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Perinatal Substance Use Coordinated Care and Support: Plans of Safe Care Pilot

Pilot Design Report

REPORT HIGHLIGHTS:

Plans of Safe Care (POSC) are recognized as a lever for improving cross-system care coordination and health outcomes for **families affected by prenatal substance use.**

The Division of Child Welfare is **resourcing a pilot** to advance coordinated care strategies.

The pilot goal is to develop a **data-informed strategic framework for coordinated POSC** in the catchment area with replicability across Colorado.

This report outlines the **pilot design** that emerged from the planning year, including:

- Why POSC are needed
- Essential elements of the POSC Framework
- Pathways to activate and implement a POSC for families to achieve coordinated care
- Building infrastructure to support alignment
- Building evidence to assess outcomes and inform strategic learning

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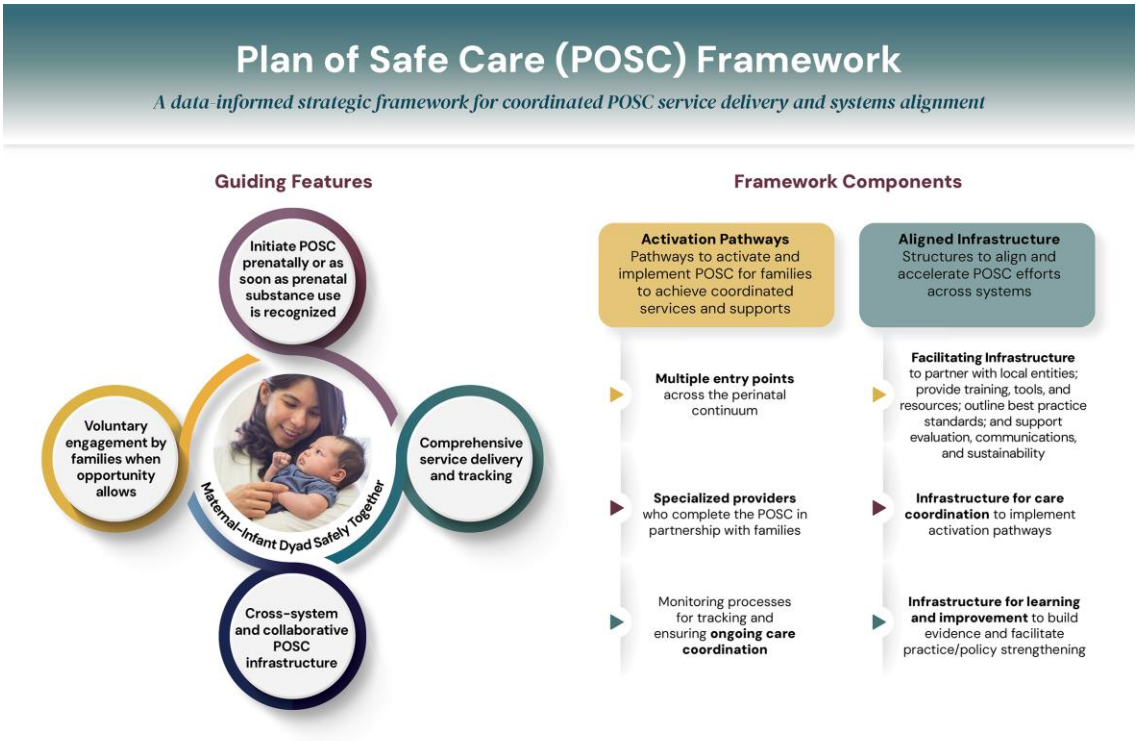
Executive Summary

Substance use during pregnancy is a growing issue that demands data-informed, family-centered solutions. Based on study findings from the Perinatal Substance Use Data Linkage Project, emergent opportunities from Colorado practice investments, and national legislation, Plans of Safe Care (POSC) were identified by policy, provider, community, and family stakeholders as a lever for improving cross-system care coordination and health outcomes for affected families.

The Colorado Department of Human Services, Division of Child Welfare, is resourcing a pilot to align and accelerate POSC progress. The goal is to develop a data-informed strategic framework for coordinated POSC in the catchment area with replicability across Colorado. This report describes the design of the POSC Framework (resulting from the first year of the pilot) and the approach to implementation and evidence-building (planned for years two through four of the pilot).

POSC Framework Design Overview. The POSC Framework acts as the strategic container to align and coordinate approaches across different models, programs, and practices serving families affected by prenatal substance use. The POSC Framework is made up of four guiding features necessary to produce the desired impact as well as two components that guide implementation. The guiding assumption is that a POSC is—in and of itself—not helpful as a document, but requires implementation of the plan after development. This design work was an outcome of the planning period (year one). Implementation will occur in years through two through four.



Evidence Building Overview. In years two through four of the pilot, evidence-building will focus on leveraging the design work (step 1 of evidence building) to explore outputs and outcomes. This will occur in the defined catchment area. *Unite Us* is Social Health Information Exchange (S-HIE) that will be beta tested during this pilot as the technology platform to support care coordination and analytics.

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Acknowledgements

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Thank you to SuPPoRT Colorado: Supporting Perinatal Substance Use Prevention, Treatment, and Recovery in Colorado and its Steering Committee, Family Advisory Board, and Working Groups for their subject matter expertise and guidance on the design of the POSC Framework. SuPPoRT Colorado is a subcommittee of the Attorney General's Colorado Substance Abuse Trend and Response Task Force.

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Note on Gender-Inclusive Language

The Colorado Lab affirms our commitment to the use of gender-inclusive language. We are committed to honoring the unique gender identity of each project participant and validate that pregnancy, birth, and family formation are experienced by individuals across the gender continuum. Throughout this report, we follow the guidance of the Associated Press Stylebook and the Chicago Manual of Style and use the gender-neutral, singular "they" when appropriate and use gender-inclusive terms when referring to experiences of childbirth.

Introduction

Plans of Safe Care (POSC) are recognized by policy leaders, health care providers, community members, and families as an important means to coordinate care across systems and improve health for families affected by prenatal substance use.

The Colorado Department of Human Services (Division of Child Welfare) is resourcing a pilot to align and accelerate POSC progress.

The goal of this pilot is to develop a data-informed strategic Framework for coordinated POSC in the catchment area with replicability across Colorado.

Substance use during pregnancy is a growing issue that demands data-informed, family-centered solutions. Based on study findings from the Perinatal Substance Use Data Linkage Project, emergent opportunities from Colorado practice investments, and national legislation, Plans of Safe Care (POSC) were identified by policy, provider, community, and family stakeholders as a lever for improving cross-system care coordination and health outcomes for affected families.

> A POSC is a process intended to ensure the safety and well-being of an infant and caregiver affected by prenatal substance use, including connection to needed resources to stabilize the dyad together when possible.

The Colorado Evaluation and Action Lab (Colorado Lab) developed a policy brief outlining a vision for using POSC as a key activation pathway to: 1) guide cross-system policy and practice investments that improve outcomes for families; 2) support Colorado state agencies in meeting state and federal responsibilities around caring for affected infants and caregivers; and 3) cultivate a culture of collaborative responsibility for ensuring these Colorado families have every opportunity to thrive. This vision and the considerations outlined in the policy brief were co-developed and refined through partnership with key leaders from the Colorado Department of Human Services (CDHS) Division of Child Welfare (DCW), the Colorado Department of Public Health and Environment (CDPHE), medical providers, research experts, community-facing providers, and families.

During these partnership discussions, DCW issued a resourced opportunity to move this vision from concept to execution. The Colorado Lab, in partnership with Illuminate Colorado (Illuminate) and the Kempe Center for the Prevention and Treatment of Child Abuse and Neglect (Kempe Center), was awarded the contract to develop, execute, and build evidence for a four-year POSC pilot to advance coordinated care strategies. The pilot is expected to run from Federal Fiscal Year (FFY) 2023 to 2026, with FFY23 serving as the planning year.

This report outlines the **pilot design** that emerged from the planning year, including:

- Call to action: Why POSC are needed
- Essential elements of the POSC Framework
- Pathways to activate and implement a POSC for families to achieve coordinated care
- Building infrastructure to support systems alignment
- Building evidence to assess outcomes and inform strategic learning

Pilot Design

Substance use in the perinatal period is skyrocketing in Colorado with generational impacts on children and families.

The goal of this pilot is to develop a data-informed strategic framework for coordinated POSC in the catchment area with replicability across Colorado.

The Framework emphasizes prenatal initiation, investment in community-based entry points, and voluntary engagement by families.

The Framework is made up of four guiding features and two key components: 1) Activation Pathways; and 2) Aligned Infrastructure.

A Call to Action: Why POSC are Needed

Substance use in the perinatal period is not just an acute crisis facing childbearing families, but one that impacts the life course of an infant and their family. Nationally, data show a 131% increase in opioid use-related diagnoses at delivery between 2010 to 2017.[1] In Colorado, between 2012 to 2018, there was an 98% increase in newborns exposed to opioids prenatally.[2] In 2021, fentanyl exposure/ingestion accounted for 15.6% of fatal incidents of child maltreatment in Colorado and 35.3% of near fatal child maltreatment incidents.[3] Unintentional drug overdose was the second leading cause of maternal death in Colorado and substance use or mental health conditions contributed to 1 in 2 pregnancy-related deaths.[4]

Substance use in pregnancy and in the postpartum period increase the risk of poor outcomes for the pregnant/postpartum person, the infant, and their family, while also having community and system effects due to higher demands on services.[5,6] Racism and discrimination affect patterns of substance use, outcomes, and equitable access to treatment; in Colorado, discrimination contributed to nearly 60% of maternal deaths.[4, 7,8,9] Fragmented care systems, coupled with experiences of provider bias and extensive stigma within health and human service systems, are leading barriers to accessing and navigating needed supports.[10,11] Importantly, engagement in care during the childbearing year can influence how a family navigates health and human services in the years to come. If experiences are positive and valued, caregivers may be more likely to seek support for themselves and their children; conversely, if experiences are wrought with stigma and no real impact, caregivers may subsequently avoid seeking care and enrolling their children in needed services.

POSC are a leading strategy to address the complex origins of perinatal substance use and the need for diverse wraparound services for families (e.g., behavioral health outpatient programs, new parent social support, substance use disorder (SUD) treatment, obstetric care, concrete supports). In 2016, CAPTA was amended by Congress with a requirement that states utilize a POSC for an infant born with and identified as being affected by substance use, withdrawal symptoms, or fetal alcohol spectrum disorders. In 2022, there were 1,578 infants reported to child welfare for substance exposure of a newborn. Yet only 39% had a POSC.[12] Importantly, states are given flexibility in implementation of this CAPTA requirement and a cross-system, collaborative approach to meet the wide-ranging needs of infants and their families is recommended. As part of this flexibility, the POSC can be initiated prenatally by a designated community organization, since child welfare cannot become involved with the family due to prenatal substance exposure until after the birth event. Initiating prenatally and engaging families voluntarily is vital to taking an upstream approach to maternal-infant health and helping families thrive, together.

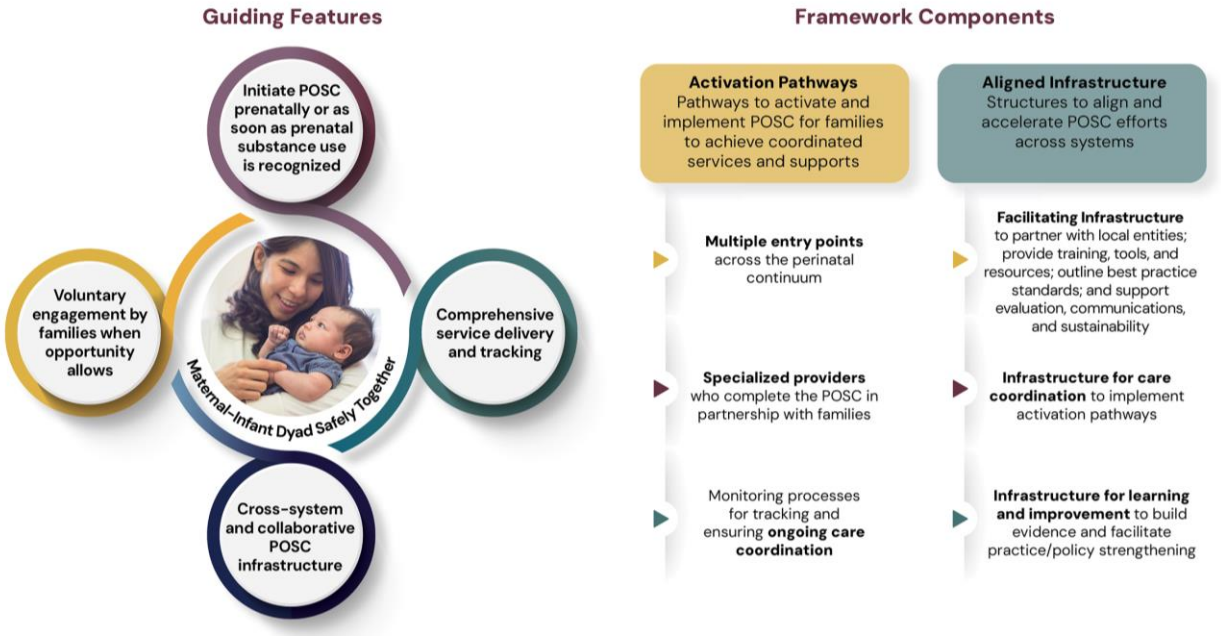
The essential elements of the POSC Framework are designed in response to this call for action.

