirmed that prenatal substance abuse was a significant problem among Kaiser Permanente Northern California (KPNC) patients. An internal prevalence study conducted by neonatologist Marc Usatin, MD (Walnut Creek), from 1989 to 1990 tested newborn meconium for prenatal exposure to street drugs but not alcohol. An overall exposure rate of 3.2% was found for all KPNC birthing facilities. Shortly thereafter, the California Department of Alcohol and Drug Programs conducted a study that included five KPNC hospitals and found rates of perinatal alcohol and drug exposure ranging from 10% to 18% of all births (two KPNC sites had rates higher than the statewide average of 11.35%).[1] This information, coupled with a body of literature documenting adverse neonatal outcomes such as placental abruption, fetal death, premature delivery, and babies born small for gestational age,[2–7] prompted the development of a new approach to treating this population.

Historically, pregnant women at KPNC who were identified as having substance abuse problems were referred by their prenatal clinician to existing internal or community-based treatment programs. These efforts were largely unsuccessful; only a fraction of the women referred to these programs attended them. Several clinicians, concerned about the poor outcomes and poor intervention record with this approach, explored other successful prenatal substance abuse intervention models, all of which were in the public sector at that time. To capitalize on KPNC's strength and history as a vertically integrated program, the clinicians identified models that would further integrate services. Experts from Born Free, a program in Contra Costa County that routinely screened

Historically, pregnant women at KPNC who were identified as having substance abuse problems were referred by their prenatal clinician to existing internal or community-based treatment programs. These efforts were largely unsuccessful …

Cosette Taillac, LCSW, BCD, is the Director of the Early Start Program for the Patient Care Services Department of Kaiser Permanente Northern California. E-mail: cosette.taillac@kp.org.
Nancy Goler, MD, is an Ob/Gyn at the Fremont Medical Center; Regional Medical Director for the Early Start Program

Continuum of Care: Opportunities to Improve Outcomes

- **Pre-pregnancy**: During this time, interventions can include promoting awareness among women of child-bearing age and their family members of the effects that prenatal substance use can have on infants.
- **Prenatal:** During this time, health care providers have the opportunity to screen pregnant women for substance use as part of routine prenatal care and to make referrals that facilitate access to treatment and related services for the women who need these services.
- **Birth**: Interventions during this time include health care providers testing newborns for prenatal substance exposure at the time of delivery.
- **Neonatal**: During this time, health care providers can conduct a developmental assessment of the newborn, review the Plan of Care and ensure access to services for the newborn as well as the family.
- **Throughout childhood and adolescence**: During this time, interventions include the ongoing provision of coordinated services for both child and family.

Federal Law

The 2016 Comprehensive Addiction and Recovery Act (CARA) amended the Child Abuse Prevention and Treatment Act (CAPTA) to require that states identify and report annually on the following:

- Number of substance-exposed infants born;
- Number of substance-exposed infants for whom a **Plan of Care** has been created; and
- Number of infants with a **Plan of Care** for whom referrals were made to appropriate services, including services for affected family members or caregivers.

State Law

New Mexico has passed a law supporting CARA amendments to CAPTA.

The new law…

- Gives CYFD until January 1, 2020 to develop rules that guide stakeholders in the care of newborns who exhibit physical, neurological, or behavioral symptoms consistent with prenatal drug exposure or fetal alcohol spectrum disorder.
- Specifies that the rules are to include guidance on the creation of a **Plan of Care** for any substance-exposed newborn.
- Provides that pregnant women who communicate use of drugs or alcohol will be offered supports through a **Plan of Care**.
- Provides that CYFD shall be notified if a baby is born substance-exposed, in addition to receiving referrals for suspected abuse or neglect if such referrals are warranted.

Wait! We now Notify *and* Refer?

CYFD Notification

To comply with federal reporting requirements under CARA, CYFD must be notified of any infant born substance-exposed. The notification is accomplished by providing a copy of the Plan of Care to CYFD through a portal being designed for this purpose.

