Perinatal Substance Use Coordinated Care and Support Pilot: A Community-Based Approach to Plans of Safe Care

Implementation Learnings: Year One

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 in the San Luis Valley** to accelerate POSC.
- The pilot goal is to create a **data-informed strategic framework** for coordinated POSC that can be scaled and replicated across Colorado communities.
- The **POSC Framework emphasizes** prenatal POSC for upstream prevention, a community-based approach to reduce stigma, and care coordination across providers to achieve family thriving.
- This report summarizes **learning and design insights** from year one of implementation, with an eye toward statewide capacity building and alignment.

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Executive Summary

Background: 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,[1] opportunities from Colorado practice, and national legislation, POSC were identified as a lever[2] for improving cross-system care coordination and health outcomes for affected families. To align and accelerate POSC progress, the Colorado Department of Human Services (CDHS), Division of Child Welfare (DCW), is resourcing a four-year pilot in the San Luis Valley, with potential for replication and scaling statewide. This report documents learning insights from year one of implementation (pilot launch). Details on pilot design can be found here.[3]

POSC are a leading strategy to address the complex origins of prenatal substance use and the need for wraparound services for families. Since 2016, POSC are a requirement of the Child Abuse Prevention and Treatment Act (CAPTA). In Colorado, CDHS is responsible for meeting mandates on substance exposed newborns. States are given flexibility in implementing this CAPTA requirement, including the option for community partnership and POSC prenatal initiation.

Pilot Overview: The pilot's goal is to develop a data-informed strategic framework for coordinated POSC that can be scaled and replicated across Colorado. The guiding assumption is that a POSC is—in and of itself—not helpful as a document or compliance tool. To make POSC meaningful, they must be used as a tool for care coordination across the childbearing period and they must center family choice. The guiding features of the POSC Framework are: 1) Prenatal POSC initiation, 2) Voluntary engagement by families, 3) Comprehensive service delivery and tracking; and 3) Cross-system collaboration using a community-based approach. These guiding features are implemented through activation pathways (how POSC are initiated and how care coordination occurs) and structures that support local partners (i.e., an intermediary) and generate data for learning (i.e., evidence-building).

Year One Implementation Learnings: Four successes emerged in year one of implementation:

- Activation Pathways: How will this look in my community?
- Support Infrastructure: What does it take to make it successful?
- Community Engagement: How do we ensure it is community-led?
- Building Evidence: How will we know if it works?

Together, the four successes showcase pilot learnings and the potential for the POSC Framework to inform statewide alignment in the care of families affected by prenatal substance use.

Moving Forward: A POSC Framework (versus a program or model) was selected in order to ensure rapid scaling and alignment across the state. As pressure and demand grows to implement POSC in communities across Colorado, use of the POSC Framework provides an unprecedented opportunity for statewide alignment. The POSC Pilot team welcomes opportunities to discuss the POSC Framework and exchange learnings with families, communities, and systems committed to the prevention, treatment, and recovery of prenatal substance use.

Table of Contents

Acknowledgements

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This pilot is led by the Colorado Evaluation and Action Lab (Colorado Lab), in collaboration with Illuminate Colorado and the Kempe Center for the Prevention and Treatment of Child Abuse and Neglect (Kempe Center).

- **Evidence building and policy lead:** Colorado Lab
- **Plans of Safe Care pilot intermediary in the catchment area:** Illuminate Colorado
- **Technical support:** Kempe Center

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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.

Introduction

The Colorado Department of Human Services (CDHS), Division of Child Welfare (DCW), is resourcing a pilot to align and accelerate Plans of Safe Care (POSC) progress.

The goal of this pilot is to develop a data-informed strategic framework for coordinated POSC that can be scaled and replicated across Colorado.

The POSC Framework emphasizes prenatal POSC for upstream prevention, building a community-based approach to reduce stigma, and advancing care coordination across providers to achieve family thriving.

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,[4] emergent opportunities from Colorado practice, and national legislation, 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 Evaluation and Action Lab (Colorado Lab) issued a policy brief[5] outlining a vision for using POSC, in collaboration with state agencies, medical providers, research experts, community-facing providers, and families.

To align and accelerate POSC progress, the CDHS DCW is resourcing a four-year pilot in the San Luis Valley, with potential for replication and scaling statewide. The pilot runs from Federal Fiscal Year (FFY) 2023 to FFY26. FFY23 was the planning year and FFY24 through FFY26 are implementation and evidence-building years. This report documents learning insights from year one of implementation (pilot launch). Details on pilot design can be found here.[6]

What are Plans of Safe Care?

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.

POSC are a leading strategy to address the complex origins of prenatal substance use and the need for wraparound services for families (e.g., behavioral health outpatient programs, new parent social support, substance use disorder treatment, obstetric care, concrete supports). In 2016, the Child Abuse Prevention and Treatment Act (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 Colorado, the CDHS Division of Child Welfare is responsible for fulfilling legislation related to substance exposed newborns. In 2022, there were 1,578 infants reported to child welfare for substance exposure of a newborn. Yet only 39%[7] had a POSC. Importantly, states are given flexibility in implementation of this CAPTA requirement. Best practice is to take a cross-system, collaborative approach to meet the wide-ranging needs of

infants and their families. 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.

Pilot Overview

The pilot's goal is to develop a data-informed strategic framework for coordinated POSC that can be scaled and replicated across Colorado. The guiding assumption is that a POSC is—in and of itself—not helpful as a document or compliance tool. To make POSC meaningful, they must be used as a tool for care coordination across the childbearing period and they must center family choice.

The POSC Framework is made up of four guiding features that, together, advance a public health approach to supporting families affected by prenatal substance use (Figure 1). The features are implemented in local communities through activation pathways and an aligned infrastructure. 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.

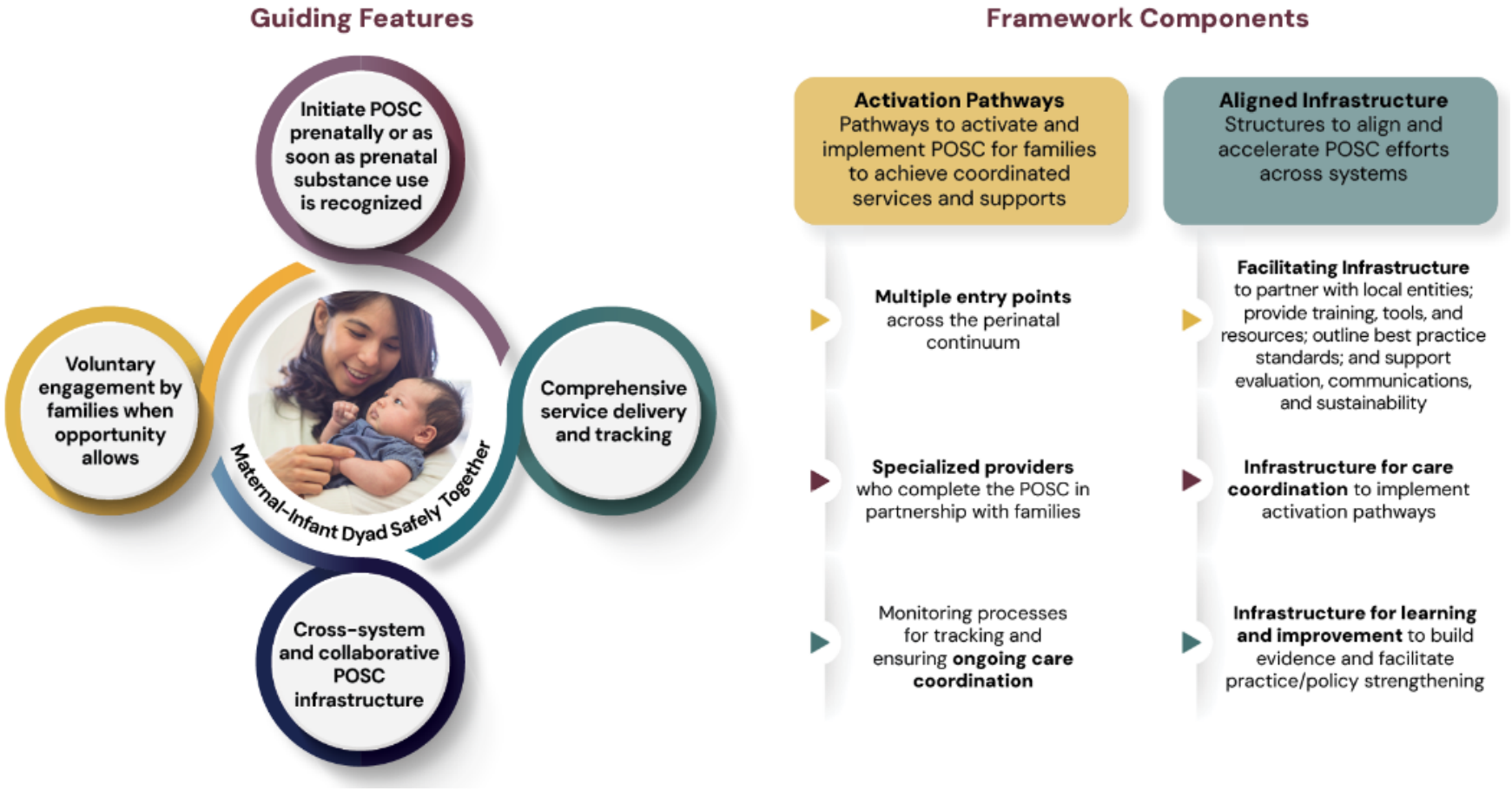
The guiding features are:

- Initiate POSC prenatally or as soon as prenatal substance use is recognized to wrap services around families as early as possible. **This guiding feature may prevent the need for some families' involvement in child welfare 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 helps ensure **families gain access to coordinated services before there is a safety issue, while reducing stigma.**
- Comprehensive service delivery and tracking enables rigorous evidence building, best practice elevation, and community collaboration. This guiding feature can **inform future investments and approaches to scaling the POSC Framework**.
- A cross-system, community-based POSC infrastructure reduces the burden of implementing and monitoring POSC, ensuring shared responsibility. This guiding feature supports **upstream prevention to improve outcomes.**

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 community organizations** and providers to honor family choice and reduce harm.
- Aligned Infrastructure: How structures and systems are aligned to accelerate POSC efforts within a community. This component is the behind the scenes work to create a **shared understanding** of how best to provide POSC, while ensuring communities can meet their unique needs. It also builds capacity to separate notification of a substance exposed newborn from a report of child abuse and neglect.

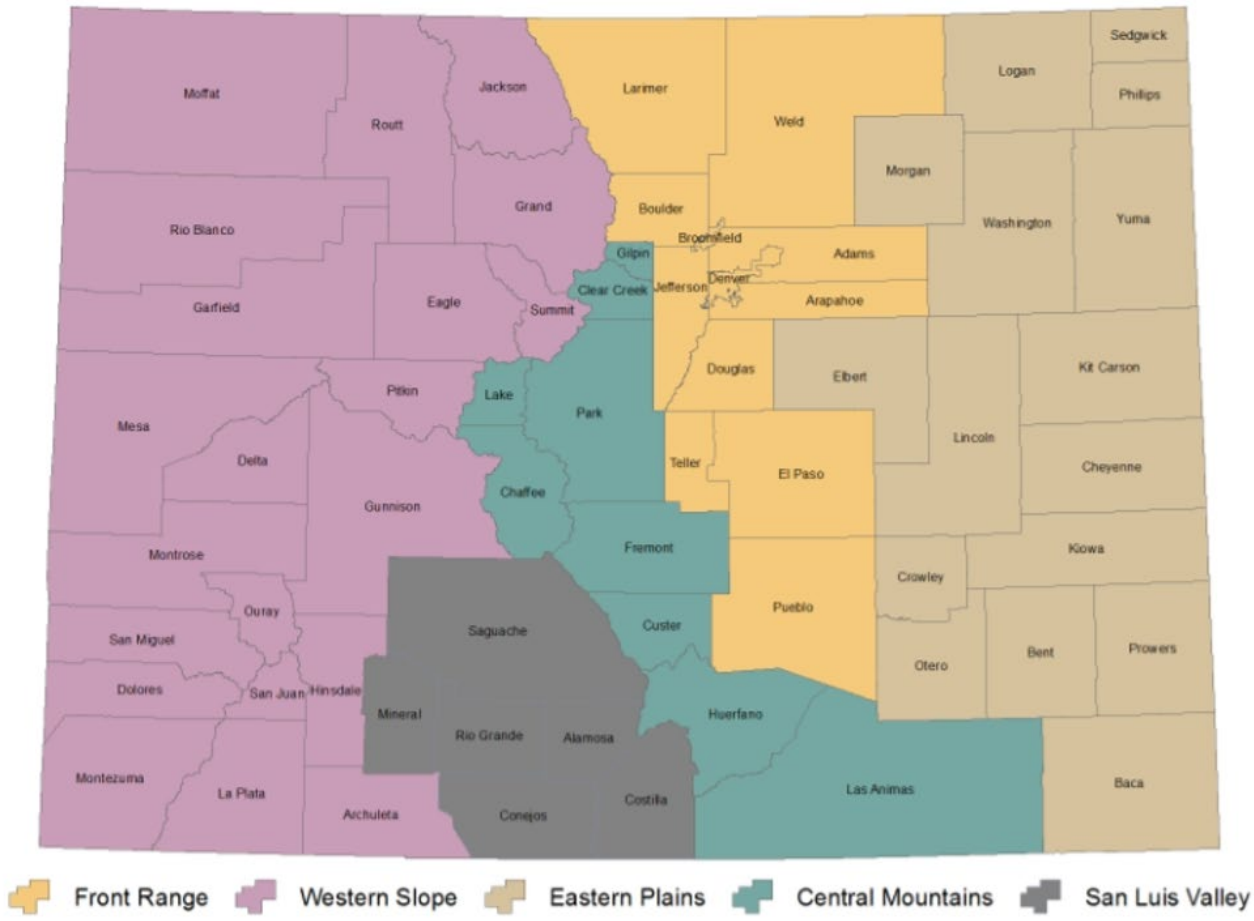
Figure 1. A Framework for Coordinated POSC Service Delivery and Systems Alignment



Catchment Area

The San Luis Valley (SLV) serves as the catchment area to pilot the POSC Framework and build evidence on its potential. Six counties make up the SLV (Figure 2). The SLV was chosen from a systematic, data-informed process that assessed need, sociodemographic diversity, and implementation readiness. The SLV provides an excellent opportunity to build on previous prevention investments in prenatal substance use, engage strategic learning of the POSC Framework's potential, and ensure sustainability across local systems.

Figure 2. San Luis Valley Counties and Location in Colorado



San Luis Valley Data Points

SLV data show complex social determinants of health[8] (SDOH) that contribute to prenatal substance use and that increase the likelihood of child welfare involvement, including:

- The top two Colorado counties with the highest child poverty rates[9] are Costilla (36%) and Saguache (35%), compared to the state rate of 12%.

