National Center on
Substance Abuse
and Child Welfare

MODULE 5

# PLAN OF SAFE CARE LEARNING MODULES

## OVERSEEING STATE PLANS OF SAFE CARE SYSTEMS & REPORTING DATA

# 5 IMPLEMENTING & MONITORING PLANS OF SAFE CARE

*Prepared by the National Center on Substance Abuse and Child Welfare (NCSACW), this module is one of a five-part series on Plans of Safe Care for infants affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a fetal alcohol spectrum disorder (FASD), and their family or caregiver. The series is intended to guide state, Tribal, and local collaborative partners who aim to improve systems and services for infants affected by prenatal substance exposure and their families. The policy and practice strategies included in these modules are derived from NCSACW's years of practice-based experience providing technical assistance to states, Tribes, and communities. Points of view or opinions expressed in this tool are those of the authors and do not necessarily represent the official position or policies of the Substance Abuse and Mental Health Services Administration or the Administration on Children, Youth, and Families.*

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## About This Module

Each state that receives a grant under the Child Abuse Prevention and Treatment Act (CAPTA) is to provide, to the maximum extent practicable, a report on key data points, including the number of identified infants, the number of infants for whom a Plan of Safe Care was developed, and the number of infants for whom a referral was made, including services for the affected family or caregiver. In addition, states are required to develop and implement monitoring systems of Plans of Safe Care to determine whether and in what manner local entities are making referrals and delivering appropriate services to infants affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure or an FASD, and to their affected family or caregivers. This module explores how to develop and monitor policies and procedures related to Plans of Safe Care and strategies to enhance the ability of states to report data to the National Child Abuse and Neglect Data System (NCANDS).[1]

CAPTA requires that states collect and submit, "to the extent practicable," to NCANDS:

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| **NCANDS DATA ELEMENTS** | • Number of "affected" infants<br>• Number of infants with a Plan of Safe Care developed<br>• Number of infants with a referral to an appropriate service, including services for affected family/caregiver |
| **MONITORING REQUIREMENT** | • Develop and implement a monitoring system for implementing Plans of Safe Care<br>• Determine in what manner local entities are making referrals to and delivering appropriate services for infants and affected families or caregivers |

In reviewing the extent to which state child welfare agencies currently collect the data that CAPTA specifies be reported to the Children's Bureau, states can identify barriers in collecting these data, such as data systems that do not capture the required data elements or data that need to be provided by a partner system or agency. The challenge for collaborative teams is to find the right methods to collect and share the information needed for the required reporting in NCANDS while also maintaining their agency's privacy and data-sharing standards. Data systems may need to be modified to be able to capture both Plans of Safe Care developed by the child welfare agency and the Plans of Safe Care developed by community agencies. In addition, the data systems should collect data regarding service referrals and service delivery for both infants and affected family members. This comprehensive data approach ensures that all are infants and affected family/caregivers are accounted for and service referral and delivery are documented. Absent this approach, collaborative teams are hindered in their ability to use the data to inform and measure the impact of policy and practice changes. In the absence of integrated data systems or data warehouses, data-sharing agreements among partner agencies that serve these families can provide access to key data points. Updates to data collection policies and procedures are critical for guiding partner agencies as they develop and implement Plans of Safe Care, particularly partners outside of CPS. Regardless of which partner agency or system develops, implements, and oversees Plans of Safe Care, the child welfare agency is responsible for submitting quantitative data, to the extent practicable, to NCANDS.