CYFD Referral or Report

As in the past, you are expected to report a family to CYFD Child Protective Services if you reasonably suspect that abuse or neglect (either or both) are occurring or are likely to occur in the postpartum phase.

Key Elements of Implementation

Notification and Copy of Plan of Care to CYFD

- Lets CYFD know that a substance-exposed infant has been born
- Includes providing a copy of the Plan of Care to CYFD

Copy of Plan of Care to NM DOH

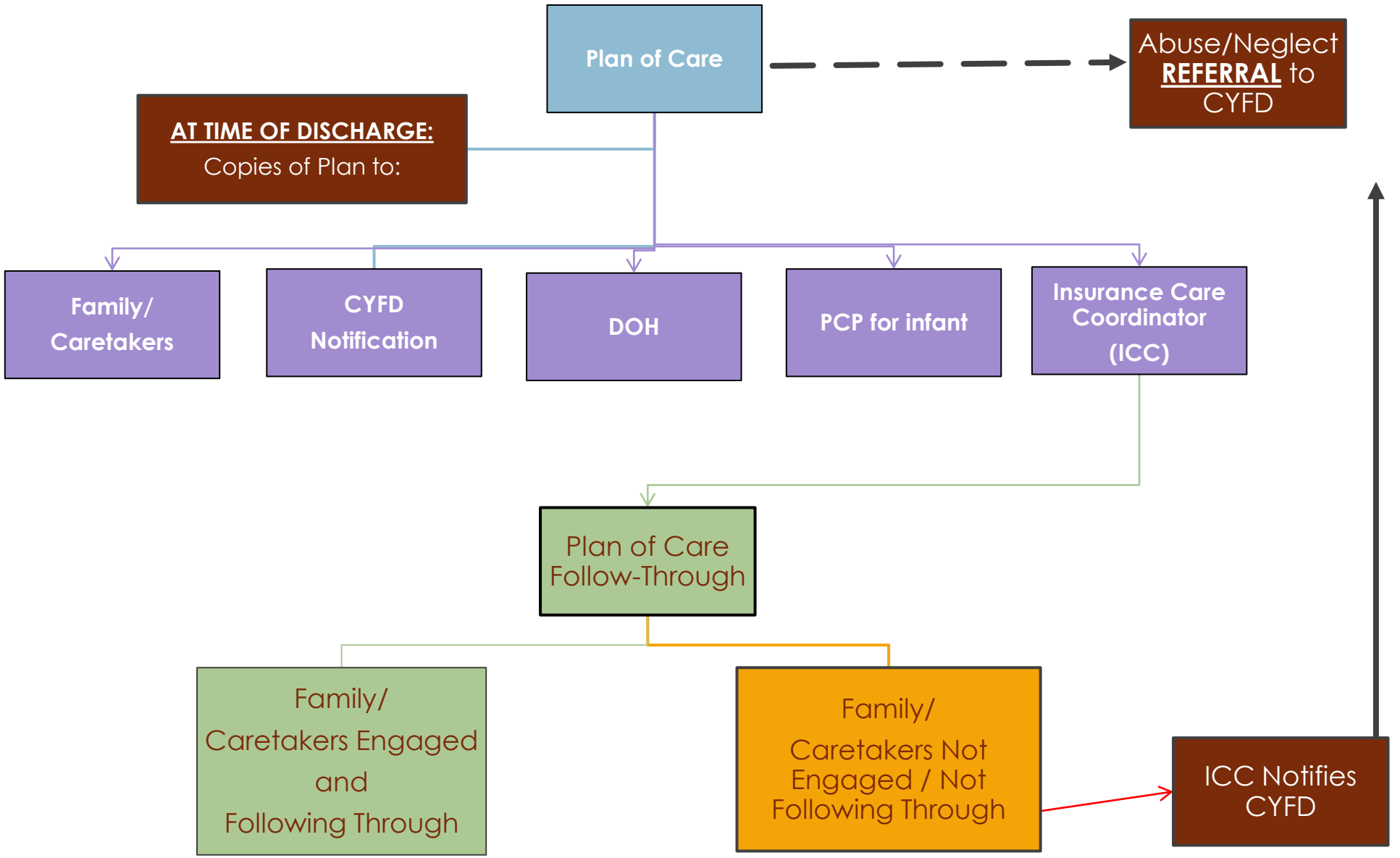
- Allows integration of substance-exposure and Plan of Care with broader epidemiological data
- Sets the stage for insurance and care coordination for families lacking these supports

What is a Plan of Care?