- Annual rates of drug overdoses[10] are highest in the SLV, ranging from 44.9 to 165.02 per 100,000.
- 13.6% experience postpartum depression[11] (likely underdiagnosed).
- Alamosa (34.6%), Conejos (44.1%), Costilla (57.3%), Rio Grande (32.0%), and Saguache (31.2%) Counties all have higher rates of linguistically isolated households.[12]
- The SLV has the highest average of households with children receiving Supplemental Nutrition Assistance Program (SNAP),[13] and Temporary Assistance for Needy Families (TANF).[14]
- Referrals to child welfare for a substance exposed newborn[15] range from 20.9 to 32.2 per 1,000 live births among SLV counties, compared to a state average of 9.2 per 1,000.

Building on Local Investments

The SLV has made several investments to improve care and outcomes for families affected by prenatal substance use. Most notably this includes:

SLV Neonatal Task Force: The SLV Neonatal Task Force, founded in 2012, is one of the longest-standing groups in the state focused on healthy births. Comprised of representatives from health care and social services providers in the region, they have been instrumental in developing local Medicated-Assisted Treatment programs, syringe access, prenatal substance use treatment, family supports, and education efforts. The Task Force members also sit on the SLV Consortium.

The SLV Consortium: In 2021 and 2023, the SLV received funding from the U.S. Department of Health and Human Services (HHS) Health Resources and Services Administration (HRSA) through the Rural Communities Opioid Response Program-Neonatal Abstinence Syndrome (NAS) initiative. As part of the grant, a multi-sector NAS Grant Consortium was formed. The SLV Consortium is made up of health care providers, early childhood specialists, local cultural groups, and statewide advocacy groups. The SLV Consortium met for years ahead of the first HRSA funding opportunity and has done important regional capacity building.

Together the SLV Neonatal Task Force and SLV Consortium provide the local capacity necessary to pilot the POSC Framework and ensure sustainability post-pilot.

What Makes this Pilot Unique?

POSC are gaining traction across Colorado and nationally. However, most pilots continue to test processes or programs that occur within hospital settings. This is largely a byproduct of CAPTA requiring a POSC for safe discharge of an infant after the birth. While health care providers are key partners in POSC, the hospital cannot be the sole setting for POSC development. Like child welfare, stigma and biased care are pervasive in the medical system. This stunts positive outcomes and limits family engagement. Emphasizing POSC initiation at the time of birth is also too late. To influence health outcomes and stabilize a family, support must occur much earlier.

What Makes this Pilot Unique?

That is why the POSC Framework takes a public health prevention approach, emphasizing a **community-based infrastructure**, **prenatal POSC initiation, an intermediary to align care coordination across systems, and family choice.**

The pilot intentionally chose a *framework* versus a traditional program, practice, or model. This is because **a framework better enables rapid scaling and alignment across the state**. The POSC Framework is based on research evidence that shows how to improve outcomes for families. Yet every community is different. A strict program may not allow flexibility to account for local context. By using a data-informed framework, essential elements can be adapted for each community and build on their existing resources and partnerships. Support by a POSC intermediary is key to success, so that fidelity to the framework is maintained during adaptation.

Year One Implementation Successes

Four successes emerged in year one of implementation:

- **Activation Pathways:** How will this look in my community?
- **Support Infrastructure:** What does it take to make it successful?
- **Community Engagement:** How do we ensure it is community-led?
- **Building Evidence:** How will we know if it works?

Together, the four successes showcase pilot learnings and the potential for the POSC Framework to inform statewide alignment in the care of families affected by prenatal substance use.

Below, we outline each success, focusing on learning and design insights from implementation of the POSC Framework in the pilot's catchment area of the SLV. Challenges are also noted to provide anticipatory guidance to other communities on areas that need special attention when adapting the POSC Framework to their locale.

Success One: Activation Pathways

The first success is seen in how the POSC Framework can be translated and adopted by local communities. In the POSC pilot, this is being done in the catchment area of the SLV.

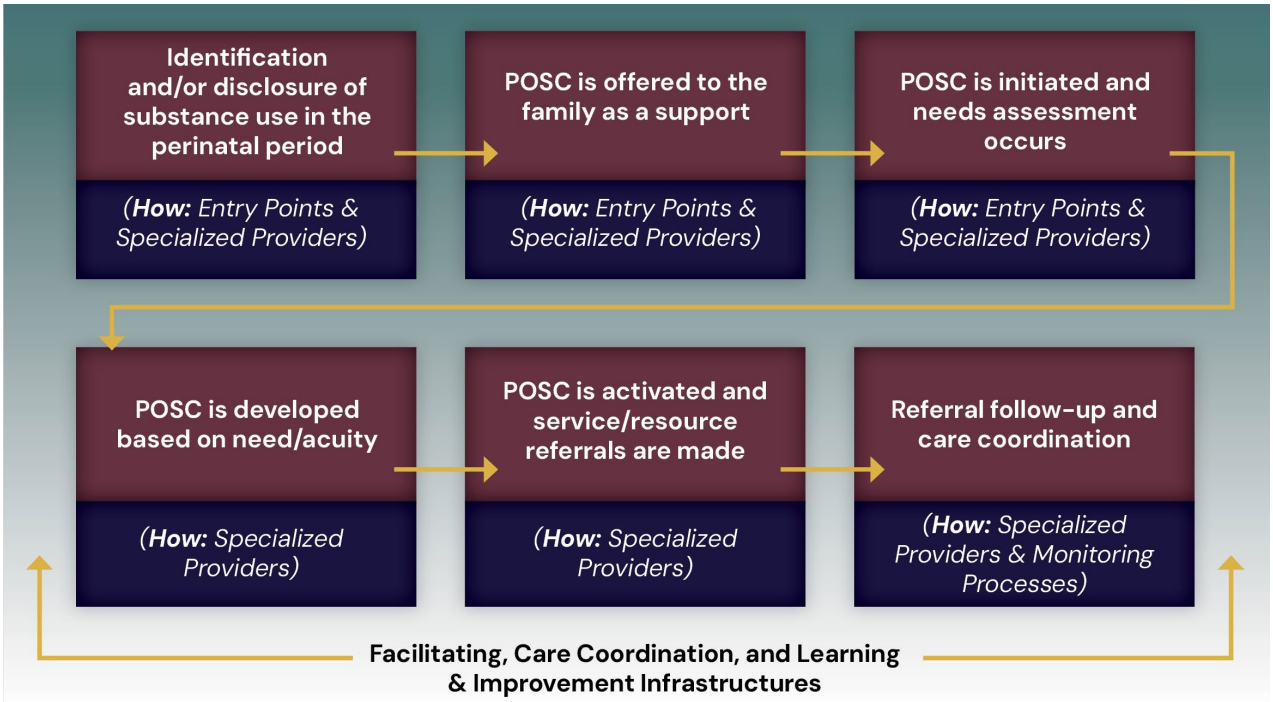
Activation pathways outline how and when POSC are initiated and developed—and care coordination achieved--to wrap support around families. There are two activation pathways in the SLV's implementation:

- **Community-based activation pathway**
- **Child welfare activation pathway**

Activation pathways were co-developed with local partners and are tailored to meet the needs and strengths of different populations, communities, and entry points.

To meet the guiding features of the pilot, it is imperative that the POSC be initiated at multiple entry points beyond the birthing hospital or child welfare; that voluntary engagement of families in POSC is promoted; and that providers in health care, child welfare, and community-based spaces understand their unique role. This can be understood as key functions in initiating and activating a POSC (Figure 3).