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[1] See Chapter 7, Child Maltreatment 2018. https://www.acf.hhs.gov/cb/resource/child-maltreatment-2018

- ***CAPTA Reporting Requirements***

Section 108(e) of CAPTA requires states receiving a CAPTA State Grant to submit an annual report describing its use of the grant. In addition, states must address new requirements enacted into law. For instance, in the state's 2021 annual CAPTA report update, states are directed to provide an update on the state's continued efforts to support and address the needs of infants born and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder. Reporting requirements include items such as:

  - The plans for using CAPTA State Grant funding to support the development, implementation, and monitoring of Plans of Safe Care for substance-exposed infants.
  - The current monitoring processes of Plans of Safe Care to determine whether and in what manner local entities are providing referrals to and delivery of appropriate services for substance-exposed infants and affected family members and caregivers.[2]

As outlined in *Module 1, Preparing for Plans of Safe Care Implementation*, statutes, policies, regulations, and guidance may affect the manner in which the state oversees Plans of Safe Care implementation and reports required data.

## KEY IMPLEMENTATION CONSIDERATIONS

- ***Identifying Baseline Data and Developing Comprehensive Data Dashboards***

Many jurisdictions lack baseline data that defines the needs within and across systems. Baseline data are needed to analyze potential cost savings and outcome improvements. Collaborative teams that have partners from a variety of systems can draw upon the resources of their members to access available data: for example, the number of pregnant women in publicly funded substance use disorder (SUD) treatment programs[3] or the number of infants born with Neonatal Abstinence Syndrome (NAS).[4]

States might consider obtaining Medicaid claims data or public heath live birth data to establish a baseline of infants affected by substance abuse, and determine whether notifications to CPS from hospitals reflect the prevalence of infants born with and identified as being affected by prenatal substance exposure. Identifying discrepancies between these data points can prompt team discussions on improving notifications from hospitals.

- ***Limitations of Currently Available Data***

Although many hospital systems have mechanisms to collect data on the number of infants diagnosed with NAS, few states have found ways to consistently gather data about the full range of infants born with and affected by substance abuse or withdrawal, or an FASD. Some states have updated their Comprehensive Child Welfare Information System (CCWIS) to serve as a monitoring tool to identify areas for system improvements. However, the data collection is limited to families with active child welfare involvement. Electronic health records and CCWIS case plans may include information that can indicate whether and how their systems providers are making referrals for the infant and affected caregiver. However, these information sources are not linked to other agencies. Without a connection to other agencies, agencies cannot rely on their information systems alone to determine whether the referred providers are delivering appropriate services to the infant and affected caregiver and whether the family is participating in those services. To compensate for the lack of interoperability of most of these information systems, teams should establish information sharing protocols, guided by data and information sharing agreements, and a shared responsibility for cross-system outcomes.

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[2] https://www.acf.hhs.gov/sites/default/files/cb/pi2002.pdf

[3] State Substance Abuse and Medicaid agencies

[4] State Department of Health

*A study in the Child Abuse and Neglect journal found that data collected by the Illinois Department of Public Health recorded 1,838 reports of substance-exposed newborn infants. By contrast, Illinois Department of Children and Family Services recorded 459 reports of infants with prenatal substance exposure. The researchers recommended that clinicians' partner with parents, researchers, and policy makers to consider generating statewide protocols to decrease unnecessary variation in both testing and mandated reporting of infants affected by prenatal substance exposure.*[5]

*The Massachusetts Department of Public Health designed a web-based NAS metric dashboard in partnership with several state and community organizations. The dashboard provides population-based prevalence data on NAS diagnoses and other key indicators related to perinatal opioid use, as well as disaggregated data by maternal characteristics, education, age, and insurance coverage.*

- ***Quality and Consistency of Data***

By developing standardized data collection protocols and multisystem data-sharing agreements, collaborative teams can collect data that may not otherwise be available.