A Plan of Care is a document created by a healthcare professional and involved family members or caretakers to ensure the safety and well-being of an infant born substance exposed.

The Plan of Care:

- Identifies the newborn and his/her primary caretakers
- Details prenatal substance exposures
- Indicates the post-discharge housing plan
- Details support services engaged prenatally or referred to since delivery for infant and affected family/caregivers
- Notes referral to CYFD Child Protective Services, if applicable


Plan of Care
Abuse/Neglect REFERRAL to CYFD
AT TIME OF DISCHARGE:
Copies of Plan to:
Family/ Caretakers
CYFD Notification
DOH
PCP for infant
Insurance Care Coordinator (ICC)
Plan of Care Follow-Through
Family/ Caretakers Engaged and Following Through
Family/ Caretakers Not Engaged / Not Following Through
ICC Notifies CYFD

Possible Short and Long-Term Effects of Substance Exposure

IMMEDIATE EFFECTS:

- Birth Anomalies
- Fetal Growth Restriction and Nutrition
- Neurobehavioral Adaptations
- Withdrawal – NAS

LONG TERM EFFECTS:

- Achievement
- Cognition
- Language
- Self-Regulation
- Behavior – Internalizing/Externalizing

WHY WE NEED A PLAN

Behnke & Smith, 2013

Timeline

Prenatal Period

- Consider need for Plan of Care at birth
- Educate family/caretakers about Plans of Care

Time of Birth

- Develop Plan of Care with the family or caregivers
- Refer to CYFD Child Protective Services if concerned about abuse / neglect

Time of Discharge

- Fax Plan of Care to Insurance Care Coordinator, DOH, and PCP
- Notify CYFD (with copy of Plan) through designated portal

Prenatal Care:

Scenarios that could trigger the need for a Plan of Care

A pregnant woman enters prenatal care and screens positive for substance use, including alcohol or marijuana. Substance use behavior is determined to be a dependency with known risks to the neonate.

A pregnant woman and her family are enrolled in wrap-around services including treatment for Substance Use Disorder. Infant is expected to deliver with substance exposure (even if limited to treatment medications).

A pregnant woman discloses that she was using medically prescribed opioids for pain management before she became pregnant and that she continues to use these medications in pregnancy.

Occasional use of wine or marijuana?

Perception that marijuana is safe for nausea and vomiting.

Questions that may help you decide

Is this pregnant woman:

- Chemically dependent?
- Abusing Substances?
- At risk for alcohol and/ or substance use?

Does this pregnant woman's use behavior have the potential to affect her child's early learning capacity and brain development?

Teaching and learning opportunities on Marijuana use

- Pregnant women using marijuana (or reporting having used marijuana) for nausea and vomiting may not be aware that there are safer alternatives to marijuana to control these symptoms.
- Pregnant women may not be aware that marijuana use during pregnancy may affect neonate brain development and early learning capacity.

Teaching and learning opportunities

Alcohol and Nicotine

- You can work with expectant moms to make a distinction between episodic alcohol use and alcohol dependency.
- Breastfeeding (normally recommended) is not appropriate if the mother-to-be is alcohol dependent.

- Smoking during pregnancy can cause tissue damage in the unborn baby, particularly in the lungs and brain.
- Studies also suggest a relationship between tobacco use and miscarriage.
- Smoking cessation medications may be safer than continuing to smoke tobacco.

Plan of Care Trigger Scenarios

Hospital Discharge Planners

A pregnant woman enters into medical care for delivery and reports substance use during her pregnancy. She received very little to no prenatal care.