Figure 3. Key Functions in Initiating and Activating a POSC

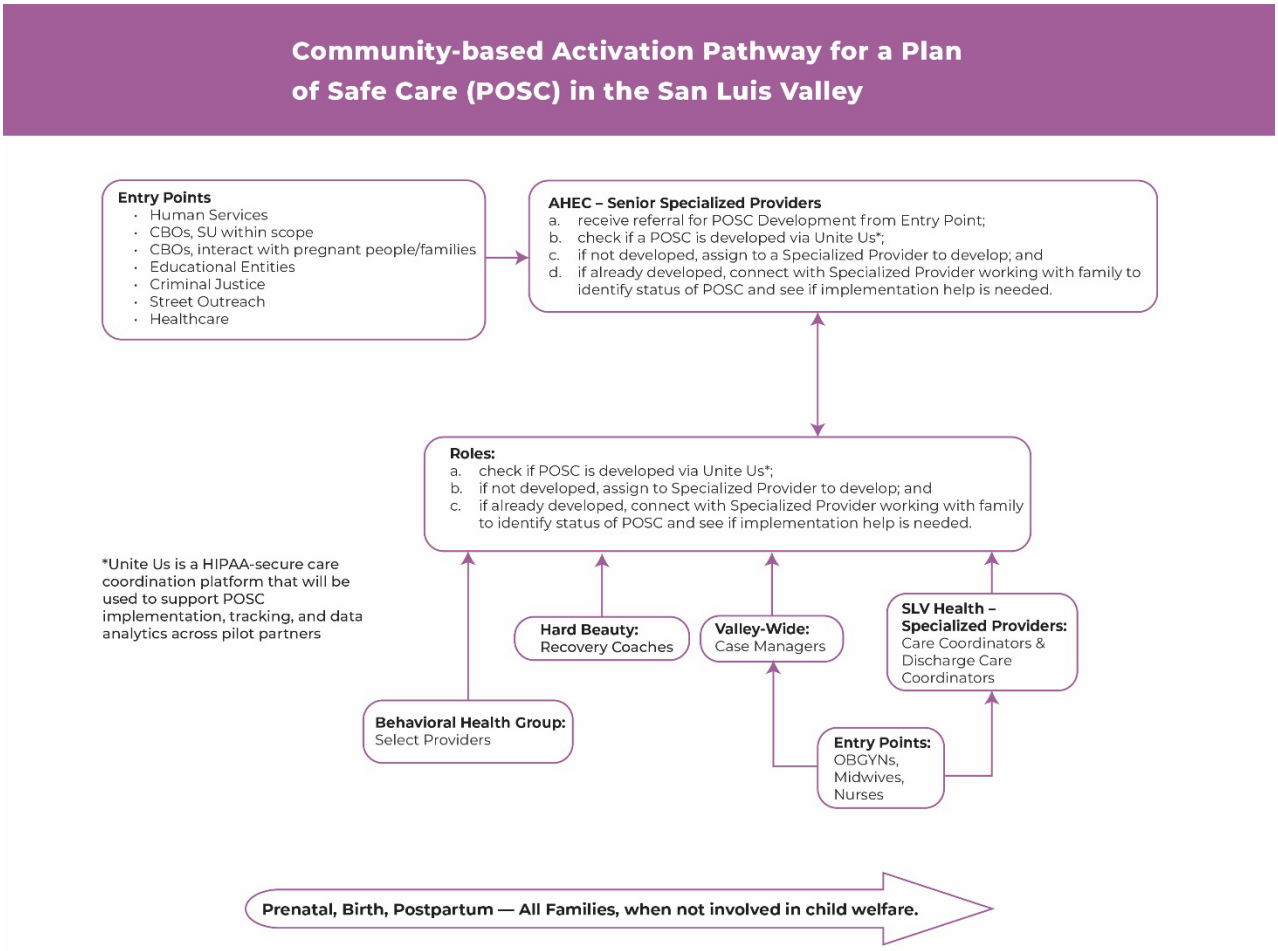


When adapting to a new local context, the key functions are translated to concrete activation pathways, or workflows. In the POSC pilot, this means developing pathways that uniquely account for the SLV rural health context and previous investments. The activation pathways developed for the SLV context ensure there are policies and procedures in place for the maternal-infant dyad to be offered a POSC and connected to resources and providers by a warm handoff. This includes identifying, referring, tracking and follow-up for care coordination.

Community-Based Activation Pathway

Because the ideal is to focus on POSC in the prenatal period using trusted community partners, the community-based activation pathway is the first focus (Figure 4).

Figure 4. Community-Based Activation Pathway for a Plan of Safe Care in the San Luis Valley



The activation pathway begins with entry points, which are defined as community-based organizations and other entities who regularly interface with pregnant people who may be impacted by substance use, and who could benefit from a POSC. Entry points do not need to be specialized in supporting prenatal substance use and are only responsible for initiating a POSC by making a referral to a POSC specialized provider, who are equipped to support the family in developing a POSC, connecting them to services, and ensuring ongoing care coordination.

In co-designing the activation pathways, SLV partners identified who in the community will serve as primary entry points as well as specialized providers. In the SLV, the entry points are:

- Human Services
- Community-based organizations, substance use within scope
- Community-based organizations who interact with pregnant people/families, substance use not within scope
- Educational entities
- Criminal justice system

- Street outreach
- Healthcare

The San Luis Valley Area Health Education Center (AHEC), SLV Health, Valley-Wide Health, and SLV Behavioral Health were identified by the community as the specialized providers who are equipped to develop a POSC and ensure ongoing care coordination for the infant/birthing person dyad. In responding to an emergent opportunity, Hard Beauty was also added as a specialized provider. Hard Beauty consists of a statewide team of lived experience expert recovery coaches. The process of developing workflows was an opportunity for multiple sectors and services in the community to strengthen their collaboration and solidify their communication pathways, with the common goal of supporting pregnant people impacted by substance use.

Entry points are critical to design because they a) allow a no wrong door model for families, and b) breakdown silos to ensure entities that interact with these families (e.g., the criminal justice system) have a direct line of communication with specialized providers best equipped to support this population. Further, initiating POSC prenatally through a community-based activation pathway can help connect families early with resources and maximize chances for stability, which can then help divert families from the child welfare system. The ultimate goal of a prenatal POSC is for families to actively engage in development of a plan and receive matched services in order to safely care for their baby and themselves.

Designating specialized providers is critical to design because it a) ensures those developing POSC—and providing care coordination—have the specialized skills and capacity necessary to support the complex needs of families affected by prenatal substance use, and b) enables better collaboration and coordination within the community, to reduce duplication of efforts while buffering against any given family "slipping through the cracks." Designating specialized providers also improves the ability to meet state and federal legislation around caring for substance exposed newborns and keep up with ever-evolving best practices in POSC. The senior specialized provider acts as a "clearinghouse" to help organize and assign incoming referrals for a POSC to a specialized provider. Having multiple specialized providers is essential to ensure demand can be met and that families already working with a trusted provider can continue to do so. Specific roles of each specialized provider are detailed in Figure 4.