Essential Elements of the POSC Framework

The pilot's goal is to develop a data-informed strategic framework for coordinated POSC in the catchment area with replicability across Colorado. The guiding assumption is that a POSC is—in and of itself—not helpful as a document, but requires implementation of the plan after development. The POSC Framework acts as the strategic container to align and coordinate approaches across different models, programs, and practices serving families affected by prenatal substance use.

The POSC Framework is made up of four guiding features necessary to produce the desired impact as well as two components that guide implementation (Figure 1).

Figure 1. A Framework for Coordinated POSC Service Delivery and Systems Alignment



The guiding features that anchor the POSC Framework and guide fidelity are what surrounds the approach to keeping maternal-infant dyads safely together. These include:

- Initiate POSC prenatally or as soon as prenatal substance use is recognized to facilitate wrapping services around families as soon as possible. This guiding feature may prevent the need for some families' involvement in child welfare involvement entirely.
- Voluntary engagement by families in the development of a POSC through multiple entry points, both within and outside of child welfare. This guiding feature is intended to ensure families gain access to coordinated services before there is a safety issue.
- Comprehensive service delivery and tracking enables rigorous evidence-building, best practice elevation, and community collaboration. This guiding feature may inform future investments and approaches to scaling the POSC Framework.
- A cross-system, aligned POSC infrastructure reduces the burden of implementing and monitoring POSC, ensuring shared responsibility and improving family engagement. This guiding feature supports the upstream preventative approach that is fundamental to the POSC Framework design.

The two components that guide implementation are:

- Activation Pathways: how and when POSC are initiated for families to achieve coordinated services and supports. This component maximizes the use of trusted organizations and providers to meet the families where they are.
- Aligned Infrastructure: how structures and systems are aligned to accelerate POSC efforts within a community. This component is the behind the scenes work that creates shared understanding of how best to provide POSC while ensuring communities can meet their unique needs. It also builds capacity to separate notification from reporting.

Essential Elements of the POSC Framework

Essential elements are the core functions and the associated activities ("active ingredients") that are necessary for the POSC Framework to produce its desired impact. Essential elements unpack:

What assumptions is the POSC Framework grounded in?
What are the major drivers of the POSC Framework?
What does implementation of the Framework look like in the catchment area?

Learn more by reading Appendix A: Essential Elements

Spotlight on *Activation Pathways*

The POSC Framework includes multiple pathways to activate and implement a POSC for families to achieve coordinated services and support. These include:

- **Entry Points** across the perinatal continuum with a focus on prenatal initiation whenever possible.
- **Specialized Providers** who complete the POSC in partnership with families.
- **Monitoring Processes** for tracking and ensuring ongoing care coordination.

In the catchment area, the activation pathways "come alive" through identification, training, and support of the entry points, specialized providers, and monitoring processes, as follows:

- **Entry Points:** Entry Points refers to the multiple providers or community members across the perinatal continuum that may recognize substance use during a pregnancy, but it is outside the scope for their practice or role to develop a POSC.

Initial points of entry vary from community to community and may include health care providers, community-based organizations, human service systems, and more. Leaning into trusted organizations and providers that meet families where they are is an anchor point for identifying entry points in a community. Entry Points offer a POSC, initiate the POSC if the family accepts, and then ensure connection with a Specialized Provider for full development of the POSC. Initiation of the POSC requires an assessment of need and acuity of need to address any immediate or emergency needs. To ensure a POSC is accessible to all families prenatally throughout the first year postnatally, and to promote voluntary family engagement, entry points are identified during pregnancy, around the time of birth, and through the first year postpartum. A specific focus is on training and supporting those providers and community members that can support prenatal initiation of POSC whenever possible.

- **Specialized Providers:** Specialized Providers are providers or community organizations for whom perinatal substance use and/or POSC is part of their usual scope of practice. Specialized providers can both initiate a POSC and lead development.

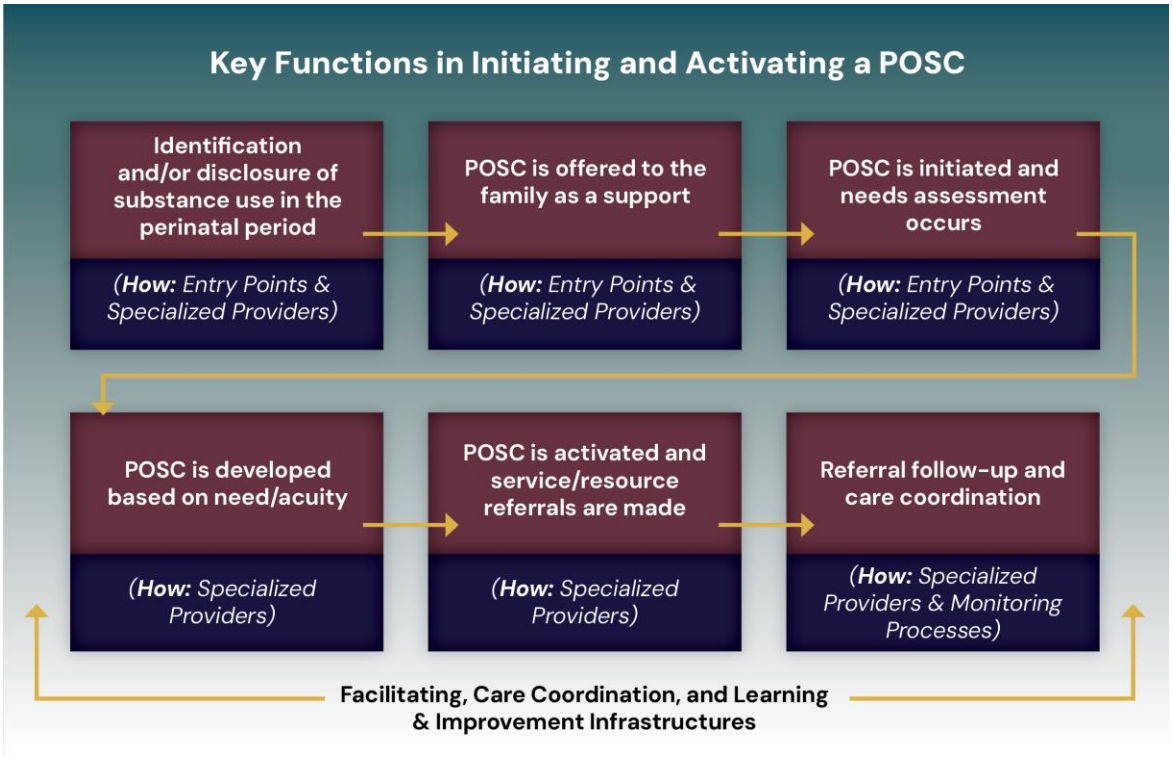
Similar to Entry Points, specialized providers may identify substance use in the perinatal period, offer a POSC, and initiate the POSC if the family accepts. What distinguishes a Specialized Provider from an Entry Point is that the Specialized Provider then goes on to develop the POSC based on need and acuity, and activates the POSC through initial referrals, follow-up, and care coordination. A Specialized Provider may also receive a referral from a (non-specialized entry point) indicating a family would like to develop a POSC. The initiation and development of the POSC may be completed at the same time or across multiple interactions, based on the needs, acuity, and desires of the family, as long as the assessment of need and acuity of need to address any immediate or emergency needs is completed with the initiation of the POSC.

- **Monitoring Processes:** Monitoring Processes are established to support implementation of the POSC after development and ensure that the POSC is more than just a document, but rather an approach for families to achieve coordinated care throughout the childbearing year.

Monitoring Processes include referral follow-up and connection to ongoing services and supports, based on the needs, acuity, and desire of the family. Two touchpoints by the Specialized Provider that created the POSC are standardized in the POSC Framework design, with additional touchpoints individualized to the family.

Six key functions align initiation, development, and ongoing implementation of the POSC (Figure 2).

Figure 2. Key Functions in Initiating and Activating a POSC



Design of Activation Pathways

To create a shared understanding and implement activation pathways in the catchment area, each essential function is accompanied by operational definitions as well as identified trainings, tools, and resources that are necessary for success. Examples of how this is anticipated to show up in catchment area, alongside key considerations that underscore the design, are also provided.

Learn more by reading Appendix B: Design of Activation Pathways

Spotlight on *Aligned Infrastructures*

Implementation of the POSC Framework is supported by structures to align and accelerate POSC coordination. These include:

- **Facilitating Infrastructure** to partner with local entities; provide training, tools, and resources; outline best practice standards; and support alignment with evaluation, communications, and sustainability efforts.
- **Infrastructure for care coordination** to implement activation pathways.
- **Infrastructure for learning and improvement** to build evidence and facilitate practice/policy strengthening.

In the catchment area, these infrastructures are co-designed with community partners and iteratively refined through continual use of data and feedback. Details on each structure are below.

Facilitating Infrastructure: The Facilitating Infrastructure for the POSC Framework is established through an intermediary for the catchment area ("Intermediary") to partner with local entities; provide training, tools, and resources; outline best practice standards; and support alignment with evaluation, communications, and sustainability efforts.

Responsibilities of the Intermediary include:

- Serve as the subject matter expert in the POSC Framework, implementation procedures, and outline best practice standards.
- Identify and partner with local entities to promote community engagement.
- Provide training and education to Entry Points and Specialized Providers.
- Provide technical assistance, tools, and resources for local sites.
- Support and align implementation communications.
- Coordinate data and evaluation functions, in alignment with evaluators.
- Support ongoing funding and sustainability.
- Explore scaling/replication/expansion as informed by evidence.

Intermediary Role and Responsibilities

An intermediary for the catchment area is vital to meeting the POSC Framework guiding features and maximizing effectiveness of the activation pathways. The role of the Intermediary is best understood through the lens of the responsibilities they fulfill to build the facilitating infrastructure.

Learn more by reading Appendix C: Role and Responsibilities of the Intermediary

Care Coordination Infrastructure: The infrastructure for care coordination to implement activation pathways is supported by a standard set of training, tools, and resources necessary for local activities and systems alignment. These include:

- Standardized use of the Colorado Plan of Safe Care template developed by the SuPPoRT Colorado Plan of Safe Care Work group.
- POSC Framework training for Entry Points, including an overview of the POSC Framework, the Colorado Plan of Safe Care template, the process for initiating a POSC, and the process for connecting families with Specialized Providers to complete the POSC.
- POSC Framework training for Specialized Providers, including an overview of the POSC Framework, the Colorado Plan of Safe Care template, the process for initiating a POSC, the process for developing a POSC and making referrals for supports or services, and the POSC Monitoring Processes.
- Training on the use of the comprehensive service delivery and data collection system.
- Scripts and/or practice guidance for both Entry Points and Specialized Providers to support offering, initiating, developing, and monitoring a POSC.
- Standardized tools for Entry Points and Specialized Providers to identify substance use disorders or misuse during the perinatal period.
- Standardized tools for Entry Points and Specialized Providers to identify a family's immediate needs and severity or acuity of those needs.
- Processes to connect families with crisis services for immediate or emergency needs.
- Memorandums of Understanding and Data Sharing Agreements for community partners.
- Consent forms (including a release of information) for families upon initiating a POSC.
- A communications campaign, including a toolkit for community partners and family ffacing documents to support families understanding of a POSC and process for initiating their own POSC.

When lifting the POSC Framework in the catchment area, additional training, tools, and resources are identified on an ongoing basis to meet emergent community needs, and the development or delivery of such is coordinated as needed based on partner priorities. Examples of additional training topics include substance use, substance use disorders, bias, stigma, and the impacts of prenatal substance exposure.

Trainings, Tools, and Resources

A set of standard trainings, tools, and resources support the infrastructure for care coordination. These tools, trainings, and resources are matched to different players in the activation pathways, including the local lead partner entity, entry points, and specialized providers.

Learn more by reading Appendix D: Training, Tools, and Resources

Learning and Improvement Infrastructure: The infrastructure for learning and improvement is focused on building evidence and facilitating practice/policy strengthening. The infrastructure is made up of customization and utilization of a technology platform to track service delivery, support referral processes, and monitor outcomes. Components of the data and service delivery platform include:

- Workflows that enable a POSC to be initiated, developed, and monitored across multiple Entry Points and Specialized Providers.
- Comprehensive analytics to identify implementation learnings and track outcomes at person- and system-levels.
- Tailored consent forms and releases of information that are built into the data system.
- Mechanisms for health care providers and/or child welfare to confirm whether or not a POSC has already been developed for a family.
- Mechanism to support continuity of services and a seamless connection between Entry Points and Specialized Providers that will be completing the POSC.
- Standardized tools (including the Colorado Plan of Safe Care template) that are integrated into the technology system to ensure consistency of implementation.
- An automated closed loop referral process to track referrals, support care coordination with services, and monitor implementation of the plan.
- Notifications to alert Specialized Providers of new POSC that need to be developed, as well as Monitoring Processes at different points in time after the POSC development.
- Ability to integrate with other data collection systems as needed to minimize duplication of data entry and ensure interoperability with data collection systems already in place.