A pregnant woman enters into medical care for delivery and reports substance use ***in treatment or relapse*** during her pregnancy.

A newborn tests positive for treatment or non-treatment substance exposure with no prior disclosure from birth mother.

Wild Card

Plan of Care Trigger Scenarios

Insurance Care Coordinators

A pregnant woman is referred to Care Coordination through her insurance provider. The woman discloses to her Care Coordinator that she struggles with substance use. This may include alcohol or marijuana.

A pregnant woman is referred by a healthcare provider for Care Coordination. She is in treatment for substance use disorder.

Mother and infant have been discharged. Insurance Care Coordinator receives referral on newborn and parent. Parent discloses that infant was substance-exposed in utero. There is no Plan of Care.

Wild Card

Plan of Care, role of the infant's Primary Care Physician

- Baby is discharged from the hospital, parents bring baby for first well check following discharge. You have records from the hospital indicating the baby was exposed to substances.
- Does this baby have a Plan of Care?
- Does the family have a copy of the Plan of Care to give you at the first visit?
- Was a Plan of Care faxed over to you?
- Who can you contact if you do not have a copy of the Plan of Care, and the family does not remember to bring a copy?
- How do you find out who the MCO Care Coordinator is for the infant?
- (at the end of this presentation are the key contacts for Care Coordination)