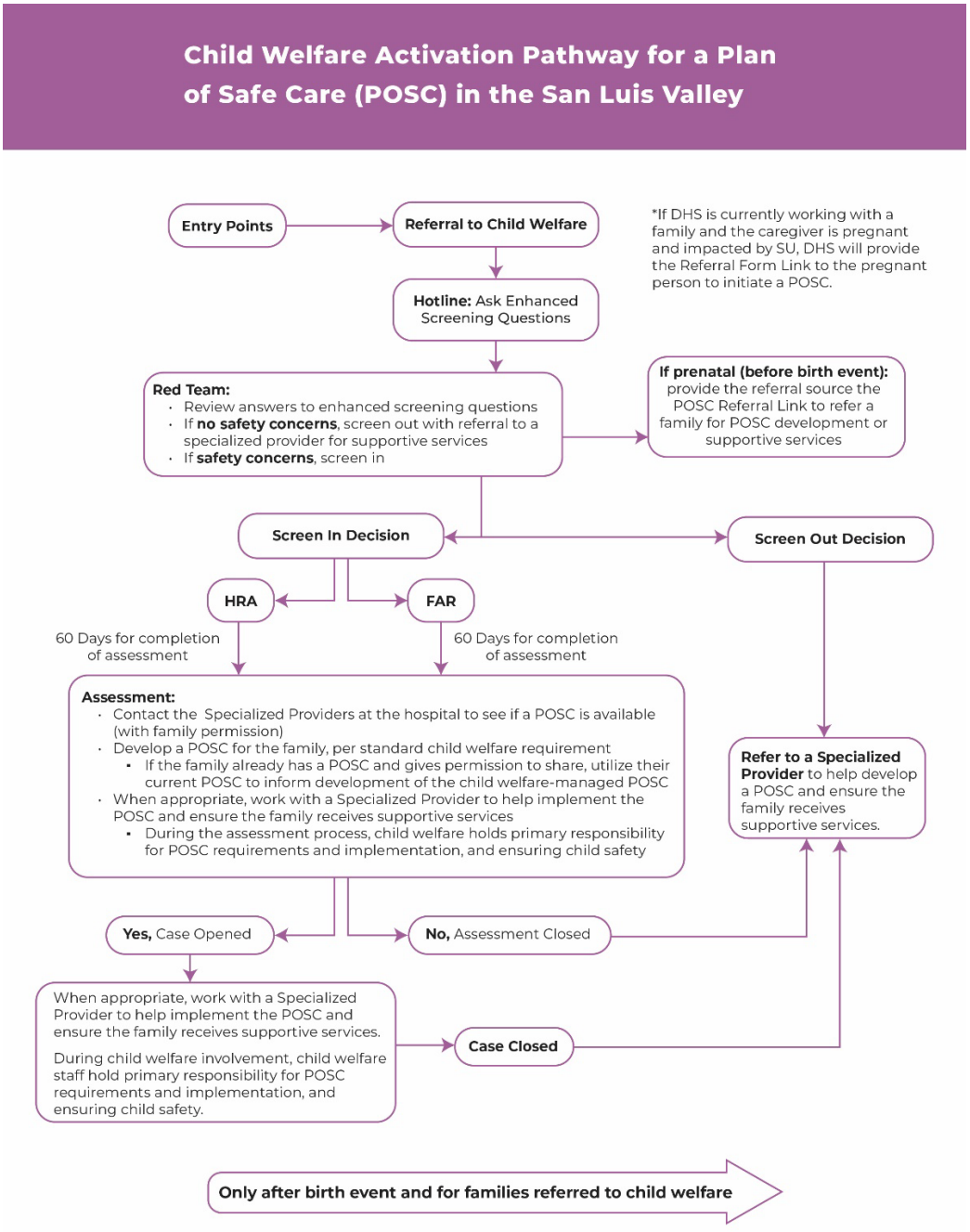
Here is an example of how the community-based activation pathway may be used in the SLV: Delia is six months pregnant and is misusing opioids. During a verbal screening by probation (entry point), her prenatal substance use is identified. The probation officer completes a referral for a POSC to be initiated. Delia and her partner, Jeffrey, develop their POSC with a specialized provider. The specialized provider connects the family to supportive services through a warm handoff, including to substance use therapy for Delia, couples mental health therapy, a diaper bank, and food benefits. The specialized provider continues to work with the family prenatally to ensure service receipt and ongoing care coordination. At birth, the family is encouraged to share their POSC with the hospital and the hospital care coordinator updates the POSC with the infant care plan. Because of the strong support prenatally, all safety concerns are mitigated and there is no report of abuse or neglect to child welfare. The specialized provider continues to provide the

family care coordination for six months after birth, to reflect new needs arising as Delia moves into recovery and as parenting demands evolve.

Child Welfare Activation Pathway

While the community-based activation pathway is the ideal state, there will continue to be circumstances where safety is not fully mitigated and child welfare assessment and/or involvement is necessary (Figure 5).

Figure 5. Child Welfare Activation Pathway for a POSC in the SLV



In co-designing the activation pathways, the SLV Departments of Human Services (DHS) helped develop a workflow for engaging families in POSC when child welfare involvement is necessary. If a family has a POSC developed prior to child welfare involvement, the family has the option to share their plan with child welfare and the caseworker may use this is as a strengths-based jumping off point for developing the family's child welfare-required POSC and ensuring all state and federal requirements are met. When a prenatal POSC has not been initiated and prenatal substance use is identified at birth and there are safety concerns, child welfare will develop the POSC and the family will be offered specialized support from hospital care coordinators.

If a family is already involved in child welfare due to an older child and one of the parents is now pregnant again, child welfare will offer the family a referral to have a POSC initiated prenatally with a specialized provider. If child welfare receives a referral prenatally for substance use, they cannot get involved until there is a live birth. As such, child welfare will offer the referral source a link they can share with the family to connect them with a specialized provider for prenatal POSC development.

The ideal state is that the family gives permission to share their POSC with child welfare, as this helps everyone involved have a shared understanding of the family's strengths, the progress they have made to date, and where they still have gaps. Once a family becomes involved in child welfare, it is the responsibility of the caseworker to ensure all requirements for a POSC and the substance exposed newborn are met. Specialized providers may be used as a supportive service to the family during child welfare involvement.

SLV partners acknowledge there is deep-rooted stigma that can prevent families impacted by prenatal substance use from seeking prenatal care or engaging in other services. This local knowledge reflects statewide qualitative research[16] prioritizing family voice. Stigma and bias will continue to be a barrier for initiating a POSC upstream and keeping families engaged. Fear of being separated from their child is also a major deterrent for families when engaging in a POSC or working with systems. Such recognition underscores the importance of collaboration across child welfare, health care, and community-based providers.

Spotlight: Communication and Collaboration Prenatally between a Community-Based Specialized Provider and a Criminal Justice Entry Point

The POSC Kickoff was held in July 2024. Since the Kickoff, SLV AHEC (the senior specialized provider) has received referrals from the criminal justice system (an entry point) to support pregnant people who could benefit from a POSC and care coordination while incarcerated.

Overcoming Challenges and Barriers

Successes observed thus far in activation pathways are not without challenges and barriers. In the SLV, this has included:

- Tension between POSC as a state and federal child welfare requirement alongside family distrust of the child welfare system, while working to move POSC upstream to community-based providers with more family trust.
- The challenge of needing to share information across specialized providers and caseworkers when families become involved in child welfare, while abiding by laws governing protected health information and consent procedures.
- Among local partners, lack of shared language around POSC and accurate understanding of state and federal rules and best practices.
- Tension between wanting to ensure broad opportunities for families to access a POSC and the specialized knowledge it takes to develop and coordinate a POSC with quality.
- Longstanding interpersonal challenges across some local entities, which can hamper workflows.
- Lack of responsiveness by some local partners due to bandwidth considerations or de-prioritizing participation due to competing priorities.
- Very high turnover within local organizations and entities across the essential sectors of health care, child welfare, and community-based providers.

When local communities are adapting activation pathways to their locale, these challenges should be kept in mind and opportunities to mitigate should be identified early and often.

Success Two: Support Infrastructure

The second success is seen in what it will take to ensure local partners have the support necessary to be successful in implementing the POSC Framework.

> **It is critical that supportive infrastructure is in place to help local partners be successful in implementing the POSC Framework. Having a POSC intermediary to deliver and coordinate this support is critical. Major support needs expressed by local partners in year one include:**
>
> - **Trainings and communication tools**
> - **POSC template**
> - **Platform for care coordination and consent forms**

Role of POSC Intermediary

Designing and implementing the activation pathways requires coordinated support from an outside entity. The addition of Illuminate Colorado as the catchment area intermediary has been critical to

successes. In the POSC Framework, this is referred to as the facilitating infrastructure. The catchment area intermediary supports local partners by providing training, tools, and resources; outlining best practice standards; and supporting alignment with evaluation, communication, and sustainability efforts.