For a description of the evidence building plan and selected technology platform, please see the evaluation synthesis.

Separating Notification from Reporting

A final component of the infrastructure that is critical for piloting the POSC Framework is a process to separate notification of a substance exposed newborn from a formal referral (report of abuse/neglect) in the catchment area. Federal Law requires that all infants born and identified as prenatally exposed to substances have a POSC in place. In Colorado Rules and Regulations, the Child Welfare System is responsible for ensuring a POSC is in place for any referrals accepted for assessment and the child meets the definition of substance exposed newborn as described in 19-1-103(1)(a)(vii), C.R.S and 19-3-102(1)(g), C.R.S. In these cases, when a Colorado Plan of Safe Care has been developed by a medical, treatment or community provider, the caseworker shall update the Colorado Plan of Safe Care to reflect the current circumstances. If a Colorado Plan of Safe Care has not been created by a medical, treatment or community provider, the caseworker shall create a Colorado Plan of Safe Care.

The pilot is a key opportunity to beta-test a practice and build infrastructure for how notification of a substance exposed newborn can be separated from reports of child abuse and neglect. The anticipated branching point is tied to whether concerns for the safety of the child are present.

- If an Entry Point or Specialized Provider is aware of a situation that meets the definitions in statute and rule of "Affected by alcohol or substance exposure" and "Threatened by substance use," the provider will be mandated to report their concerns to Child Welfare.
- If there is no concern for child safety or the situation does not meet the definitions in statute and rule, a CAPTA notification would occur instead and would not contain any personally identifying information. The data and service delivery platform can be leveraged for notification.

Beta-Testing a Practice for Separating Notification from Reporting

Separating notification from formal reports of child abuse and neglect is a key lever to meet the guiding features of the POSC Framework and further support families affected by prenatal substance use in non-stigmatizing ways, with the goal of achieving sustained family strengthening. The pilot is a prime opportunity to beta-testing a practice for separating notification from reporting.

Learn more by reading Appendix E: Separating Notification from Reporting

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Launching the Pilot

Catchment Area Selection and Local Implementation

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Catchment Area Selection and Local Implementation

Using a systematic, data-informed approach, the San Luis Valley (SLV) was proposed as the pilot catchment area.

Key human service, health, and community partners in SLV were invited to collaborate and have accepted the invitation to serve as the pilot's catchment area.

Design elements will be further refined and co-developed with SLV partners as part of pilot launch and implementation.

San Luis Valley Identified as Primary Catchment Area

The POSC will be initially piloted and studied in a defined catchment area, with the collective goals of: 1) drive at feasibility in piloting the Framework, 2) design for sustainability, and c) maximize learnings that can inform future scaling and strengthening of the Framework.

A systematic, data-informed approach to catchment area selection was applied by the POSC Pilot Team. Data indicators were selected and sourced to inform areas with demonstrable need and community readiness for piloting the Framework. Data sources included findings from the perinatal substance use data linkage project; Health eMoms; Colorado Health Information Dataset, CDPHE Open Data; the Colorado Child Fatality Prevention Systems; and County Health Rankings by the Robert Wood Johnson Foundation. Using a screening tool, three potential clusters were identified: 1) SLV (geographically bound); 2) Pueblo County and select surrounding areas, including Las Animas, Otero, and Freemont Counties (geographically bound); and 3) Family Connects counties, including Boulder, Denver, Jeffco, and Eagle (opportunistic versus geographically bound).

Catchment Area Selection

A screening tool was developed to guide catchment area selection and decision-making. The tool includes a set of strategic criteria answered through data indicators at regional/county levels and a community readiness inventory.

Learn more by reading Appendix F: Screening Tool with Data Indicators and Readiness Inventory

These three potential clusters were discussed with DCW. DCW provided valuable insights on the county/agency child welfare landscape in the different areas that could positively or negatively influence the pilot's success. **Based on the dialogue, the group collaboratively decided on SLV as the proposed catchment area.**

Making Transparent Trade-Offs in Catchment Area Selection

The discussion between the POSC Pilot Team and DCW helped make trade-offs of choosing one cluster or another more transparent. As a result, potential benefits of proposing SLV were documented during decision-making, as were the potential limitations to learning and impact.

Potential benefits include: a) demonstrable need based on several key data indicators related to substance use, the pregnant/parenting population, and child welfare involvement; b) sociodemographic diversity; c) community dedication to coordinated care approaches for this population; d) sustained partnerships with Illuminate and strong coalitional will, including the SLV Neonatal Task Force; e) rurality with multiple counties represented; f) readiness in health care, child welfare, and community-based spaces; and g) opportunity to deepen local-level capacity and take an "ecosystem" approach to pilot learnings.

Potential limitations include: a) lack of urban perspective and infrastructure; b) SLV is already committed to prenatal substance use prevention, treatment, and recovery, which means their participation in the pilot looks different than areas or spaces just getting started in this issue area; and c) lifting in a geographically bound catchment area will generate different insights than lifting through sites with a specific niche in the perinatal continuum.

Proactively identifying benefits and limitations helps to inform the evidence-building and learning process, both during the pilot and long-term in replicating the POSC Framework to other catchment areas of Colorado.

Extending the Invitation to SLV Partners

SLV was approached in September 2023 with an invitation (slidedeck, 2-pager) to partner in the POSC Pilot through the San Luis Neonatal Task Force and through the SLV Child Welfare Directors. The SLV counties accepted the invitation to serve as the catchment area. The San Luis Neonatal Task Force has agreed to serve as the local lead entity.

The POSC Framework will be launched for local implementation, using a co-design model to build community capacity and promote long-term sustainability. With the support of the POSC Pilot Team, catchment area representatives and the Intermediary will:

- Orient catchment area representatives to the POSC Framework, including
    - essential elements, shared definitions and terminology;
    - design of activation pathways and essential functions;
    - facilitation, care coordination, and learning and improvement infrastructures; and
    - child welfare notification and reporting requirements and possible beta-testing of a new practice to separate.
- Invite feedback from catchment area representatives on the POSC Framework.
- Survey stakeholders in the catchment area to identify support needs, challenges, and opportunities for implementing the POSC activation pathways.
- Engage the local lead entity and establish clear expectations for all parties through a Memorandum of Understanding.
- Conduct an assessment of community resources to identify potential Entry Points and Specialized Providers.
- Engage local entities to participate in the POSC Pilot utilizing the POSC Framework.

- Implement a process for local entities (including health care providers and community partners) to use the POSC Framework and definitions to assess their capacity and commit to serve as an Entry Point or a Specialized Provider for the pilot.
- Execute Memorandums of Understanding and Data Sharing Agreements with local community partners based on their identified role.
- Establish clear expectations and processes related to data collection, the shared data system, and learning and improvement activities.
- Provide training, tools, and resources to local entities based on their identified role.
- Jointly establish a date for beginning to serve families using the aligned processes and structures lifted in the POSC Framework.

The process of inviting, engaging, and co-designing POSC Framework implementation in the pilot's catchment area will be documented and studied to understand areas for learning and improvement, and prepare for future replication in additional catchment areas, as appropriate.

Timeline for Local Implementation

Year two of the POSC Pilot kicks off on October 1, 2023. During the first quarter of year two (October–December 2023), implementation will focus on:

- Executing roles and responsibilities of the Intermediary for the catchment area.
- Partnering with SLV leads, using the process described above, to co-design implementation of the POSC Framework in the catchment area.
- Finalizing the trainings, tools, and resources, as outlined in the co-design process described above.

During the second quarter of year two (January to March 2024), implementation will focus on:

- Co-developing a plan for providing training to local entities, both Entry Points and Specialized Providers.
- Executing the training plan, as well as sharing additional tools and resources.
- Ensuring shared alignment and responsibility in implementing the POSC Framework in the catchment area.
- Launching the comprehensive data and service delivery platform.

It is anticipated that the POSC pilot will begin serving families no later than April 1, 2024, to enable a full two years of data collection and strategic learning (April 2024 through April 2026). During implementation, the Intermediary will work closely with the local lead entity and community partners in the catchment area, alongside the POSC Pilot Team and the DCW, to document learnings, share successes, address challenges, and implement the evidence building plan.

Resourcing the Pilot to Maximize Success in Impact and Learning

A major consideration for the pilot is the resources available to both the POSC Pilot Team and the proposed catchment area (SLV). The funding from DCW has supported the development of the POSC Framework and will be utilized to support the POSC Pilot Team in implementing the POSC Framework in the catchment area. That said, resources to support local partners in SLV in implementing their roles (e.g.,

Entry Points and Specialized Providers to offer, initiate, develop, monitor, and track POSCs) are also needed. One of the driving factors in proposing SLV as the catchment area is the presence of already secured funding for local partners for the next three years (aligning with years 2 to 4 of the POSC Pilot funding) that is complementary to the project through the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA). As the POSC Framework is implemented in this catchment area, it will be critical to identify and advocate for sustainable funding models, should the pilot be successful.

Moving forward, the POSC Pilot Team is committed to advancing the POSC Framework in the catchment area and beyond, should results of the pilot be favorable. Long term success will depend on sufficient resourcing and sustainability on a local level, as well as dissemination of learnings and impact broadly.

Colorado Evaluation & Action Lab
UNIVERSITY OF DENVER

Building Evidence for the Pilot

Evaluation Synthesis

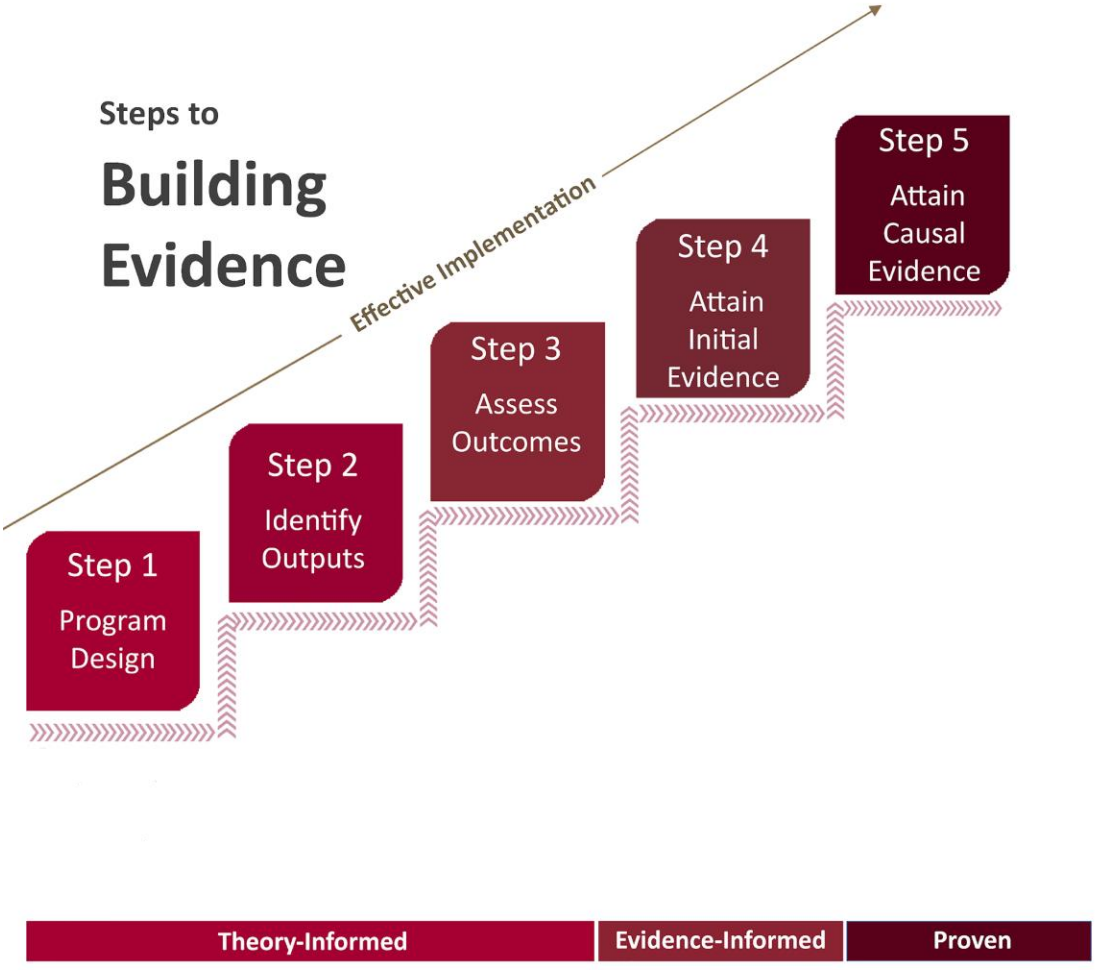
The Value of Evidence-Building

Building evidence on pilot implementation and outcomes is critical to inform strengthening, sustainability, and scaling of the POSC Framework.