For example:

- Reliable, unduplicated counts for women who were pregnant at the time of admission to SUD treatment in both publicly funded and private programs
- Consistent reporting regarding infants with prenatal substance exposure, based on shared definitions including infants with withdrawal symptoms those with an FASD and infants with prenatal exposure to other drugs
- Data that differentiates infants born to mothers who are in medication-assisted treatment programs or who take medications as prescribed, from data on infants born to mothers who take illegal opioids or who do not take medications as prescribed
- Data that can differentiate involvement in the child welfare system and access to services

- ***Challenges with Collaborative Information and Data Sharing***

Although collaboration with agencies improves the process of developing and implementing Plans of Safe Care, data sharing is challenging for agencies that do not have access to shared systems for data collection or reporting. Many local communities are challenged with how to translate individual case data from multiple partner agencies into usable data so that child welfare agencies can fulfill the CAPTA reporting requirements. States may not be able to retrieve information for notification cases that do not require child welfare involvement or in cases where information is not housed within the child welfare data system. Several states have established policies to guide the appropriate data collection and information-sharing procedures for notifications that do not include reports to CPS for safety concerns. In these states, data shared to child welfare about notifications may not be case specific, and data submission forms may include de-identified data. Because some states permit healthcare providers to submit de-identified data in aggregate form for cases that are low risk or do not require an abuse or neglect report, these data may not be included in a state's CCWIS. Jurisdictions that implement prenatal Plans of Safe Care are also beginning to collect data on the supports provided during pregnancy, when the infant was able to remain in the care of the parents at the time of hospital discharge, and when a formal child welfare case was not opened.

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[5] Hoerr, J. J.; et al. (2018). Substance-exposed newborn infants and public health law: Differences in addressing the legal mandate to report. *Child Abuse & Neglect, 81*, 206-213. https://doi.org/10.1016/j.chiabu.2018.04.021

*New York state statute does not define prenatal substance exposure as abuse or neglect. Healthcare providers involved in the delivery or care of infants are required to notify the child welfare system when they have an indication that infants have been exposed to substances during the prenatal stage. They also are required to report suspected child abuse or neglect of any infant to CPS. When infants and mothers are determined to need a notification, the hospital staff can share with the child welfare system non-identifying information in aggregate form to ensure that the child welfare system is able to meet federal reporting requirements. Hospital staff or other community partners may also develop a Plan of Safe Care with families.*

- ***Importance of Data Collection for Developing Comprehensive Cross-Agency Systems***

Data collection is needed not only to meet federal requirements; it also serves the purpose of helping partners develop comprehensive, collaborative approaches to addressing the needs of infants with prenatal substance exposure and their families. Data helps collaborative teams to fully understand several important aspects of planning and implementation:

  - Characteristics of the target population to be served compared to the general population
  - Comparisons of local and statewide data
  - Analysis of child welfare and SUD treatment data
  - Analysis of the extent of the needs
  - Review of the effects of policy and practice changes and whether they result in improved outcomes

- ***Information Sharing to Ensure Appropriate Oversight***

Many jurisdictions cite confidentiality regulations (HIPAA, 42 CFR, Child Protection Services[6]) and failure to gain consent from women to share information as reasons for not sharing Plans of Safe Care information among critical partners (e.g., physicians, substance use disorder treatment, child welfare professionals, and other maternal and infant healthcare providers). Jurisdictions have codified through policy and written practice guidance how individual case specific information should be shared and used among partners in assessment and decision making. The written guidance clearly delineates applicable state and federal confidentiality regulations When these cross-system policies and practices are codified in a Memorandum of Understanding (MOU) or information sharing agreements, and used consistently, partners within the collaborative team build trust among each other, and with the families receiving Plans of Safe Care. A lack of trust and the ability to share information creates barriers to determining how local entities are making referrals and delivering appropriate services.

- ***Recognizing the Impact of System Changes on Data and Outcomes***

Reviewing data across multiple systems helps teams better understand how achieving outcomes in one system can have an impact on another system. As an example, screening more women for substance use disorders will likely result in identifying the need for additional SUD treatment capacity. Reducing the prevalence of infants born with NAS, a public health goal, can be impacted by increasing access to medication-assisted treatment (an SUD treatment system goal). This necessitates having data that can differentiate between those infants born to women who are on medication-assisted treatment, those taking other opioids under the care of a physician, and those taking illegal opioids or misusing prescribed medications. Medicaid directors, managed care entities, and hospitals must be engaged in discussions about data collection and reporting so that each system understands the outcomes that are expected, how these outcomes relate to each other, and each system's role in achieving them.