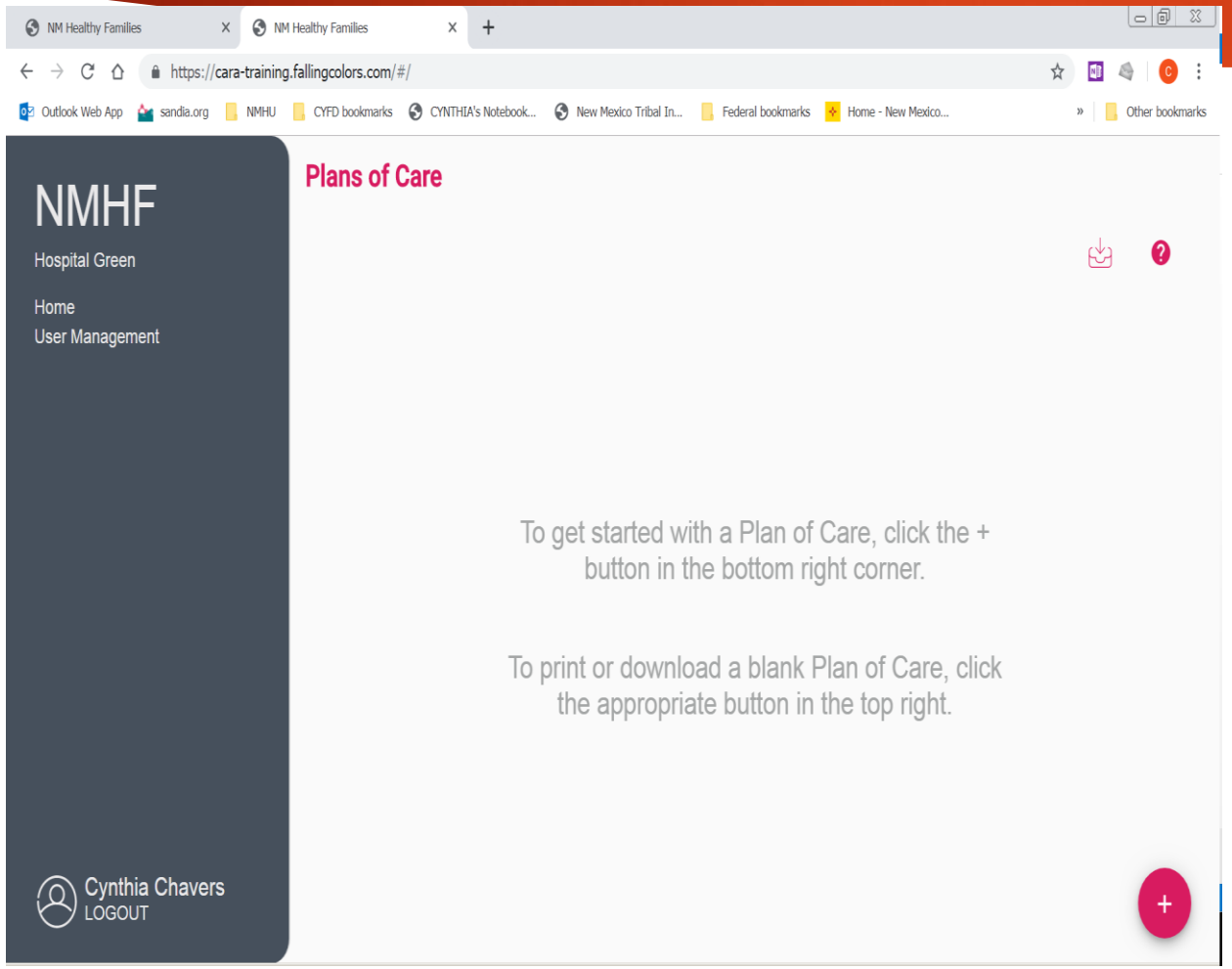
Plan of Care Resources

Assessment of Need: Use the Assessment of Need for Plan of Care form if you are unsure about the need for a Plan of Care.

Plan of Care: Enlist the infant's family (or caregivers) to create the Plan of Care customized to their needs and values.

Follow-up Priorities: Use the Plan of Care Follow-up Priorities form to support implementation.

NM Healthy Families Portal for Notification and Plan of Care



If substance use disorder or other factors are interfering with the parents' ability to care for the infant, or if there are concerns that the family does not have adequate supports, a referral shall be made to CYFD Child Protective Services for potential child abuse/neglect. Creating a Plan of Care does not exempt the family from potential investigation by CYFD. Dial #SAFE.

Plan of Care

This 3-page document must be completed before discharge.

Infant Name:	Admission Date:
D.O.B.:	Discharge Date:
Discharge Address (Street, City, Zip Code):	Discharge Phone:

Infant's Discharge Housing Status (Circle one):

Parental Home Designated Caregiver Home Facility/Shelter Precariously Housed

Notification of Transfer

If substance use disorder or other factors are interfering with the parents' ability to care for the infant, or if there are concerns that the family does not have adequate supports, a referral shall be made to CYFD Child Protective Services for potential child abuse/neglect. Creating a Plan of Care does not exempt the family from potential investigation by CYFD. Dial #SAFE.

Notification of Newborn and Transfer to another Facility /or baby born outside of NM but will return to live in NM

Infant Name:	Admission Date:
D.O.B.:	Discharge/Transfer Date:
Address (Street, City, Zip Code): (for adult who accompanies infant)	Phone: (for adult who accompanies infant)

Hospital infant is transferring to:

Hospital baby born at outside of NM:

Adult accompanying infant on transfer: (parent(s) or other care givers)

Assessment of Need for Plan of Care

Mark the boxes "M," "F," or "M&F" for substances used before or during pregnancy.

Assessment of Need for Plan of Care and Potential CYFD Referral*

**If substance use disorder or other factors are interfering with the parents' ability to care for the infant, or if there are concerns that the family does not have adequate supports, a referral shall be made to CYFD for potential child abuse/neglect. Creating a Plan of Care does not exempt the family from potential investigation by CYFD. Dial #Safe.*

This is a needs assessment tool to help you determine the need for a CARA-mandated Plan of Care. Please do not include patient identifiers. Please do not forward.

Applicable Criteria: Use "M" to indicate birth mother, "F" to indicate birth father, or "M&F" to indicate both birth mother and birth father.

Criterion	Before Pregnancy	During Pregnancy	Current/Ongoing
Alcohol			
Benzodiazepines			
Buprenorphine			
Marijuana			
Methadone			
Methamphetamine			
Opioids			
Tobacco			
Cocaine			
Heroin			

☐ Newborn was treated for withdrawal symptoms.