The evaluation will focus on Steps 1 through 3 of the evidence building process, from identifying drivers of change to implementation indicators to assessing outcomes.

The pilot evaluation will build evidence on what works for POSC coordinated service delivery and tracking, under what conditions, and for whom. Colorado's Steps to Building Evidence (Figure 3) guides this process and, as an innovative pilot in the state, the focus is on the first three steps. Evaluation findings will inform both longer-term replicability of the pilot and the strategic investments needed to scale, as well as strengthening of the pilot through a focus on continuous quality improvement and data-for-learning.

Figure 3. Colorado's Steps to Building Evidence



Step 1. Program Design

Step 1: Program Design. The first step in building evidence is clearly and explicitly defining the essential elements of the pilot, understanding the logic behind why those elements are expected to lead to change in the desired outcomes, and formalizing pilot expectations and requirements. Step 1 was the focus of the planning year and resulted in a) the POSC Framework essential elements document; b) the POSC Framework logic model; and c) selection of a data and service technology platform.

Essential Elements

Essential elements are the core functions and the associated activities ("active ingredients") that are necessary for the POSC Framework to produce its desired impact. The essential elements document serves a dual purpose during evidence building and pilot innovation. First, it provides a big-picture, long-term view of the POSC Framework in its aspirational form for Colorado. This provides Colorado a roadmap for investing and strengthening in POSC in more aligned and cohesive ways. Second, it makes explicit the key Framework components that will be tested during the pilot period. Select components will be tested for feasibility of implementation, acceptability by catchment area partners, value to families and providers, and effectiveness in driving person- and system-level outcomes. Learnings will be used to strengthen the POSC Framework and ready it for replicability.

Logic Model

The logic model identifies pilot inputs, implementation activities, implementation outputs, and expected outcomes. Importantly, the logic model is a tool intended to serve Colorado beyond the pilot period, to reflect our focus on designing for sustainability and scalability of pilot investments. First "use case" of the logic model will occur during the pilot. The logic model will be revised after the pilot period based on emergent learnings and outcomes assessed to inform future strategic investments.

Logic Model

The logic model for the POSC Framework guides evidence-building, including a focus on both process metrics and measurable outcomes, as well as integration of qualitative and quantitative data.

Learn more by reading Appendix G: POSC Framework Logic Model

Step 2: Identify Outputs.

The second step in building evidence is to determine if, and to what extent, providers are consistently and effectively delivering the POSC Framework as designed. A fidelity of implementation (FOI) rubric is an important tool that can be used by the intermediary for the catchment area to track activities listed in the logic model and essential elements of the POSC Framework being piloted. Data from the FOI tool will be used to engage in continuous quality improvement, with a specific focus on varied entry points and diverse populations.

Documenting Lessons Learned for Replicability

Monitoring fidelity and measuring implementation progress is critical to within-pilot strengthening and to readying the Framework for long-term replicability. Below are examples of how the outputs in the logic

model can be used in combination with reflective conversations with DCW, the POSC Pilot Team, and catchment area partners:

- Facilitating Infrastructure: "Number of cases within the POSC intermediary catchment area" may be used to refine estimates for a) navigator to case ratios, and b) level of staffing within the Intermediary.
- Infrastructure for Care Coordination: "Data transfer of notifications that meet the CAPTA requirements" can be leveraged to begin setting goals within and across catchment areas for meeting the spirit of a notification process (e.g., utilization by provider type).
- Infrastructure for Learning and Improvement: "Fidelity monitoring" can be used to identify aspects of the Framework that may be particularly challenging to implement or require more resources or support than initially envisioned.

Step 3. Assess Outcomes

The third step in building evidence is assessing pilot outcomes, but without a control group. Outcomes will focus on both impact to families and to providers/systems and will be anchored to changes across the perinatal period, from prenatal through the first year postpartum. Whenever possible, the maternal-infant dyad will be paired during outcomes analysis. This approach recognizes that the health and well-being of infants and caregivers are intimately connected. Outcomes data will come from a number of cross-system data sources to reflect the pilot's focus on cross-system care coordination across multiple entry points and provider types. The *Unite Us* HIPAA-secure data platform will be the primary data source to understanding information on POSC initiation, including Entry Points and perinatal period; POSC completion among diverse populations; Specialized Provider type and activation pathways; resource referrals, including the social determinants of health (SDOH) facing affected families and the service array able to meet those needs; and resource connections and follow-up, including referral success rate and timeliness.

The *Unite Us* platform will include a unique identifier that allows data from this pilot to be connected to other state administered data sources (e.g., Trails, birth certificate data, medical claims data), via the perinatal substance use data linkage project. This will allow analysis of child welfare involvement and well-being outcomes for maternal-infant dyads.

Assessing Outcomes to Inform Strategic Investments

Outcomes assessment will help to inform strategic investments in the POSC Framework for Colorado overtime. Below are examples of how the outcomes in the logic model can be used to inform and perhaps inspire strategic investments at the state and catchment area levels.

- Postnatal: Outcome such as "reduced rates of child welfare involvement" and "increased placement with kin and reunification rates" may inform return on investment for child welfare and/or funding streams that can be leveraged to support replication or scaling.
- Prenatal Period: Outcomes such as "increased percent receiving adequate prenatal care and WIC prenatally" are maternal health levers that may inspire strategic investments in POSC by additional agencies or organizations.
- Perinatal: Outcomes such as "percent of POSC that resulted in referral and needed service connection" may be used in combination with SDOH data and referral directory to target investments in building partnerships and strengthening referral processes in catchment areas.

HIPAA-Secure Data Platform

A discovery process was used to identify a HIPAA-compliant platform that can be used for POSC service delivery and tracking in the catchment area.

***Unite Us* was selected as the data platform for the POSC pilot and will be used in the catchment area to facilitate care coordination and evidence-building.**

A major challenge to coordinating care across systems is lack of technology platforms that can facilitate safe and confidential information sharing across providers and reflect real-time changes in the needs of families. This challenge is especially acute when thinking through care coordination in the perinatal period and when substance use is involved. Information on caring for individuals affected by substance use is subject to not only the Health Insurance Portability and Accountability Act (HIPAA), but also requirements of 42 CFR Part 2, which outline additional protections around substance use data. For childbearing individuals, both their needs and their care providers can change from pregnancy to the birth to the postpartum period, making information sharing less than straightforward.

The POSC pilot is enabling exploration of technology platforms that can address this challenge and promote effective POSC service delivery and tracking. A discovery process was used to identify a HIPAA-compliant platform that can be tested in the catchment area. We started the discovery process by drafting a set of data collection and technology requirements. These requirements were then applied to five potential platforms as part of the discovery process: CHESS Health, Safe4Both, Apricot, RedCap, and Unite Us. Using this approach, *Unite Us* was selected as the platform with the greatest ability to meet outlined requirements and proved the most viable in terms of cost and feasibility for using in the SLV (as the proposed catchment area).

What is Needed in a Technology Platform?

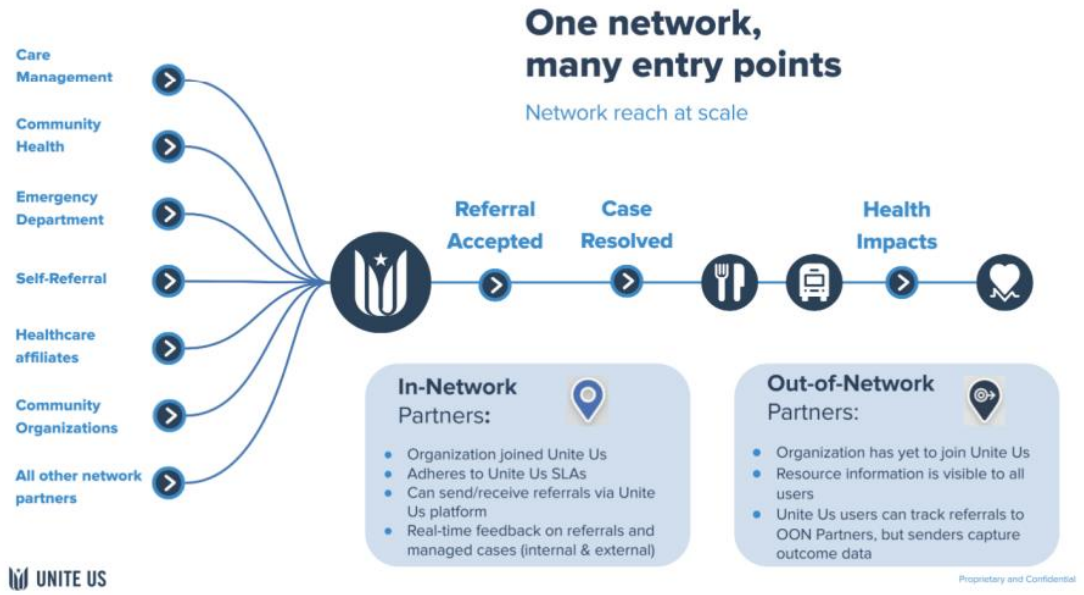
Outlining use case specific needs around data collection and POSC service delivery helps to make clear the ideal set of requirements that a technology platform must have to meet pilot learning goals and POSC Framework implementation.

Learn more by reading Appendix H: Data Collection and Technology Requirements

Unite Us Overview

Unite Us is a social-health information exchange (S-HIE) platform (Figure 5) that provides social care infrastructure to enhance care coordination across community, health care, and social service providers. *Unite Us* enables a no wrong door approach to initiating care; in the case of the POSC pilot, this is reflected in the focus on initiating a POSC across multiple Entry Points (including self-referrals), to meet families where they are. After care is initiated, the platform supports closed-loop referrals and ongoing care coordination, including follow-up; in the case of the POSC pilot, this is reflected in the focus on Specialized Providers completing the POSC and Monitoring Processes to support ongoing care coordination. *Unite Us* is also heavily focused on health and business analytics that can inform infrastructure strengthening in the community; in the case of the POSC pilot, this is reflected in the evidence building process and using data-for-learning.

Figure 5. Unite Us Approach to Care Coordination



Advantages

Unite Us has several advantages that make it a best choice for the POSC Framework and the pilot catchment area. *Unite Us* is HIPAA-compliant and has built-in capabilities for meeting 42 CFR Part 2 requirements, including release of information and consent processes. The POSC template can be built into the workflow and can be updated real-time as the needs of families evolve across the perinatal period. *Unite Us* is already being used in the SLV, including in health, human service, and community spaces. The penetration is impressive and signals acceptability of the platform to catchment area partners. The platform also uses an in-network and out-of-network partner dual-design, which ensures that all resources in the catchment area can be used during care coordination, whether or not the provider/service is licensed on the platform. This improves feasibility and sustainability in using the platform for coordinated POSC. The *Unite Us* platform also has a built-in referral directory that removes the burden on Specialized Providers in locating resources to meet needs identified during POSC development.

Conclusion

The goal of this pilot is to develop a data-informed strategic framework for coordinated POSC in the catchment area with replicability across Colorado. The POSC Framework acts as a strategic container to align and coordinate approaches across different models, programs, and practices serving families affected by prenatal substance use. Lessons learned from this pilot can be used to strengthen and replicate the POSC Framework across Colorado, including identifying needed investments and legislative actions required to scale. As such, this pilot has the potential to accelerate use of POSC in the state and promote a cross-systems infrastructure that can drive family strengthening and healthy outcomes across the life course.

Appendix A: Essential Elements

Essential elements are the core functions and the associated activities ("active ingredients") that are necessary for the POSC Framework to produce its desired impact.

This pilot's goal is to develop a data-informed strategic framework for coordinated POSC in the catchment area with replicability across Colorado. The POSC Framework acts as the strategic container to align and coordinate approaches across different models, programs, and practices serving families affected by prenatal substance use.

These essential elements reflect long-term, aspirational hopes for Colorado in moving towards using POSC as a strategic lever to support families affected by prenatal substance. Aspects of the Framework that are displayed in grayscale are aspirational and beyond the scope of the pilot in the catchment area.

Table 1. Plans of Safe Care (POSC) Framework: Essential Elements

Principles *What assumptions is the POSC Framework grounded in?*	**Context and Structure** *What are the major drivers of the POSC Framework?*
Overarching: POSC are—in and of itself—not helpful as a document, but require implementation of the plan after development. ***Initiate Prenatally or as Soon as Prenatal Substance Use is Recognized*** • POSC are best leveraged when initiated during pregnancy; child welfare cannot get involved until after a baby is born, requiring a more upstream approach. • Help shift the focus of POSC from treatment to prevention. ***Opportunity for Voluntary Engagement by Families*** • Intense stigma surrounding substance use, especially when pregnant and caregiving. • Fear of child welfare involvement experienced by pregnant persons with substance use is a serious barrier to health care and service utilization.	***Initiate Prenatally or as Soon as Prenatal Substance Use is Recognized*** • POSC initiation is accessible to families wherever their prenatal, birth, or postpartum entry point may be. • Possible number of infants exposed to substance use can be identified as early as the prenatal period. ***Opportunity for Voluntary Engagement by Families*** • POSC can be a voluntary support tool available to maternal-infant dyads affected by perinatal substance use. • POSC can also be a support tool by child welfare to strengthen families. ***Cross-System and Collaborative POSC Infrastructure*** • Families do not exist in silos, but rather navigate needs and hopes across systems. • Build infrastructure to separate notification of a substance exposed

- Therefore, it's necessary to have entry points for the development and implementation of POSC that are outside of child welfare involvement.