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[6] This refers to confidentiality regulations for health care, substance use disorder treatment, and child welfare protected information.

- ***Monitoring Plans of Safe Care for Families Without an Open Child Welfare Case***

Some jurisdictions are developing and monitoring Plans of Safe Care for families who do not have child welfare system involvement. In these jurisdictions, the medical community and community-based service providers, such as family resource centers, SUD treatment agencies, home visiting programs, or Healthy Start Coalitions oversee progress for a Plan of Safe Care. Shared policies, effective data sharing, and strong cross-system communication among the collaborative partners helps ensure that these oversight systems are effective in coordinating care for families in multiple services systems.

*Through a contract with the Delaware Department of Children and Families, a statewide outpatient SUD treatment provider is developing, implementing, monitoring, and reporting to the child welfare division on Plans of Safe Care for families with a low risk of safety concerns that do not require an open child welfare case.*

- ***Monitoring Plans of Safe Care Policies and Procedures***

States across the country use a variety of methods to monitor service referrals and whether families are able to engage in services. Within child welfare practice, these strategies include:

  - Periodic case reviews to determine if referrals and linkages to services were made
  - Integration of Plans of Safe Care records into quality assurance/continuous quality improvement processes
  - Changes to the state's automated CCWIS system to track referrals and service participation
  - Specialized child welfare units or positions to monitor Plans of Safe Care

Some states also work with their collaborative teams to monitor Plans of Safe Care by using team-based meetings across systems of care or assigning other agencies or entities to monitor Plans of Safe Care.

*In Maricopa, Arizona, the Safe Healthy Infants and Families Thrive program has developed systems and reports that capture the experiences of families served by the child welfare system and the families participating in prenatal or postpartum Plans of Safe Care with community-based organizations. The cross-system Executive Committee utilizes the Infants with Prenatal Substance Exposure and Family Treatment Court Statistical Report to address service needs and gaps by understanding how the number of infants with prenatal substance exposure are impacting dependency courts filings and how frequently these families are served by specialty courts and services. The program has developed protocols to ensure that families can receive supports and services from either child welfare or a community-based organization for up to one year after the mother gives birth.*

*Delaware and Tennessee have Plans of Safe Care coordinator positions. These individuals monitor Plans of Safe Care for families and provide feedback to supervisors and managers. Delaware's coordinator tracks several data elements, including referrals made on behalf of the infant, mother and/or father, or secondary caregiver. The coordinator also reviews the family's level of engagement with the service. Tennessee's coordinator monitors the development of Plans of Safe Care that CPS creates and provides regular feedback to regional CPS supervisors to help them create plans that are appropriately tailored to the needs of the parents and the infant.*

## PLANNING STEPS AND RELATED RESOURCES

### *Identify Technology Opportunities to Enhance Data Collection*

Develop a basic data dashboard to track reports of infants born with prenatal substance exposure, parents with cases in the child welfare system who have substance use related issues, treatment referrals and admissions for this population, and the CAPTA Plans of Safe Care data elements. Collaborative teams should periodically review the data dashboard across all systems and analyze the data to identify any changes in community conditions. Data dashboards or annual cross-system data reports support continuous monitoring and quality improvement.

- **Resource: Center for Children and Family Futures'** *Infants with Prenatal Substance Exposure Data Matrix*[7]

Review current state agency health information technology systems to identify opportunities to streamline data entry and improve efficiency in information sharing and data collection across multiple partners.

Identify the Plan of Safe Care format that best supports developing, sharing, and updating the plan. Is an online application, state portal, electronic medical record, hard copy, or another format preferred?