Assessment of Need for Plan of Care

Where will the family go at time of discharge?

Birth Parents' Housing Status: Where will the family go at time of discharge?

☐ Home owned or rented by birth parent(s), adoptive or foster parent(s), or caregivers
☐ Precariously Housed
☐ Shelter (Specify type: _____)
☐ Treatment Facility
☐ Correctional Facility

☐ Newborn will be discharged to location other than birth parent's discharge loca
☐ Assessed for referral to Statewide Central Intake (SCI), CYFD.

Support Services: Place a checkmark to indicate status of birth parents or designat regarding support services. Support services include items such as counseling, treatme classes, but need not be specified.

Support Services	During Pregnancy	Referred Since Delivery	Referred Sinc Delivery and Declined
Parent 1			
Parent 2			
Caregiver(s)			

Plan of Care: ☐Needed/Required; ☐Completed and signed; ☐Provided to newborn's Primary Care Provider for ongoing monitoring; ☐Submitted notification and Plan of Care through the Portal

You may determine need for a Plan of Care *and* a CYFD referral.

Services used or referred do not need to be specified.

Note your decision regarding follow-through at the bottom of the Assessment Tool.

Plan of Care

Provide key identifying information for infant and note discharge housing arrangement.

If substance use disorder or other factors are interfering with the parents' ability to care for the infant, or if there are concerns that the family does not have adequate supports, a referral shall be made to CYFD Child Protective Services for potential child abuse/neglect. Creating a Plan of Care does not exempt the family from potential investigation by CYFD. Dial #SAFE.

Plan of Care

This 3-page document must be completed before discharge.

Infant Name:	Admission Date:
D.O.B.:	Discharge Date:
Discharge Address (Street, City, Zip Code):	Discharge Phone:

Infant's Discharge Housing Status (Circle one):

Parental Home Designated Caregiver Home Facility/Shelter

Precariously Housed Foster Home

Biological Parents Discharge Housing Status if different from Infant (Circle one): Homeless
Unknown Home (Rented or Owned)
Correctional Facility Facility/Shelter Precariously Housed

Plan of Care

Identify ICC and PCP as well as key household members.

Infant's Insurance Care Coordinator (ICC):	Infant's Primary Care Provider (PCP):
ICC Phone:	PCP Phone:
ICC Fax:	PCP Fax:
Health Insurance Company: _____ Health Insurance Plan: _____	First Appointment Following Discharge: _____/_____/_____ _____:_____ AM/PM

List Household Members over the age of 18 for this infant:

Name	DOB	Relationship to Infant	Contact Information
1.			
2.			
3.			

Plan of Care

Indicate in utero exposures.

Review and select appropriate services.

Applicable Criteria for Plan of Care: Check all substances to which infant was exposed in utero.

Substance	✓	Substance	✓
Alcohol		Methamphetamine	
Benzodiazepines		Nicotine	
Buprenorphine (Subutex, Suboxone)		Opioids	
Marijuana		Other (Specify):	
Methadone		Other (Specify):	

Support Services (continues on page 3):

Service	Name of Organization / Contact	Current ✓	Referred ✓	Declined ✓	Unavail-able ✓
12-Step Program					
Childcare					
Children's Medical Services					
Domestic Violence Services					
Early Intervention					
Family Wrap-Around Services to 3 years					

Plan of Care

Note referral to Protective Services (if applicable).

Share the Plan with all key stakeholders.

◯ Family has been reported to CYFD Child Protective Services Division.

Name of CYFD Caseworker (if applicable): _____

I hereby authorize the State of New Mexico to obtain pertinent information to include medical, social and educational information. I authorize the State of New Mexico to release information received by organizations referred to in the Support Services section and the following providers identified in the plan of care: Department of Health Children's Medical Services, Family/Caregivers, Primary Care Provider, Insurance Care Coordinator, Children, Youth and Families Department, third party payors.
I also hereby authorize that a photocopy of this authorization be accepted with the same authority as this original. Any person or agency receiving this information will be directed to treat it as confidential and for the sole purpose of collaboration on this plan of care.
This release is valid for two years.