Cross-System and Collaborative POSC Infrastructure

- Currently, families may touch none, one, or more systems during their childbearing journey.
- POSC are a current requirement within child welfare and the burden of federal reporting requirements fall to the state's child welfare agency; co-ownership is needed to use POSC as a support, not just as a reporting, tool.
- Families affected by perinatal substance use do not inherently have safety and risk concerns; hence, separating reporting to child welfare from notification is needed.
- Reduce duplication of existing approaches and trainings related to POSC.
- Help improve governmental investments efficiency that improve outcomes for families.
- A coordinated POSC Framework will better position Colorado to meet the spirit and provisions of current and future Child Abuse Prevention and Treatment Act legislation.
- Cross-system and collaborative POSC infrastructure will help Colorado reduce burden of implementing and tracking POSC, while promoting the state's commitment to data-driven policy and practice strategies.

Comprehensive Service Delivery and Tracking

- There is a pressing need for diverse, family-centered wraparound services.
- POSC can act as a leverage point for cross-system care coordination that drives improved outcomes for children and families.

newborn, separate from a formal referral (report of abuse/neglect), in the catchment area.

- Alignment of existing POSC approaches and related perinatal substance use prevention and treatment in the catchment area, and ultimately across the state.
- Enhanced cross-system investments in caring for families affected by perinatal substance use.

Comprehensive Service Delivery and Tracking

- An intermediary for the catchment area to partner with local entities; provide training, tools, and resources; outline best practice standards; and support evaluation, communications, and sustainability.
- A comprehensive data collection system that tracks service delivery and outcomes during the pilot in the catchment area.
- A sustained community-based and hospital-based infrastructure for POSC in the catchment area that can be scaled statewide as desirable.
- Health care providers, caseworkers, community-facing supports, substance use treatment providers, and family strengthening programs all have the opportunity to initiate a POSC.
- POSC can be accessible to families wherever their prenatal entry point may be and there is a well-resourced infrastructure in place to support families throughout the first year postnatally.

- Robust evidence-building is needed to strengthen, scale, and sustain favorable approaches in the Framework.

Major Activities
What does implementation of the POSC Framework look like in the catchment area?

Pathways to activate and implement a POSC for families to achieve coordinated services and support, to include:

- Entry Points across the perinatal continuum with a focus on prenatal initiation whenever possible.
- Specialized Providers who complete the POSC in partnership with families.
- Monitoring Processes for tracking and ensuring ongoing care coordination.

Structures to align and accelerate POSC efforts in the catchment area, to include:

- Facilitating Infrastructure to partner with local entities; provide training, tools, and resources; outline best practice standards; and support evaluation, communications, and sustainability.
- Infrastructure for care coordination to implement activation pathways.
- Infrastructure for learning and improvement to build evidence and facilitate practice/policy strengthening.

Appendix B: Design of Activation Pathways

Table 2. Plans of Safe Care (POSC) Framework: Design of Activation Pathways

Function	Definitions to Operationalize	Training, Tools, and Resources
1. Identification and/or disclosure of substance use and perinatal period (Entry Points and Specialized Providers)	Entry Points use standardized screening tools (written or verbal) to identify perinatal substance use • If yes to substance use during pregnancy, or history or substance use and requesting support, move to step 2	• Script or practice guidance • Training • Standardized or recommended tools
2. POSC is offered to the family as a support (Entry Points and Specialized Providers)	Entry Points will verbally offer POSC to family • If consent, give info card and proceed to Step 3—initiate POSC • If maybe, give info card • If decline, capture "no" & offer info card	• Script or Practice Guidance • Training • Information card for families, with QR Code to where families can self-initiate POSC
3. POSC is initiated and needs assessment occurs (Entry Points and Specialized Providers)	To Initiate the POSC, the Entry Point will: • Collect basic information and enter into the shared data system • Utilize standard tool to identify immediate needs • Provide crisis referrals to address immediate needs within capacity ** Entry Points connect family to a Specialized Provider for step 4—develop POSC*	• Script or practice guidance • Training • Standard tool to identify immediate needs • Resource list for crisis referrals • Data system and referral process • List of Specialized Providers
4. POSC is developed based on need/acuity (Specialized Providers)	To develop the POSC, the Specialized Provider will partner with family to: • Sign Consents (including Releases of Information (ROI), as needed) • Identify family needs and desires • Complete the POSC in Data System	• Script or practice guidance • Training • Consent and ROI Forms • Standard process for identification of needs • Data system and referral process

Function	Definitions to Operationalize	Training, Tools, and Resources
	• Schedule follow up in 1–3 weeks to revisit POSC based on family need	
5. POSC is activated, and service/resource referrals are made (Specialized Providers)	To activate the POSC, the Specialized Provider will initiate and complete referrals in the data system and conduct follow up with family to: • Identify areas of continued need • Track services received and still needed	• Script or practice guidance • Training • Data system and referral process • Follow up reminders
6. Referral follow-up and care coordination (Specialized Providers & Monitoring Processes)	Specialized Provider ensures care coordination for families, based on family need and desire, local resources, and services eligibility • Conducts 1 additional follow up at 3 months postpartum (or 3 months after POSC development if POSC developed postnatally) • Identify areas of continued need • Track services received and still needed	• Script or practice guidance • Training • Data system and referral process • Follow up reminders

The POSC Framework provides guidance on how to identify substance use in the perinatal period, offer a POSC to a family, initiate a POSC with a family, develop a POSC with the family, and track and monitor service initiation. Substance use in the perinatal period may look vastly different across individuals based on frequency of substance use and severity of substance use disorder, substances used during the perinatal period, co-occurring diagnoses, supportive relationships, protective factors and capacities, involvement with medical and behavioral health systems, and many other factors. Therefore, the needs of a family, as well as the level of acuity of those needs, will vary greatly from one family to the next. The POSC Framework is designed to allow for multiple different Entry Points across the perinatal continuum. By allowing multiple Entry Points, the POSC Framework seeks to create space for pregnant and parenting people to be supported with a POSC through whatever route suits their life and circumstances best.

POSCs are ideally initiated in the prenatal stage as soon as it has been determined that a pregnant individual is using substances, but may also be initiated at birth or during the first year postpartum. Initiating a POSC in the prenatal stage can benefit both the pregnant person and the fetus by providing time to develop the plan and begin receiving support and services prior to giving birth.
Initial identification of substance use will occur through standardized verbal or written screening or self disclosure by a pregnant or parenting person. Identification of the need for a POSC can arise through one of the multiple providers or community members across the perinatal continuum for whom perinatal

substance use and/or POSC is outside their usual responsibilities and knowledge, but who are in a position to identify substance use in the perinatal period (Entry Points). Alternatively, identification of the need for a POSC could arise in working with a provider for whom perinatal substance use and/or the plan of safe care is part of their typical scope of practice in working with pregnant or parenting people (Specialized Providers). In participating in the POSC Pilot, Entry Points will be engaged to identify families and initiate POSCs, and then connect families with Specialized Providers to develop and monitor the POSC. In addition, Specialized Providers will be identified in their community-based on their capacity to work with families across the perinatal continuum in developing and monitoring POSCs. Similar to Entry Points, Specialized Providers identify substance use in the perinatal period, offer a POSC, and initiate the POSC if the family accepts. Entry Points and Specialized Providers will be provided training on offering, initiating, developing, and monitoring POSCs based on their identified roles.

Entry Point A provider or community member across the perinatal continuum for whom perinatal substance use and/or POSC is outside their usual responsibilities and knowledge.

- Role is to identify substance use, initiate a POSC, and connect to Specialized Provider for development.
- Role is NOT to develop a POSC.
- May be different prenatally, at time of birth, and post-birth.
- Entry Points are offered training and resources on POSC.

Characteristics of Entry Points (as demonstrated by job descriptions, resumes, experience):

- Interfaces with families that may be impacted by substance use during pregnancy.
- Identifies substance use and connects families with Specialized Providers.
- Collect data and uses data system to initiate POSC.
- Completes training on substance use disorders and POSC.
- Utilizes standardized screening tools, scripts, training, practice guidance.

Examples: Any community-based entity/provider interfacing with families in a position to identify substance use and pregnancy including those based in health systems (e.g., hospitals, birthing centers, clinics, OB/GYN or pediatric provider); public health (e.g., WIC, public health nurses, immunization teams, food assistance), behavioral health (e.g., mental health, treatment, recovery, peers); human services (e.g., income, food, child care, housing assistance, child welfare); criminal justice (e.g., probation, parole, law enforcement, court professionals, victim advocates); community services (e.g., home visitation programs, family resource centers, religious community); and crisis lines.

Specialized Providers: A provider or community organization for whom perinatal substance use and/or POSC is part of their usual scope of practice.

- Role is to identify substance use, initiate POSC, develop POSC, and monitor POSC.
- May be different prenatally, at time of birth, and post-birth.
- Specialized Providers are proactively identified and offered advanced training on POSC.
- Housed within an entity willing to sign memorandums of understanding and data sharing agreements.

Characteristics of Specialized Provider (as demonstrated by job descriptions, resumes, experience):

- Builds capacity to accept referrals to create POSC.
- Collects data and uses data system to initiate, develop, and monitor POSC.
- Experience with care coordination, navigation, case management, referral processing.
- Experience and/or training with substance use disorders.
- Flexible, adaptable, creative approach with families.
- Partners with families and demonstrates empathy.
- Utilizes standardized screening tools, scripts, training, practice guidance.
- Completes advanced training on POSC.

Examples: Child welfare caseworker/supervisors/prevention teams (for families involved with Child Welfare); Health System (e.g., hospitals, birthing centers, clinics, OB/GYN or pediatric provider); public health, behavioral health, or community-based care coordinators (e.g., patient navigators, case managers, family navigators, social workers or other providers); doulas; home visitors (based on role/model); and certified peer specialists.

Monitoring Processes A mechanism to support implementation of the POSC after development and ensure care coordination for families as needed to achieve coordinated services and support. Monitoring Processes include referral follow up and connection to ongoing care coordination, based on the needs, acuity, and desire of the family.

- Role is to ensure ongoing access to care coordination, services, and support for family as needed
- May be different prenatally, at time of birth, and post-birth
- Two standardized touchpoints are built into the framework design, including one at 1 to 3 weeks after POSC development and one at 3 months postpartum (or 3 months after POSC development if POSC developed postnatally)
- Additional touchpoints are individualized to the family based on whether or not the family has an ongoing relationship with the Specialized Provider, or whether the family engages in a longer-term relationship with a support provider

Examples: Child welfare caseworker/supervisors/prevention teams (for families involved with Child Welfare); Health System (e.g., hospitals, birthing centers, clinics, OB/GYN or pediatric provider), public health, behavioral health, or community based care coordinators (e.g., patient navigators, case managers, family navigators, social workers or other providers); doulas; home visitors (based on role / model); and certified peer specialists.

Key Considerations of the POSC Framework Design

- Ideally, all Entry Points and Specialized Providers would utilize standardized or recommended verbal or written screening tools to identify families with substance use during the perinatal period and would be trained on administering and interpreting screening tools.

- In addition to standardized screening tools, all Entry Points and Specialized Providers are encouraged to build a rapport and create an environment in which pregnant or parenting people are able to self-disclose their substance use without fear of judgment or stigma.
- All Entry Points and Specialized Providers are encouraged to build standardized prompts or tracking mechanisms into their individual processes related to the identification of substance use during the perinatal period and determine if a family is in need of a POSC, such as:
    - **Is the individual pregnant?** If yes, go to question #2.
    - **Has the individual screened positive for substance use?** If yes, go to question #3.
    - **Has the individual been offered a POSC?** If yes, go to question #4.
    - **Did the individual accept the POSC?** If yes, initiate POSC.
- A principle of the POSC Framework is that the POSC is voluntary, for all Entry Points other than child welfare. All offers of POSC are to be entered into the shared data system, whether accepted, delayed, or declined. If a pregnant or parenting person is unsure of or declines a POSC, additional information should be provided about POSC and how to self-initiate a POSC or request a POSC from an Entry Point at another time.
- Specialized Providers are responsible for ensuring that the appropriate consent forms and releases of information have been obtained prior to any information gathering with the pregnant/parenting person.
    - With consent, obtaining copies of assessments that the person has already completed can provide valuable information and reduce the need to retell a traumatic experience.
    - Once existing information has been obtained, the Specialized Provider can use the information to determine what additional information is needed from the pregnant/parenting person to complete the POSC utilizing a standardized process.
    - This process will assist the Specialized Provider and the family in identifying any areas of need that can be addressed in the POSC.
    - Determine if the family already has goals in place that the POSC can support. If needed, a simple goal setting process will be initiated to identify priorities and problem solve challenges that may arise and that could interfere with the implementation of the POSC. Goals setting will be entered into the shared data system and referrals will be made to needed services and support.
    - The Specialized Provider will ensure a connection to services and support to ensure successful referrals.
- Monitoring Processes are designed to ensure successful service connections and referral processes are completed. Specialized Providers will follow up with families at least twice—on standard intervals—following the development of the POSC to ensure the family is receiving the needed services and supports and to offer additional resources as needed.
- Training on any practices beta-tested for how notification of a substance exposed newborn can be separated from reports of child abuse and neglect.