Specific responsibilities of the intermediary include:

- Serve as the subject matter expert in the POSC Framework, implementation procedures, and 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 for local sites.
- Support and align implementation communications.
- Coordinate data and evaluation functions, in alignment with the evaluation team.
- Support ongoing funding and sustainability.
- Explore scaling/replication/expansion as appropriate.

The role of the intermediary also includes monitoring fidelity to the essential elements of the POSC Framework. Having an intermediary to monitor fidelity is vital to ensure that during local adaptation of the POSC Framework, the data-informed elements that can contribute to positive change are not lost.

Trainings and Communication Tools

A Tools and Resources document was developed[17] as a starting place to build out care coordination tools within the activation pathways. This resource was discussed and refined with local SLV partners to ensure it hit the mark on needs and was in addition, rather than duplicative, of existing tools. In addition, the Kempe Center for the Prevention and Treatment of Child Abuse and Neglect readied and shared an Implementation Guide,[18] which includes an outreach script (page 43), goal setting sheet (page 45), program intake form (page 32) and relevant components [page 3]) from the Perinatal Navigator Program of the Colorado Hospitals Substance Exposed Newborns Collaborative (CHoSEN). The Implementation Guide may support specialized providers in developing the POSC, such as service mapping and goal setting with families. A glossary of key terms[19] was also created to facilitate a shared understanding across partners and systems.

POSC Template

One of the most critical needs identified by local partners is a POSC template that reflects best practices and improves alignment across systems and communities. Historically, Colorado has experienced challenges related to the lack of a standardized template. To meet this challenge, the statewide Supporting Perinatal Substance Use Prevention, Treatment, and Recovery in Colorado (SuPPoRT Colorado), POSC Work Group, and CDHS developed a POSC Template[20] that can be used

prenatally, at birth, and postpartum. The POSC Template is being adopted by pilot partners in the SLV and will be programmed into the care coordination platform for use. Having the template developed in the platform will enhance ease of completion with families, initiation of referrals, and ability to close the loop on the referral after service initiation. Families will be able to receive an electronic copy of their plan that can be shared at their discretion with providers, child welfare, and other supports for the family.

Spotlight: Cohesive Training and Support

The POSC Pilot Kickoff, held in July 2024, provided a prime opportunity to align training for cross-system entry points and specialized providers on the POSC Framework and the activation pathways. By training together, collaboration was deepened and scenario-based practice of workflows helped to make the pilot concept come to life in concrete ways.

Platform for Care Coordination

Cross-system collaboration that prioritizes family engagement with wraparound services requires strong relationships and technology support. In the SLV's implementation, Unite Us (https://uniteus.com/) was selected as the HIPAA-secure platform to enable care coordination and make possible the activation pathways. Unite Us will be used to receive POSC referrals from entry points; complete and store the actual POSC document, using the statewide template; make updates to the plan over the course of the childbearing and recovery journey; track whether a POSC has been developed for a given family; and support ongoing care coordination. Use of Unite Us closely follows the workflow specified in the community-based activation pathways flowchart (Figure 4), where specialized providers will be "in network" with Unite Us and hold licenses for full capabilities in the system. Entry points will use a special form baked into the platform to initiate a referral for a POSC to a specialized provider. They may also make a direct referral to a specialized provider, who can then log this into the Unite Us system.

In designing for feasibility and sustainability, there is no intention to require SLV child welfare staff to use Unite Us. Child welfare staff will continue to use Trails for case management. However, POSC documents stored in Unite Us can be shared with child welfare, with a family's permission. If a family becomes involved in child welfare and is receiving care coordination from a specialized provider, the ideal is to have child welfare staff use the existing POSC as a strengths-based jumping off point to developing the child welfare-required POSC with the family.

Overcoming Challenges and Barriers

Successes observed thus far in the support infrastructure are not without challenges and barriers. In the pilot, this has included:

- A lengthier-than-anticipated process to co-design materials with local partners.
- Aligning processes and tools with a rapidly changing statewide landscape led by the Division of Child Welfare (DCW), while respecting innovation in the pilot.

- An extensive process to design and lift a HIPAA-secure platform for care coordination, including ensuring all entities can meet legal requirements as covered health entities, business associates, and in obtaining family consent.

When expanding the intermediary role and support infrastructure to other communities, these challenges should be kept in mind and opportunities to mitigate identified early and often.

Success Three: Community Engagement

The third success is seen in how adoption of the POSC Framework can be community-led to promote feasibility and acceptability with local partners.

> To ensure the POSC Framework can be adapted to local strengths and context, community engagement is critical. A co-design approach can help ensure processes are feasible and acceptable to families, systems, and community partners. Co-design in the SLV has focused:
>
> - activation pathways,
> - bringing in emergent and new partners, and
> - establishing continuous feedback loops.

Co-Designing Activation Pathways

In-person site visits were held in the SLV to co-develop activation pathways and provide cohesive training on the POSC Framework. Site visits provided the opportunity to align on the "why" behind the pilot and the practical application of the POSC Framework in the SLV. The co-design process has led to enhanced collaboration across systems, solidified communication pathways, helped breakdown traditional system silos, identified areas of additional support needed, and elevated new collaborative opportunities.

Bringing in Emergent and New Partners

In any local community, the co-design process will not be a one-and-done situation. While an initial set of entry points and designated specialized providers were identified by local partners, options in the SLV (as with any community) are constantly changing. As such, it is important to establish mechanisms that allow emergent and new potential partners to identify their role in the activation pathway as entry points or specialized providers. The adaptable nature of the POSC Framework means activation pathways can be built and enhanced as needed by local communities. The POSC intermediary plays a key role in facilitating this dialogue between new entities and existing partners and then integrating them into the workflows and providing training.

Two examples of this have already occurred in the SLV. In August 2024, a new substance use treatment provider, Hope in the Valley, opened a detox and residential center in Alamosa County. The program director reached out to the pilot intermediary to establish their role as an entry point. Hard Beauty has begun working with families in the SLV and identified an opportunity to

collaborate with the pilot and SLV partners as both an entry point and a specialized provider. Hard Beauty will be ramping up the presence of recovery coaches for mothers in the SLV and have been added as a specialized provider.

Establishing Continuous Feedback Loops

Collaboration does not happen by accident. As part of the POSC intermediary role, continuous feedback loops from the SLV community back to the POSC Pilot team are being established.

Continuous feedback loops support ongoing data-informed learning, provide local partners an opportunity to give feedback to the intermediary on the utility of activation pathways and tools, and identify successes, barriers, and opportunities. Through monthly technical assistance calls, the pilot intermediary will provide and coordinate coaching, identify additional training/tool needs, and facilitate the development and delivery of resources.

In addition to real-time feedback and learning together, establishing clear expectations is also critical. A key role of the intermediary is to support local partners in executing Memorandums of Understanding (MOU) or similar agreements that clearly define roles and responsibilities. It is especially important to have a clear line of communication between specialized providers and DHS, as DHS is ultimately mandated to create and log a POSC with families who enter the child welfare system. Continuous feedback on how well agreed-upon expectations are fulfilled is essential to the success of the collaboration and to identify processes that may need to be adjusted.

Overcoming Challenges and Barriers

Successes observed thus far in community engagement are not without challenges and barriers. In the SLV, this has included:

- Striking the right balance during co-design, from the time it takes to who should approve.
- Maintaining consistent participation by local partners in feedback loops and opportunities for cohesive learning and improvement.
- Right-sizing when to bring in new partners for success versus when it is disruptive.
- Ensuring no one system or entity overly dominates the cross-collaborative nature of the POSC Framework.