_____	_____
Parent/Caregiver Name	Staff Person Name
_____	_____
Parent/Caregiver Signature	Staff Person Signature

Follow-up Priorities

A Plan of Care is only as good as the follow-up that results. Use this tool to establish follow-up priorities.

Plan of Care Follow-up Priorities

This is a worksheet for planning and documenting implementation of the CARA*-mandated Plan of Care for substance-exposed infants and their affected family members/caregivers. Please do not forward to NMDOH. Please do forward (along with the Plan of Care) to the family and/or caregiver, the Insurance Care Coordinator, and the Primary Care Provider.

Infant Name:	Parent/Caretaker Name:	Primary Care Provider:	Insurance Care Coordinator:
	Contact:	Contact:	Contact:

Follow-up Priorities:

Action Step	Target Date	Barriers	Supports	Outcome

So many plans…Integrate the Plan of Care into any other Plan for the Infant and Family

Plan Type	Purpose	How Plan of Care Differs
CYFD Safety Plan	Immediate safety of infant	Addresses health and SUD needs of infant and parents/caregivers
Substance-Use Treatment Plans	Treatment of SUD in parent/caregiver	Comprehensive plan for infant and parents /caregivers
Hospital Discharge Plans	Health and wellbeing of substance-exposed infant at time of discharge	Addresses ongoing health and development needs of infant as well as parents/caregivers

Best Practices: Timing

- The best time to consider the need for a Plan of Care is in the prenatal phase. Initiate a plan that supports formal creation of a Plan of Care at the time of delivery.
- Birth parents and their families have a natural interest in positive outcomes for their newborns.
- Pregnant women struggling with substance use may be most amenable to treatment when they understand that their choices during pregnancy may have lasting effects on their offspring.
- The new state law clarifies that substance abuse on the part of a pregnant woman is not, in and of itself, grounds for a report to CYFD Protective Services. This should reduce inhibition regarding uptake of prenatal care.

Safety Plan/Plan of Care Dovetail

A well-developed and effectively implemented Plan of Care may prevent removal of an infant from his/her family or provide an opportunity for quick reunification if initial placement is away from the birth mother or father.

A strong Plan of Care benefits an infant and his/her caregivers by addressing their treatment needs, regardless of immediate child placement decisions.*

*National Center on Substance Abuse and Child Welfare (2018). *A planning guide: Steps to support a comprehensive approach to Plans of Safe Care; March 2018 Draft.*

Challenges to Mother-Infant Dyad Affected by Substance Use Disorders

For the Mother

- Altered Responses
- Lack of Parenting Role Models
- Low Parental Confidence
- Exposure to Violence or Chaotic Environment
- Maternal Brain Changes:
  - Parenting may not feel rewarding;
  - Infant cues may be perceived as irritating;
  - Difficulties with self-regulation
- Psychiatric Comorbidities
  - Depression
  - Anxiety
  - PTSD

(Velez & Jansson, 2008; Jansson & Velez, 2012)

For the Infant/Young Child

- Maltreatment – Neglect or Abuse
- Risk of Maltreatment
- Repeated Exposure: in-utero or secondary exposure
- Altered Trajectories of Development due to Parental Responsiveness
- Exposure to Trauma or Violence
- Attachment Disturbances that interfere with Social and Emotional Well-Being
- Health, Feeding and/or Sleep Concerns

Best Practices: Warm Hand-Off

- Direct contact with the client, either in person or by phone, and directly connecting the client to the resource:
- With the Plan of Care Model, once a client accepts a referral, a direct call to a Care Coordination Unit or a Provider from the person making the referral. The social worker or discharge planner has already assured that the client is ready to receive the services. Within CMS and the Family Health Bureau this type of referral is done regularly to enroll clients into WIC. The client gives permission to share a good contact number with a back up phone number, this information is given directly to the local WIC office who in turn calls the client that day to schedule the appointment.
- The handoffs from one point to the next and the linkages needed to coordinate services, become a comprehensive services framework, rather than a series of fragmented initiatives.