### *Develop Protocols to Share Information Among Partner Agencies*

Create protocols that facilitates sharing Plans of Safe Care to ensure that this format is shareable among the various partners who implement Plans of Safe Care or are providing services to families with a Plan of Safe Care.

- **Resource: The National Center on Substance Abuse and Child Welfare's** technical assistance toolkit entitled *On the Ground: How States are Addressing Plans of Safe Care for Infants with Prenatal Substance Exposure and their Families* provides examples of Plans of Safe Care templates.

Develop information-sharing policies, protocols, and practices that will support managing Plans of Safe Care. This includes memorandums of understanding that outline the roles of service delivery partners and consent forms for clients to sign, so that partners can share the information necessary to implement Plans of Safe Care successfully.

- **Resource: Vermont's Children and Recovering Mothers (CHARM) Collaborative** Memorandum of Understanding (Attachment A p.109)
- **Resource: Legal Action Center** guide to federal confidentiality law and regulations that protect the privacy of substance use disorder (SUD) patient records

Create a data and information-sharing protocol that meets the data reporting, evaluation, and case management needs of partners implementing Plans of Safe Care and adheres to confidentiality regulations.

- **Example: Jefferson County Collaborative** Information Sharing Document[8]

*Ohio has created enhancements to their Statewide Automated Child Welfare Information System to document each aspect of CAPTA/Plans of Safe Care requirements, including intake reporting, case response type, and reason for case closure. The system yields sophisticated reports that delineate both county and state outcomes on key metrics. These reports have enabled managers to monitor changes in the frequency of referrals, determine which drugs were associated with the referrals, show whether low risk cases were assigned to a differential response track, and determine how frequently families were referred for ongoing services. Cross-disciplinary leadership teams review these metrics to determine whether they need to address gaps in services, training needs for frontline staff, or reallocate resources for staffing and services.*

**Additional resources are available at https://ncsacw.acf.hhs.gov/.**

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[7] https://www.cffutures.org/request-ta/ for the resource

[8] https://www.cffutures.org/request-ta/ for the resource

## QUESTIONS TO DISCUSS WITH YOUR COLLABORATIVE TEAM

- What data should the team monitor on infants, parents, or caregivers affected by prenatal substance exposure?
    - How will the team collect these data?
    - Which sources will provide this information?
    - How will the team analyze and share this information to inform policy and enhance practice?
- Does the state child welfare agency collect the data to meet CAPTA reporting responsibilities? If not, which entities have access to the data, and how will those data be provided to the child welfare agency?
- What information-sharing policies, protocols, and practices are in place that teams can use to help manage Plans of Safe Care?
- How can states use their health information technology systems to collect and report on the required CAPTA data elements?
- How does an agency or system outside the child welfare system collect, share, and report data and information on Plans of Safe Care?
- How will the team collect and share critical information about individual cases to review the progress and ongoing needs of infants and families or caregivers?
- Can the team measure the impact of policy and practice changes, both positive and negative, on populations served?

## THE PLANS OF SAFE CARE MODULES SERIES

Although federal and state policies, regulations, and decisions guide the implementation of Plans of Safe Care, local communities must determine how to interpret and operationalize state guidance. Additional modules in this series provide states and communities with the considerations for implementing Plans of Safe Care to support the safety and well-being of families in their jurisdictions. These modules include the following:

- ***Module 1: Preparing for Plan of Safe Care Implementation***, explores the steps states can take to understand existing statutes and structures as they strategize how to effectively address the needs of infants affected by prenatal substance exposure and their families.
- ***Module 2: Establishing Collaborative Partnerships***, explores the steps states can take to build, grow, and sustain collaborative teams critical to a comprehensive approach to Plans of Safe Care.
- ***Module 3: Determining Who Needs a Plan of Safe Care***, explores the steps states can take to define affected infants as they roll out a statewide Plan of Safe Care.
- ***Module 4: Implementing and Monitoring Plans of Safe Care***, explores how collaborative teams can translate policy decisions into practice through implementation and case monitoring.