Appendix C: Role and Responsibilities of the Intermediary for the Catchment Area

Facilitating Infrastructure for the POSC Framework will be established through an intermediary for the catchment area ("Intermediary") to partner with local entities; provide training, tools, and resources; outline best practice standards; and support alignment with evaluation, communications, and sustainability efforts. Responsibilities of the Intermediary include:

- **Serve as the subject matter expert in the POSC Framework, implementation procedures, and best practice standards.**
    - Support community partners in tailoring POSC Framework implementation to their local context, including monitoring innovations.
    - Define fidelity metrics and outline best practice standards.
    - Serve as the primary point of contact for the Catchment Area for all POSC updates, communications, etc.
- **Identify and partner with local entities to promote community engagement.**
    - Within identified catchment areas, identify and engage local lead entity and local community partners.
    - Identify Entry Points, Specialized Providers, and Monitoring Processing.
    - Support sites in execution of local memorandums of understanding.
- **Provide training and education to Entry Points and Specialized Providers**
    - Develop and deliver POSC Framework training.
    - Ensure all new site staff receive necessary training, including database trainings.
- **Provide technical assistance for local sites.**
    - Provide individual technical assistance calls per month.
    - Facilitate at least monthly technical assistance calls with community partners.
    - Provide and/or coordinate coaching and coverage support.
    - Identify additional training/tool needs and coordinate necessary development/delivery of resources.
    - Coordinate expert and/or case consultation.
    - Provide guidance and support to lead entity on community engagement in POSC Framework.
- **Support and align implementation communications.**
    - Coordinate campaign development and implementation.
    - Create and share a toolkit for community partners.
    - Maintain the communications materials for Colorado and developing additional marketing, outreach, and implementation assets.

- **Coordinate data and evaluation functions, in alignment with evaluators**
    - Ensure completion of partner data sharing agreements.
    - Offer system for CAPTA Notifications.
    - Review/approve site deliverables.
    - Offer consultation on data collection and evaluation.
    - Monitor site fidelity to the POSC Framework & Design, including implementing Continuous Quality Improvement strategies and processes for data quality monitoring, such as identification of incomplete POSC.
- **Support ongoing funding and sustainability.**
    - Monitor state/local opportunities and advance funding opportunities, including via advocacy and collaboration with system partners, that can sustain/scale the POSC Framework.
    - Develop a statewide sustainability strategy/framework and offer tools to support community partners in their local sustainability.
    - Advance statewide sustainability pathway.
- **Explore scaling / replication / expansion as informed by evidence.**
    - Support cross-site coordination and within-site learning.

Appendix D: Training, Tools, and Resources

The infrastructure for care coordination to implement activation pathways is supported by a standard set of training, tools, and resources necessary to support local activities and alignment. These are outlined below, organized by role in the catchment area.

- **Tools & Resources**
    - Best Practice Recommendations for: Collaboration and Integration of Plans of Safe Care Implementation in Colorado developed by the SuPPort Colorado Plan of Safe Care Work group.
    - Plan of Safe Care Overview developed by the SuPPort Colorado Plan of Safe Care Work group.
    - Plan of Safe Care Resources from the National Center on Substance Abuse and Child Welfare.
    - A Colorado Plan of Safe Care template developed by the SuPPort Colorado Plan of Safe Care Work group.
    - Scripts and/or Practice Guidance for both Entry Points and Specialized Providers to support offering, initiating, developing, and monitoring a POSC.
    - Standardized or recommended written or verbal screening tool for Entry Points and Specialized Providers to identify a substance use during the perinatal period.
    - Standardized tool for Entry Points and Specialized Providers to identify a family's immediate needs and severity or acuity of those needs.
    - Standardized tool for Family Goal Setting.
    - List of Crisis Services Providers and clear processes to connect families with crisis services for immediate or emergency needs.
    - Memorandums of Understanding and Data Sharing Agreements for Community Partners based on role.
    - Consent Forms (including a Release of Information) for families upon initiating a voluntary POSC.
    - A communications campaign, including a Toolkit for Community Partners and family facing documents to support families understanding POSCs and process for initiating their own POSC, if desired.
- **Training for Local Lead Entity**
    - Training on POSC Pilot Implementation to support partners as needed.
    - Training on Child Welfare Reporting versus CAPTA Notifications.

- **Training for Entry Points**
    - POSC Framework training for Entry Points, including an overview of Federal and State POSC requirements, the POSC Framework, the Colorado Plan of Safe Care, the process for initiating a POSC, and the process for connecting families with Specialized Providers to complete the POSC.
    - Training on the use of the comprehensive data collection system.
    - Training on utilization of all tools and resources.
    - Training on Child Welfare Reporting versus CAPTA Notifications.
- **Training for Specialized Providers**
    - POSC Framework Training for Specialized Providers, including an overview of Federal and State POSC requirements, the POSC Framework, the Colorado Plan of Safe Care, the process for initiating a POSC, the process for developing a POSC and making referrals for supports or services, and the POSC Monitoring and Follow Up Processes.
    - Training on the use of the comprehensive data collection system.
    - Training on utilization of all tools and resources.
    - Training on Child Welfare Reporting versus CAPTA Notifications.

Additional training, tools, and resources will be identified on an ongoing basis throughout the pilot, and the development or delivery of such will be coordinated as necessary and may include training on substance use, substance use disorders, bias, stigma, and the impacts of prenatal substance exposure. Training can also be provided to community partners not serving as a Local Lead Entity, Entry Point, or Specialized Provider as needed to support the success of the pilot.

Appendix E: Separating Notification from Reporting

What is CAPTA, CARA, and their impact on state legislation?

In 2016, the federal Comprehensive Addiction and Recovery Act (CARA) established state responsibilities for infants prenatally exposed to substances. In 2017, the Child Abuse Prevention Treatment Act (CAPTA) included required actions when a newborn is identified as affected by prenatal substance use, experiencing withdrawal symptoms at birth, or displaying fetal alcohol spectrum disorders (FASD). CAPTA requires states to have policies and procedures for completing a Plan of Safe Care (POSC) for all screened-in substance exposed newborns (SEN) referrals.

To be eligible for certain federal dollars, states need to show that policies and procedures are in place that address the needs of substance-exposed infants and their caregivers. The policies must ensure that health care providers involved in the delivery or care of substance- exposed infants:

- write referrals for the affected infants and caregivers for necessary services,
- notify child protective services, and
- create a Plan of Safe Care for the infant's and caregiver's safety and well-being following release from the facility.

The state must develop and implement statewide monitoring systems to ensure that these plans are being developed appropriately in the service of children and families.

Lastly, States must report three key numbers back to the U.S. Department of Health and Human Services:

- The number of infants identified as affected,
- The number of infants for whom a Plan of Safe Care was developed that also addressed the affected caregiver's needs, and
- The number of instances in which a referral to child welfare or any treatment service was made for the infant and/or affected caregiver.

The requirements are intended to provide the needed services and supports for infants with prenatal exposure, the birthing persons with substance use disorders, and their families to ensure a comprehensive response to the effects of prenatal exposure. Congress further specified that these notifications to child protection services, on their own, are not grounds to substantiate child abuse or neglect.

Colorado State Legislation linked to Federal CAPTA and CARA Requirements:

Mandatory Reporting: In Colorado, a mandatory reporter is defined as a professional who is obligated by law to report known or suspected incidents of child abuse and/or neglect. Mandatory reporters are part of the safety net that protects children and youth and have the ability to provide lifesaving help to child victims in our community. Any person specified in C.R.S. 19-3-304 is by law a mandatory reporter in Colorado. If a mandated reporter has reasonable cause to know or suspect that a child has been subjected to abuse or neglect, or observed the child being subjected to circumstances or conditions that would reasonably result in abuse or neglect, the mandatory reporter is required to immediately make a report to the county child welfare department, the local law enforcement agency, or through the child abuse reporting hotline system (844-CO-4-Kids).

Definition of Abuse and Neglect Specific to Substance Exposure
Colorado Senate Bill 20-028 changed the definition of child abuse and neglect for Substance Exposed Newborns. The bill de-emphasized focus on toxicology test results, removed references to the federal schedule of substances, elevated the impact of exposure to the child as the main consideration, and advanced a two-generation approach to keep parents and children together during treatment.

Colorado Revised Statute now states that "Abuse" or "Child Abuse or Nneglect", means an act or omission in one of the following categories that threatens the health or welfare of a child in:

- Any case in which a child is born affected by alcohol or substance exposure, except when taken as prescribed or recommended and monitored by a licensed health care provider, **AND** the newborn child's health or welfare is threatened by the substance use (C.R.S. 19-1-103);

And that a child is neglected or dependent if:
The child is born affected by alcohol or substance exposure, except when taken as prescribed or recommended and monitored by a licensed health care provider, **AND** the newborn child's health or welfare is threatened by substance use (C.R.S. 19-1-102).

Colorado State Rules and Regulations (12 CCR 2509-1, 7.000.2) provides additional clarity by providing definitions for terms in the Child Abuse and Neglect statute related to substance exposure:

- "Affected by alcohol or substance exposure": A child is born affected by alcohol or substance exposure when it impacts the child's physical, developmental, and/or behavioral response.
- "Threatened by substance use": The newborn child's health or welfare is threatened by substance use when the medical, physical, and/or developmental needs of the newborn child are likely to be inadequately met or parent and/or caregivers are likely unable to meet the newborn child's needs."

Plans of Safe Care
Plans of Safe Care are defined by the Code of Colorado Regulations as "a collaborative process to create a documented plan for the health, safety, and well-being of an infant reported with prenatal substance exposure, following the infant's release from the care of a healthcare provider, and address the health, support, and substance use treatment needs of the affected family or caregiver(s) according to the requirements outlined in section 7.107.5 (12 CCR 2509-2)," (12 CCR 2509-1 7.000.2(A)).

Colorado State Rules and Regulations also provide child welfare referral and assessment practice requirements for substance exposed newborn (SEN) child abuse and neglect referrals (12 CCR 2509-2 7.1000). Specifically:

- When substance exposed newborn is a referral reason, the county departments or the hotline county connection center shall ask the Colorado Plan of Safe Care enhanced questions (12 CCR 2509-2 7.103 5(A))
- When assessing allegations of substance exposed newborns, the county department shall develop and document a Colorado Plan of Safe Care according to the requirements outlined in section 7.107.5 (12 CCR 2509-2 7.104.1(C))
- The Colorado Plan of Safe Care shall be approved in the state automated case management system and approved by a supervisor within sixty (60) calendar days from the date the referral was received (12 CCR 2509-2 7.104.131(D))

- The Colorado Plan of Safe Care shall be completed with the parent/caregiver(s), documented in the state automated case management system, and approved by the supervisor within sixty (60) calendar days from the date the referral was received (12 CCR 2509-2 7.104.14(K))

Colorado State Rules and Regulations also define parameters for using Plan of Safe Care for Child Welfare.

- 7.107.5 Colorado Plan of Safe Care parameters for use, and dictate that The Colorado Plan of Safe Care shall be completed:
    - Any time a referral is accepted for assessment and the child meets the definition of substance exposed newborn as described in 19-1-103(1)(a)(vii), C.R.S. and 19-3-102(1)(g), C.R.S.
    - The Colorado Plan of Safe Care shall be completed based on the information available and based on the interview or observation of the alleged victim child(ren) and in collaboration with parents, caregivers, medical providers, and others who may be a part of the plan.
    - A Colorado Plan of Safe Care shall be documented in the state automated case management system and approved within sixty (60) calendar days from the date the referral was received.

7.107.51 When to complete a Colorado Plan of Safe Care.

The action required shall be determined and based on an assessment that contains an allegation of substance exposed newborn as follows:

- If a Colorado Plan of Safe Care has not been created by a medical, treatment or community provider, the caseworker shall create a Colorado Plan of Safe Care, and/or;
- When a Colorado Plan of Safe Care has been developed by a medical, treatment or community provider, the caseworker shall update the Colorado Plan of Safe Care to reflect the current circumstances.

Plans of Safe Care Framework: Beta-Testing a Practice for Separating Notification from Reporting

For the Plan of Safe Care Framework, the following reporting and notification practice will be explored for potential beta-testing in the pilot catchment area. The below visioning does not reflect current statewide practice.

What is the difference between a report and notification?