Best Practices: Warm Hand-off

A warm hand-off is any effort you make to assure a follow-through connection between two parties.

MCOs report that as many as 50% of referrals fail when the referring entity goes no further than supplying a name and contact information.

If you are a discharge planner, be sure that your patient knows or is introduced to her Insurance Care Coordinator (ICC) - ideally before discharge - because that is the person who will assist the family in implementing the Plan of Care.

If you are an ICC, be sure that your client knows or is introduced to support service providers identified in the Plan of Care.

Best Practices: A vision for the future

- Access to prenatal care for all pregnant women in New Mexico.
- Universal screening at first visit for substance use, ACES, domestic violence, and other needs or risk factors with a validated tool.
- Expand or replicate wrap-around service programs for families that integrate SUD treatment with prenatal and early intervention services.

How to Get a Care Coordinator/Medicaid

BCBS of NM

CARA_Care_coordination@bcbsnm.com

During pregnancy referrals will go to the Special Beginnings Program

Key Contacts:

Sabrina.Romero@bcbsnm.com, 505-816-2938

Presbyterian

Send All Referrals to this link: **CARA@phs.org**

505-923-8858 option 2

Key Contact:

Tena June Ross, RN, MA, CCM

Supervisor, Care Coordination-PH Central Team, Children and Youth with Special Healthcare Needs Consultant

Clinical Operations/PHP

O: 505-917-9025

F: 505-355-7269

tross3@phs.org

Western Sky

1-844-543-8996, #4 for Care Coordination

CARAcarecoordination@westernsky.com

For Care Coordination during pregnancy: Jennifer M. Monotya, RN

Direct: 1-505-886-6389 (extension 8095189) or 505-331-9225

Jennifer.m.Montoya@westernskycommunitycare.com

Charlene.A.Tafoya@westernskycommunitycare.com

Direct: 505-886-6290, ext. 8095090

Blue Cross Blue Shield of NM (MCO)

Eric Cibak, RN

Special Beginnings NM/Texas

Unit Manager, Clinical Operations

Eric_S_Cibak@bcbsnm.com

505-816-5725

Blue Cross Blue Shield of NM/Texas

4411 The 25 Way NE, Suite 300

Albuquerque NM 87109

Please send all referrals to:

NMCNTLSpecialBeginnings@bcbsnm.com

For referrals during pregnancy.

Blue Cross Blue Shield of Texas (Commercial)

Pre-Natal up to 34 Weeks

- Special Beginnings Program
- Email **all three**:

  Julie Milam

  Julie_s_milam@bcbstx.com

  Beth Boulanger

  Beth_boulanger@bcbstx.com

  Toni Allen

  Toni_allen@bcbstx.com

34 Weeks or more / Delivery

- Contact Customer Service at phone number on back of insurance card.
- Ask for referral to case manager

Molina Health Care and True Health New Mexico

- Molina Healthcare of New Mexico:
- **NM_CARA_Plans@MolinaHealthCare.Com**

- High Risk Maternity Case Manager: Sharon Kimmet RN, CCM
- To make a referral: Call 1-844-691-9984, covered 24/7, direct line for Care Management
- For Member and Provider Services: 1-844-508-4677

For Care Coordination referrals, NM DOH: Children's Medical Services

Susan Merrill, LCSW

Community and Social Services Coordinator for Birth Defects

Direct: 505-476-8918

FAX: 505-476-8996 or 505-827-5995

Susan.Merrill@state.nm.us

Children's Medical Services

Family Health Bureau

Public Health Division

New Mexico Department of Health

CYFD and DOH CARA

Susan Merrill, LCSW

DOH/CARA

Community and Social Services Coordinator for Birth Defects

NM DOH – Children's Medical Services

505-476-8918

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