When designing community engagement opportunities, these challenges should be kept in mind and opportunities to mitigate should be identified early and often.

Success Four: Building Evidence

The fourth success is seen in how a strategic evidence-building approach can be used to strengthen implementation and identify what works, for whom, and under what conditions.

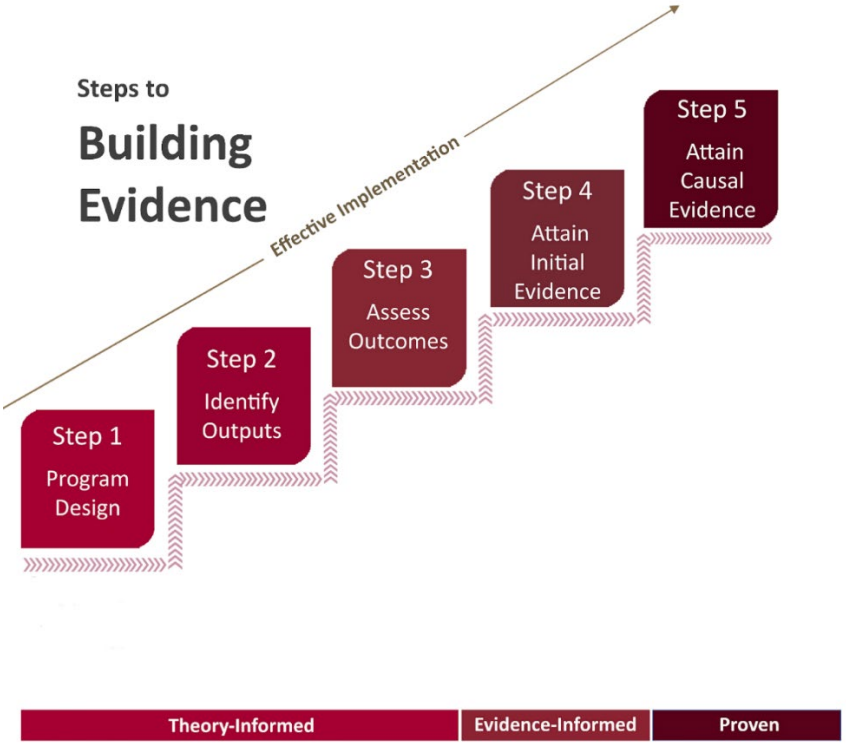
Building evidence on pilot implementation and outcomes is critical to inform strengthening, sustainability, and scaling of the POSC Framework.

The evaluation focuses on Steps 1 through 3 of building evidence, from identifying drivers of change and performance metrics to assessing initial 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 6) guides the evaluation process. As an innovative pilot in the state, the priority is the first three steps. During the pilot, the focus is on using data for continuous quality improvement and strategic learning. In the long term, evaluation findings will inform the potential for statewide replicability of the POSC Framework, as well as the strategic policy and resource investments needed to scale.

- **Step 1:** Identify essential elements of the POSC Framework and clearly document implementation. Appendix A details the core functions and activities in the POSC Framework. Appendix B is the logic model for how activities are expected to drive implementation outputs and target outcomes.
- **Step 2:** Understand the extent to which providers are consistently and effectively delivering the POSC Framework as defined. Appendix C provides the fidelity of implementation rubric.
- **Step 3:** Examine family- and system-level outcomes. Appendix D outlines the major data elements and sources used to assess outcomes and understand family experience.

Figure 6. Colorado's Steps to Building Evidence



Building on Existing Evidence

The research questions reflect the priority focus on the first three steps to building evidence:

> **REACH:** Who does the POSC Framework reach? How are activation pathways used to reach different populations?
>
> **CARE COORDINATION:** What are the most common service needs identified in the POSC? What is the referral success rate, by service type?
>
> **DYAD OUTCOMES:** What are the health and social outcomes of infant/birthing person dyads?

The research questions build on existing Colorado and national data. Through Colorado's perinatal substance use data linkage project,[21] risk and protective factors for families involved in child welfare were assessed over a five-year period. These findings[22] inspired the policy brief that serves as the basis for this pilot. Key data points from the original study will be re-examined for the pilot sample and results benchmarked against what is known about the general population of families affected by prenatal substance use.

The pilot evaluation aims to examine:

- POSC participation (referrals for a POSC, completion of a POSC, service connections made)
- Infant health outcomes (e.g., low birth weight, NICU admissions).
- Maternal health outcomes (e.g., prenatal care, postpartum mental health).
- Use of services in the community (e.g., parenting programs, housing supports).
- Child welfare involvement (e.g., referral rate, removal from home).

While POSC are identified as a strategic lever to enhance care coordination and improve outcomes, the evidence of their effectiveness remains limited. National evidence suggests that POSC are most effective when they are used to provide supportive care linkages[23] (i.e., upstream care coordination to achieve wraparound supports like housing). When POSC are done in this manner, early evidence[24] from other states suggests that child welfare involvement can be mitigated and when involvement does occur, POSC can reduce the rate of infant removal from the home. National evidence also illustrates key implementation challenges[25] around POSC, such as shortcomings in care coordination, lack of agency transparency and mutual understanding of roles, and difficulty tracking shared outcomes. As such, the pilot evaluation aims to also examine:

- Referrals by service type, both most commonly needed referrals and referral connection resolution (i.e., closed loop referral rate).
- Sectors who initiate POSC as an entry point and at what rate.
- Sectors who successfully complete POSC timely as specialized providers and at what rate.

Qualitative data[26] from families with lived experiences in Colorado also illustrate key barriers to effective POSC implementation, including biased care by health care providers and fear of child welfare involvement. Opportunities to improve effective implementation are also identified, including using peer supports and community-based organizations to coordinate care. Such findings are echoed in national qualitative family voice literature.[27] The pilot evaluation thus also aims to explore:

- Experiences of families who received care coordination under the POSC Framework.
- Experiences of specialized providers in the activation pathways.
- Experiences of entry points and child welfare in the activation pathways.

A Focus on Equitable Reach and Outcomes

Throughout the evaluation, data will be disaggregated wherever possible to better understand disparity and disproportionality. For example, are families of color having POSC initiated less or more than their white counterparts? Do outcomes vary by counties in the SLV with less access to services? Understanding outcomes for whom and under what context will be critical to ensuring the POSC Pilot drives toward equitable systems change.

Collectively, existing evidence inspires not only the strategy for evidence building, but also informs the underlying design of the pilot.[28]

Building the State's Capacity to Meet CAPTA Requirements on Substance Exposed Newborns

CAPTA requires a notification of all substance exposed newborns, which is different than a report of child abuse and neglect. Colorado has not had a way to separate notification from reporting, which creates challenges for health care providers who are the primary notifiers following a birth event. In response, Colorado is launching a new notification portal as of late-fall 2024. The pilot in the SLV provides a unique opportunity to beta-test the new notification portal, including exploring the validity and reliability of data produced by the new notification system and informing opportunities for ongoing quality improvement.

Overcoming Challenges and Barriers

Successes observed thus far in evidence building are not without challenges and barriers. In the pilot, this has included:

- An extensive process to lift a new HIPAA-secure data collection and care coordination platform, especially given the extra legal and ethical parameters around Protected Health Information[29] in pregnancy and substance use information per 42 CFR Part 2.[30]
- Aligning implementation workflows with processes in the Unite Us platform.
- A delayed kickoff event, which is anticipated to reduce the final sample available for analysis.

- Balancing the need for both person- and system-centered outcomes while keeping data collection feasible.

When creating evidence building plans, these challenges should be kept in mind and opportunities to mitigate should be identified early and often.