A Child Welfare (CW) **report or referral** is made when an individual has reasonable cause to know or suspect that a child has been subjected to abuse or neglect and contacts The Colorado Child Abuse and Neglect Hotline (844-CO-4-Kids) or county child welfare department to report their concern. County CW staff evaluate the referral to determine if there is an allegation of abuse or neglect as defined by state law, and further involvement/assessment by child welfare is necessary. Only those concerns that allege child abuse and neglect are assessed further by a caseworker.

For the purposes of the POSC pilot, a **CAPTA notification** would occur when a newborn has been prenatally exposed to substances but there are no concerns about safety. This notification does not contain any personally identifying information.

How is the pilot defining infants born substance exposed for the purposes of the CAPTA Notification?

- A newborn exposed to substances in utero.
- Newborn identified as experiencing withdrawal symptoms.
- Newborn diagnosed with a Fetal Alcohol Spectrum Disorders.

What specific substances are included and excluded in the notification?
All substances used by the birthing individual are to be considered for notification if the use of those substances results in a fetus or newborn being identified as being prenatally exposed to substances, experiencing withdrawal symptoms at birth, or displaying signs of a fetal alcohol spectrum disorder (FASD). In Colorado, this is true for legal, prescribed, and illicit substances. This includes substances used in Medication-Assisted Treatment (MAT) such as: methadone, buprenorphine, prescription opioids, and prescription benzodiazepines.

If the prenatal exposure was a result of the birthing person's substance misuse, the reporter would be directed to follow the notification procedure. Substance misuse is defined as the use of non-prescribed substances or overuse of prescribed substances by an individual.

What about cannabis use?
Any in utero exposure to cannabis constitutes meeting the requirement to submit a **notification.**

What information is provided during the notification?
There is no personally identifying information shared during a notification. The following data is required:

- Name of provider and staff making the notification.
- Zip code of family.
- Race/Ethnicity of child and birthing person.
- Birthing person's age.
- Substance that caused the withdrawal symptoms.
- Verification or development of POSC provided.
- Services identified/referred to in the POSC.

Is there a time frame for when the notification must be made?
Yes, the notification must be made by the birthing hospital as soon as possible after the birthing event and before discharge. Mandated Reporter requirements include a report or referral to child welfare within 12 hours of learning of suspicions of abuse or neglect. Notification timelines for the POSC Pilot are still to be determined.

What is the process for making a CAPTA Notification?
The process for making a CAPTA Notification is still to be determined. It is likely to be through the POSC Pilot comprehensive data collection system.

What is a Plan of Safe Care (POSC)?
A POSC is a plan designed to ensure the safety and well-being of an infant with prenatal substance exposure following release from the care of a health care provider by addressing the health and substance use treatment needs of the infant and affected family or caregiver.

The Plan of Safe Care must:

- Meet the needs of the birthing person, infant, caregiver and family.

Support and services for infant: The plan will address the safety, health, and substance use disorder treatment needs of the infant and affected family members or caregivers. Best practices indicate this should be done through the interdisciplinary coordination of services to enhance the overall well-being of the infant and their parents or caregivers.

- Developmental screening and assessment.
- Linkage to early intervention services.
- Medical services needed to meet the ongoing health needs of the newborn.
- Home visiting programs.

Support and services for adult caregivers: Best practice tells us that a POSC should be designed to meet both the short- and long term needs of the family, with the goal of strengthening the family and keeping the child safely in the home. A POSC could include the following components, depending on the needs of the family:

- Substance use assessment and services.
- Medical services needed to meet the ongoing health needs of the parents and other caregivers.
- Mental health services.
- Assistance with obtaining safe housing.
- Instruction on the special care needs of the infant.
- Provision of infant safe-sleep information and ensuring safe-sleep arrangements in the home.
- Parent education classes or caregiver support groups.
- Child care or respite care.
- Vocational training for parents seeking entry to the job market.
- Comprehensive and coordinated social services, including family therapy groups, parent-child therapy, and residential support groups.

How does the POSC get verified at the time of the birthing event?

- The birthing person may come into the hospital with a POSC. With a Release of Information, the hospital staff can contact the POSC provider.
- A family may become involved with child welfare with a POSC. With a Release of Information, the child welfare staff can contact the POSC provider.

Appendix F: Screening Tool with Data Indicators and Readiness Inventory

This decision-making strategy screen was to help the team take a data-informed approach to selecting the catchment area(s) for the POSC pilot. The considerations are reflexive in nature and not intended to be scored. The aim was to select the catchment area(s) that: 1) illustrates high need for care coordination among families affected by perinatal SUD; 2) demonstrates readiness and feasibility for piloting the POSC Framework; and 3) provides opportunity to inform the value of a POSC Framework for Colorado, with a focus on lessons learned in sustainability and scalability.

- Resource: CHSDA regional map

Process for Applying the Strategy Screen

- At the 3/23 meeting: look at new data and inventory information added – any new potentials jump out?
- At the 3/23 meeting: review the strategy screen – anything to add/refine?
- Async between 3/23 and 4/6: apply the strategy screen to the narrowed list of potentials, to identify a proposed catchment area(s). Responsibilities:
    - **Illuminate/Kempe:** fill in any parts of the strategy screen related to practice (green highlights)
    - **Co Lab**: fill in any parts related to data from the data synthesis spreadsheet (yellow highlights)
    - **All**: add in what you know to remaining places (blue highlights)
- Results of the strategy screen will be discussed by the team on 4/6
    - Goal is to decide which catchment area(s) we want to propose to CDHS partners for refinement and feedback
- The proposed catchment area(s) will then be discussed with CDHS partners on 4/7
- Then, the team will approach partners in the catchment area(s) decided upon, with an invitation to participate in the pilot. If interested in partnering, co-design process ensues.

Clusters to Apply the Strategy Screen To

- At the 2/22 meeting, the team began to review data and the inventory to identify some initial areas that may be ripe for the pilot. At the 3/23 meeting, additional potentials were added to the list.
- At the 3/23 meeting, the following three clusters were chosen to apply the strategy screen to:
    - **Cluster 1:** San Luis Valley: Alamosa, Conejos, Costilla, Mineral, Rio Grande, Sagache
    - **Cluster 2:** Pueblo, Las Animas, Otero, Fremont
    - **Cluster 3:** Family Connects counties (Boulder, Eagle, Denver and Jeffco)

How to Use

Use the tables below to conduct the strategy screen, for each identified cluster. Link out to additional documentation as needed to keep the strategy screen clean/parsimonious. *When rating each item as "not evident", "somewhat evident", and "strongly evident", do so at the county level and the cluster level for each item, whenever possible.*

Cluster 1: San Luis Valley (SLV)

Guiding Consideration	Data Sources	Not Evident, Somewhat Evident, Strongly Evident	Why?/Notes/Documentation
Magnitude of perinatal substance use disorder (SUD) issue and driving factors.	Item 1: Public Health risk factor data on perinatal SUD/substance exposed newborn (SEN) population. Item 2: Community-level risk factor data on environmental context of affected dyads.	Cluster Level **Item 1: Strongly Evident.** **Item 2: Somewhat Evident,** County Level Item 1: 6 of 6 counties show Strongly Evident. Item 2: 2 of 6 shows Strongly Evident; 4 of 6 counties show Somewhat Evident.	**Data:** We first bucketed each variable into appropriate data items. We used a percentile methodology (based on the state distribution) to first assign a rating for each variable in the data item. Then, we looked at percentage of variable ratings at the county level. Finally, we looked at percentage of variable ratings at the cluster level. Documentation available here.
Demonstrable readiness to activate the POSC Framework.	Item 3: Inventory, to illustrate potential community connections and referral sources. Item 4: Community-level protective factor data on strengths and assets for care navigation.	Cluster level: **Item 3. Strongly Evident.** **Item 4: Strongly Evident.** County level Item 4: 5 of 6 show Strongly Evident; 1 of 6 shows Not Evident (Mineral).	**Data:** We first bucketed each variable into appropriate data items. We used a percentile methodology (based on the state distribution) to first assign a rating for each variable in the data item. Then, we looked at percentage of variable ratings at the county level. Finally, we looked at percentage of variable ratings at the cluster level. Documentation available here. For protective factors, we had to use a per capita approach; there are limitations to these data and we recommend leaning more into the "inventory" for this guiding consideration. **Practice:** There are a number of resources to address SUD and serve people beginning in the prenatal stage. SLV Behavioral Health Group is very well connected to each of the counties in the cluster. The Rural Recovery Network seems well connected to the health systems in the area. I'd be curious about how well connected Crossroads Turning Points is to the area health

Guiding Consideration	Data Sources	Not Evident, Somewhat Evident, Strongly Evident	Why?/Notes/Documentation
			systems. The cluster also has the Neonatal Task Force that brings everyone together for training on SUD. Birthing Hospital is a CHoSEN Hospital.
Feasibility of activating specialized and non-specialized audiences & pathways.	Item 5: Inventory, to illustrate potential partnerships and referral sources. Item 6: Use of SHIE for specialized audiences (discussion).	**Item 5: Strongly Evident.** **Item 6: Somewhat Evident.**	**Practice:** There seem to be good partnerships established within this cluster of counties. SafeCare has struggled from time to time with getting community partners and health systems to make referrals, but the referral sources are definitely there.
Opportunity for data-informed learning on scaling and sustaining. ● Rural/urban balance. ● Heavy vs. no/little previous perinatal SUD investments. Demographics (race/ethnicity, immigration).	Item 7. Team discussion on which pilot areas are best suited to answer: ● How POSC Framework could help sustain a current initiative. ● How POSC Framework could help catalyze new efforts for an under-served area. Item 8: Inventory, to identify existing and previous SUD investments. Item 9: Community demographics data	**Item 7: Strongly Evident.** **Item 8: Strong Evident.** **Item 9: Context only/no rating.**	**Practice:** This cluster of counties have made a number of investments in the area of SUD that serve each of the counties. **Data:** This cluster seems to be more rural. Alamosa is the largest county, but population seems to drop when people reach around 20. The other counties seem to remain pretty consistent with population. Most of the counties in this cluster are made up of primarily Hispanic and White individuals, with slightly higher number of Hispanic individuals. **Practice:** SLV has an Indigenous People/Native population and SLV AHEC opened an American Indian Center.

Guiding Consideration	Data Sources	Not Evident, Somewhat Evident, Strongly Evident	Why?/Notes/Documentation
Blocking Concerns/NO-GO. Existing data or practice initiative that would be hindered/burdened by POSC pilot.	Item 10. Team discussion to identify any "no-go" areas.	No blocking concerns	N/A

Cluster 2: Pueblo, Las Animas, Otero, Fremont

Guiding Consideration	Data Sources	Not Evident, Somewhat Evident, Strongly Evident	Why?/Notes/Documentation
Magnitude of perinatal SUD issue and driving factors.	Item 1: Public Health risk factor data on perinatal SUD/SEN population. Item 2: Community-level risk factor data on environmental context of affected dyads.	Cluster Level **Item 1: Somewhat Evident.** **Item 2: Strongly Evident.** County Level Item 1: 3 of 4 counties show Strongly Evident; 1 of 4 counties shows Somewhat Evident (Pueblo). Item 2: 3 of 4 counties show Strongly Evident; 1 of 4 counties shows Somewhat Evident (Otero).	**Data:** We first bucketed each variable into appropriate data items. We used a percentile methodology (based on the state distribution) to first assign a rating for each variable in the data item. Then, we looked at percentage of variable ratings at the county level. Finally, we looked at percentage of variable ratings at the cluster level. Documentation available here.
Demonstrable readiness to activate the POSC Framework.	Item 3. Inventory, to illustrate potential community connections and referral sources.	Cluster level **Item 3. Somewhat Evident.** **Item 4: Strongly Evident.** County level	**Data:** We first bucketed each variable into appropriate data items. We used a percentile methodology (based on the state distribution) to first assign a rating for each variable in the data item. Then, we looked at percentage of variable ratings at the county level. Finally, we looked at percentage of

Guiding Consideration	Data Sources	Not Evident, Somewhat Evident, Strongly Evident	Why?/Notes/Documentation
	Item 4. Community-level protective factor data on strengths and assets for care navigation.	Item 4: 4 of 4 show Strongly Evident.	variable ratings at the cluster level. Documentation available here. For protective factors, we had to use a per capita approach; there are limitations to these data and we recommend leaning more into the "inventory" for this guiding consideration. **Practice:** There are a few SUD related programs in Pueblo, but I'm not clear what is available in the other counties or how well connected the cluster of counties is to one another. There is an Early Childhood Council in Pueblo that would serve the other 3. I'm wondering how people/families from Las Animas, Oreo and Fremont would be referred. Crossroads has an inpatient facility where children can remain with birthing person. Parkview is a CHoSEN Hospital.
Feasibility of activating specialized and non-specialized audiences & pathways.	Item 5: Inventory, to illustrate potential partnerships and referral sources. Item 6: Use of SHIE for specialized audiences (discussion).	**Item 5: Somewhat Evident.** **Item 6: Somewhat Evident.**	**Practice:** There are some SUD related programs in Pueblo, but unclear they partner or if they'd be reliable referral sources. Pueblo has Nurse Family Partnership Home visiting services. Would need CDHS help in getting child welfare agencies involved.
Opportunity for data-informed learning on scaling and sustaining.	Item 7. Team discussion on which pilot areas are best suited to answer:	**Item 7: Somewhat Evident.** **Item 8: Somewhat Evident.**	**Practice:** Some programs in Pueblo, but unclear about the other counties in the cluster.

Guiding Consideration	Data Sources	Not Evident, Somewhat Evident, Strongly Evident	Why?/Notes/Documentation
• Rural/urban balance. • Heavy vs. no/little previous perinatal SUD investments. Demographics (race/ethnicity, immigration).	• How POSC Framework could help sustain a current initiative. • -How POSC Framework could help catalyze new efforts for an under-served area. Item 8: Inventory, to identify existing and previous SUD investments. Item 9: Community demographics data.	**Item 9: Context only/no rating.**	**Data** This cluster sees a higher population and birth rate than SLV. Still primarily Hispanic and white. **Practice:** Pueblo Safe Baby Court is an opportunity.
Blocking Concerns / NO-GO Existing data or practice initiative that would be hindered/burdened by POSC pilot.	Item 10: Team discussion to identify any "no-go" areas.	None blocking concerns.	N/A

Cluster 3: Family Connects Counties

Guiding Consideration	Data Sources	Not Evident, Somewhat Evident, Strongly Evident	Why?/Notes /Documentation
Magnitude of perinatal SUD issue and driving factors.	Item 1: Public Health risk factor data on perinatal SUD/SEN population. Item 2: Community-level risk factor data on environmental context of affected dyads.	Cluster Level **Item 1: Somewhat Evident.** **Item 2: Somewhat Evident.** County Level Item 1: 1 of 4 counties shows Strongly Evident (Eagle); 3 of 4 counties show Somewhat Evident. Item 2: 2 of 4 counties show Strongly Evident; 1 of 4 counties shows Somewhat Evident (Boulder); 1 of 4 counties show Not Evident (Eagle).	**Data:** We first bucketed each variable into appropriate data items. We used a percentile methodology (based on the state distribution) to first assign a rating for each variable in the data item. Then, we looked at percentage of variable ratings at the county level. Finally, we looked at percentage of variable ratings at the cluster level. Documentation available here.
Demonstrable readiness to activate the POSC Framework.	Item 3. Inventory, to illustrate potential community connections and referral sources. Item 4: Community-level protective factor data on strengths and assets for care navigation.	Cluster level **Item 3: Strongly Evident.** **Item 4: Somewhat Evident.** County level Item 4: 2 of 4 show Strongly Evident; 2 of 4 show Not Evident.	**Data:** We first bucketed each variable into appropriate data items. We used a percentile methodology (based on the state distribution) to first assign a rating for each variable in the data item. Then, we looked at percentage of variable ratings at the county level. Finally, we looked at percentage of variable ratings at the cluster level. Documentation available here. For protective factors, we had to use a per capita approach; there are limitations to these data and we recommend leaning more into the "inventory" for this guiding consideration. **Practice:** All four counties within this cluster appear to be very well connected to their communities and there appear to be a number

			of referral opportunities within Boulder, Denver and Jeffco. Eagle county participates in IMPACT BH-Including Great Expectations- home visiting. Inpatient SUD facilities where children can remain with birthing person. CHoSEN Birthing Facilities.
Feasibility of activating specialized and non-specialized audiences & pathways.	Item 5: Inventory, to illustrate potential partnerships and referral sources. Item 6: Use of SHIE for specialized audiences (discussion).	**Item 5: Strongly Evident.** **Item 6: Somewhat Evident.**	**Practice:** The 3 metro counties all provide opportunities for potential partnerships and referral sources as there are a number of programs relating to SUD. Eagle county potential is unclear; there are a few programs there but that don't appear to offer SUD specific resources. Eagle County participates in IMPACT BH-Including Great Expectations- home visiting.
Opportunity for data-informed learning on scaling and sustaining, ● Rural/urban balance. ● Heavy vs. no/little previous perinatal SUD investments. Demographics (race/ethnicity, immigration).	Item 7. Team discussion on which pilot areas are best suited to answer: ● How POSC framework could help sustain a current initiative. ● How POSC framework could help catalyze new efforts for an under-served area.	**Item 7: Strongly Evident.** **Item 8: Strongly Evident.** **Item 9: Context only/no rating**.	**Practice:** The 3 metro counties have programming that demonstrate existing and previous SUD investments. Eagle County is unclear. **Data:** This cluster is an urban cluster as it includes Denver, Boulder and Jeffco. The population in all of the counties within the cluster is primarily White.

	Item 8: Inventory, to identify existing and previous SUD investments Item 9: Community demographics data		
Blocking Concerns / NO-GO Existing data or practice initiative that would be hindered/burdened by POSC pilot.	Item 10: Team discussion to identify any "no-go" areas.	No blocking concerns.	N/A

Appendix G: POSC Framework Logic Model

Capacity-Building

- Data-informed approach to selecting the catchment area.
- Shared definitions and terminology.
- Roles and responsibilities of intermediary for the catchment area.
- Pathways for initiating POSC across multiple entry points.
- Guidance for completing POSC by specialized providers.
- Strategies for ongoing care coordination (monitoring processes).
- Guidance on using data to develop referral directories.
- Explore, evaluate, and determine options for a HIPAA-secure platform for data collection and service delivery; assess for feasibility in a given catchment area (e.g., *Unite Us*).
- Develop an awareness campaign for POSC that is tailored to a given catchment area.

Implementation Activities

Facilitating Infrastructure

- Promote use of shared definitions/terms.
- Onboard catchment area.
- Activate the POSC catchment area intermediary.
- Determine catchment area strengths and gaps in the activation pathways.
- Identify a list of entry points and specialized providers.
- Use communication materials to promote alignment.
- Train and support providers on role and function.
- Co-refine and implement activation pathways.

Infrastructure for Care Coordination

- Implement tools for POSC service delivery and tracking.
- Explore options to separate notification from reporting using established processes.
- Build local referral pathways between child welfare and the catchment area intermediary.

Infrastructure for Learning and Improvement

- Catchment area-specific evidence-building plan.
- Shared measures across catchment areas.
- Fidelity monitoring.
- Continuous quality improvement (CQI) structure.

Implementation Activities Outputs

Facilitating Infrastructure

- Shared definitions/terms used by POSC providers.
- Retention of catchment area providers.
- Number of POSC families and providers supported by the catchment area intermediary.
- Aggregate data on local social determinants of health.
- List of entry points and specialized providers, by type.
- Analytics on reach of communication materials.
- Number of trainings provided and to whom.
- Number of activation pathways completed.

Infrastructure for Care Coordination

- Number of families with a POSC initiated, by entry point.
- Number of POSC completed, by entry point and specialized provider type
- Data transfer that meets CAPTA notification requirements.
- Number of referrals completed between child welfare and the catchment area intermediary

Infrastructure for Learning and Improvement

- Completed catchment area-specific evidence-building plan.
- List of shared measures.
- Fidelity assessments developed.
- CQI assessments developed.

Outcomes

Families and Providers in the Catchment Area

Perinatal Period

- Increased percent of entry points and specialized providers who can recognize dyads with substance use and initiate a POSC.
- Increased percent of specialized providers equipped to develop a POSC and make referrals.
- Increased availability of monitoring processes to support care coordination.
- Increased percent of developed POSC with families.
- Increased percent of POSC that result in referral and needed resource connections.

Prenatal

- Increased percent of POSC initiated prenatally
- Increased percent in adequate prenatal care.
- Increased percent in Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) enrollment prenatally.

Postnatal:

- Increased percent of POSC use across the full year of life.
- Increased well-baby and maternal health visits
- Reduced rates of child welfare involvement while maintaining children's safety.
- For children removed from the home, increased placement with kin and reunification rates.

Capacity to Sustain and Scale the Framework

- Information on infrastructure costs and case costs to inform sustaining or scaling.
- Identified barriers to sustainability or scalability and the leverage point for mitigating them (e.g., partnerships, legislation).
- Rigorous data on proportion of POSC completed by subpopulations, voluntary engagement, perinatal period, and type of initiating and completing provider.

Assumption: Logic model reflects statewide use of the POSC Framework in Colorado. If results of the pilot are favorable, this Framework could be replicated to other catchment areas.

Appendix H: Data Collection and Technology Requirements

Guiding Question: What is the ideal and the practical in a technology platform to support coordinated POSC service delivery and tracking?

Table 3. Data Collection and Technology Requirements

Requirement
HIPAA Compliant.
Offline Capability.
Interoperability with other data systems (e.g., Apricot, Salesforce).
Ability to pull data out of system for backend evidence-building and linkages.
Patient Confidentiality, ability to: • log patient Release of Information (ROI) initially, including dates and expiration; • update patient ROI; and • hide details from certain providers, depending on client ROI.
PRAPARE Risk Assessment for social determinants of health, ability to: • log consent and reason; and • complete in system.
Plan of Safe Care, ability to: • log consent and reason; • complete bare minimum while assessing for need and acuity; • trigger that a POSC needs to be developed by someone else or self; • complete in system; and • share plan with family (as they desire) and other named providers or support persons.
Onboarding entry points and specialized providers, such as: • Medical entities; • Child welfare departments • Community-based entities; and • Individual supports (e.g., faith leader).
Referral Directory (list of available resources), with ability to see: • availability in family's service area: • accepting new clients;

Requirement
• family is eligible; • culturally and linguistically responsive; and • potential to integrate with existing resources like Touch as a Mother.
Referral Directory, with ease in ability for providers to: • add own listing; • update own list; and • refresh periodically across board by outside admin.
Initiate: make electronic referral.
Confirm Receipt: provider confirms receipt of referral.
Referral Closed/Completed: • Confirm provider was able to connect with the family; and • Client said yes/no to service with reason why (dropdown plus comment box).
Automatic follow up triggers by: • set timing periods: • infant/maternal postpartum milestones; • when referrals not confirmed by receiving provider • when providers could not connect with client; and • when client said no (because there is still a need that remains).
Plan of Safe Care: Real-time updates based on closed loop referral actions (above). • ability for Colorado's Plan of Safe Care template to be integrated into the system.

Endnotes

[1] American College of Obstetricians and Gynecologists. (2017). *Opioid use and opioid use disorder in pregnancy* (Committee Opinion 711). https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy

[2] Colorado Department of Health Care Policy and Financing. (2019). *Opioid use in Colorado: Colorado Medicaid addresses addiction*. https://www.colorado.gov/pacific/sites/default/files/Opioid%20Use%20In%20Colorado%20October%202019.pdf

[3] Colorado Department of Public Health and Environment. (2023). *Child fatality prevention system: 2023 annual legislative report*. https://drive.google.com/file/d/1HnRis14uWWybCAGXeEoJBGu1mgsN4xEt/view

[4] Colorado Department of Public Health and Environment. (2023). *Maternal mortality in Colorado, 2016-2020*. https://drive.google.com/file/d/1L8YyFzO7MUKJuG17p2qa1O8mwTz_PR4T/view

[5] Substance Abuse and Mental Health Services Administration. (2016). *A collaborative approach to the treatment of pregnant women with opioid use disorders*. HHS Publication No. (SMA) 16-4978. Rockville, MD: SAMHSA. https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4978.pdf

[6] Forray, A. (2016). Substance use during pregnancy. *F1000Research*, *5*(F1000 Faculty Rev), Article 887. https://doi.org/10.12688/f1000research.7645.1

[7] Schiff, D. M., Nielsen, T., Hoeppner, B. B., Terplan, M., Hansen, H., Bernson, D., Diop, H., Bharel, M., Krans, E. E., Selk, S., Kelly, J. F., Wilens, T. E., & Taveras, E. M. (2020). Assessment of racial and ethnic disparities in the use of medication to treat opioid use disorder among pregnant women in Massachusetts. *JAMA Network Open, 3*(5), e205734. https://doi:10.1001/jamanetworkopen.2020.5734

[8] Alexander, K. (2013). Social determinants of methadone in pregnancy: Violence, social capital, and mental health. *Issues in Mental Health Nursing, 34*(10), 747–751. https://doi.org/10.3109/01612840.2013.813996

[9] Matsuzaka, S., & Knapp, M. (2020). Anti-racism and substance use treatment: Addiction does not discriminate, but do we? *Journal of Ethnicity in Substance Abuse*, *19*(4), 567–593. https://doi.org/10.1080/15332640.2018.1548323

[10] Barnett, Knight, E., Herman, R. J., Amarakaran, K., & Jankowski, M. K. (2021). Difficult binds: A systematic review of facilitators and barriers to treatment among mothers with substance use disorders. *Journal of Substance Abuse Treatment, 126*, Article 108341. https://doi.org/10.1016/j.jsat.2021.108341

[11] Stone, R. (2015). Pregnant women and substance use: fear, stigma, and barriers to care. *Health & Justice, 3*, Article 2. https://doi.org/10.1186/s40352-015-0015-5

[12] Colorado Department of Human Services. (2023). *Child Welfare Data Part I: Substance Exposed Newborns.* https://drive.google.com/file/d/1dBoq0Cb2bq0061EKF365pmfaP18jqMmE/view?usp=sharing