Replicability and Statewide Alignment

A POSC Framework (versus a program or model) was selected to enable rapid scaling and alignment across the state. As pressure and demand grows to implement POSC in communities across Colorado, use of the POSC Framework provides an unprecedented opportunity for statewide alignment. Alignment is critical to advancing equity and achieving outcomes, while minimizing confusion and duplication. In alignment with the original Request for Proposals (RFP) from DCW, this pilot was intentionally designed—from the beginning—to inform the potential for replicability and scalability, based on pilot learnings and results. This design choice helps to meet DCW's expressed goals of "supporting Colorado state agencies in meeting state and federal responsibilities around caring for infants and caregivers impacted by perinatal SUD and improving cross-system care coordination and health outcomes for families" (original RFP language). While evidence building on the POSC Framework continues in the SLV, the essential elements and framework components are ready to be explored in another community. Any opportunities for testing replication of the POSC Framework design will be explored in collaboration with DCW.

In addition, the POSC Pilot team participates in several statewide spaces where POSC implementation is discussed, including SuPPoRT Colorado and a Coordinating POSC Pilots working group convened by CDHS. Statewide alignment in design, implementation, and evidence building is critical to ensure POSC delivery in Colorado centers families—not systems—and reflects the real-world strengths and challenges of each community. The difficulty lies in innovating POSC while trying to stay aligned with swiftly moving efforts across the state.

Toward Collaborative Learning and Data-Informed Action

Evidence building for the pilot provides vital information to inform policy actions related to POSC for Colorado families. The POSC Pilot team welcomes opportunities to discuss the POSC Framework and exchange learnings with families, communities, and systems committed to the prevention, treatment, and recovery of prenatal substance use. Reach out using contact information contained in this report.

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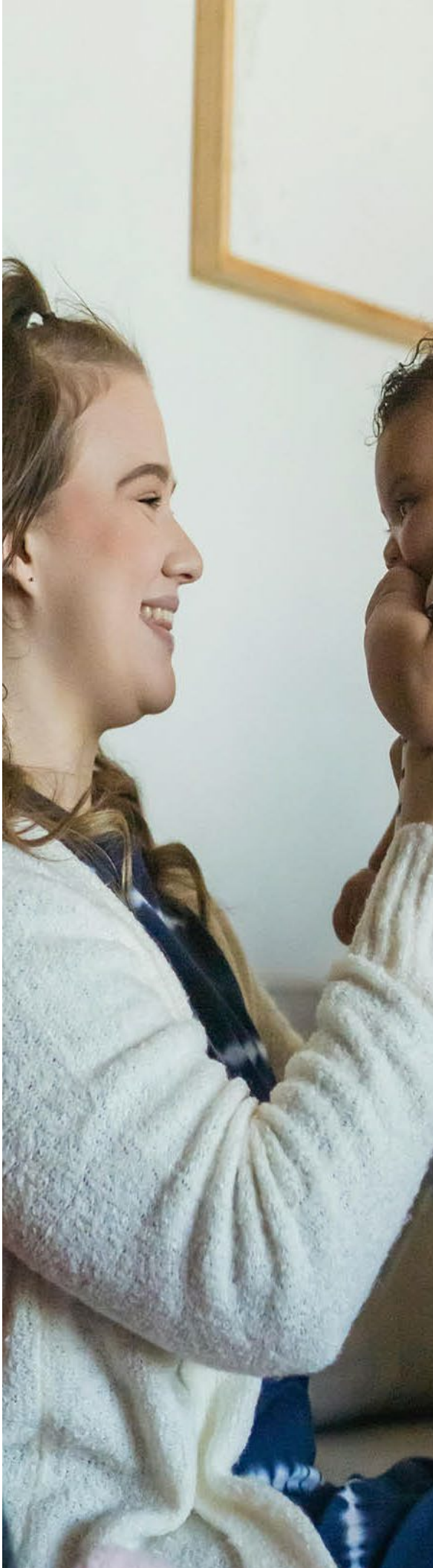
Appendices

Appendix A: Essential Elements
Appendix B: Logic Model
Appendix C: Fidelity of Implementation Rubric
Appendix D: Data Sources



Appendix A: Essential Elements

Essential elements are the core functions and the associated activities ("active ingredients") that are necessary for the Plans of Safe Care (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.	***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.

Principles *What assumptions is the POSC Framework grounded in?*	**Context and Structure** *What are the major drivers of the POSC Framework?*
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. • 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	***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 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.

Principles *What assumptions is the POSC Framework grounded in?*	**Context and Structure** *What are the major drivers of the POSC Framework?*
future Child Abuse Prevention and Treatment Act legislation. • Cross-system and collaborative POSC infrastructure will help Colorado reduce the 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. • Robust evidence building is needed to strengthen, scale, and sustain favorable approaches in the Framework.	• 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.

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: Logic Model

Capacity-Building	Implementation Activities	Implementation Activities Outputs	Outcomes	
			Families and Providers in the Catchment Area	Capacity to Sustain and Scale the Framework
• 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.	**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.	**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.	**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.	• 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 C: Fidelity of Implementation Rubric

Plans of Safe Care (POSC) Framework Fidelity of Implementation (FOI) Rubric

Fidelity refers to the extent to which the POSC Framework is being implemented as intended. It helps to answer questions of what actually happened and contributed to observed outcomes. Fidelity will be measured periodically in the pilot, to inform both continuous quality improvement and for final documentation of pilot results. *This is a living document in draft form; it will be refined upon first measurement.*

Anticipated Measurement Dates:

- ~February 2025 to reflect the first six months of serving families (late July 2024 kickoff event as anchor)
- ~August 2025 to reflect the first 12 months of serving families
- ~February 2026 to reflect the full 18 months of serving families

Guiding Features of the POSC Pilot:

- Initiate POSC prenatally or as soon as prenatal substance use is recognized
- Voluntary engagement by families when opportunity allows
- Cross-system and collaborative POSC infrastructure
- Comprehensive service delivery and tracking

POSC Framework Components:

- **Activation Pathways:** Pathways to activate and implement POSC for families to achieve coordination services and support
    - Multiple entry points across the perinatal continuum
    - Senior Specialized Providers and Specialized Providers (e.g., discharge care coordinator) who complete the POSC in partnership with families (consult activation pathways/workflows)
    - Monitoring processes for tracking referrals and ensuring ongoing care coordination
- **Aligned Infrastructure**: Structures to align and accelerate POSC efforts across systems
    - 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

FOI Rubric Scoring:

- MET = 9 to 12 points
- APPROACHING = 6 to 8 points
- NOT MET = 0 to 5 points

Fidelity Item to Assess	Measurement and Data Source	Scoring Criterion	Score
Aligned Infrastructure			
Providers and entry points across sectors in the catchment area are engaged in the pilot: 1) Health/medical care providers (specialized provider, entry points). **Essential sector: birthing hospital** 2) Child welfare caseworkers (specialized role when required, entry points). **Essential sector: child welfare offices** 3) Community based supports, especially peer supports, local organizations, recovery supports (specialized provider, entry points). **Essential sector: community-based providers.** 4) County health and human services providers, such as WIC, TANF (entry points). 5) Criminal justice and law enforcement (entry points). **Note:** This fidelity item only applies to specialized providers as well as the specialized role of child welfare when required (i.e., when a family becomes involved in child welfare). Entry point data will be used only to answer learning indicators.	Measurement: Essential sectors are engaged as evidenced by Memorandum of Understanding (or equivalent) signed; Business Associate Agreement signed for participated in Unite Us (N/A for child welfare) Source for fidelity data: Internal tracking by catchment area intermediary Source for learning indicator data: Unite Us data on what sectors are engaged via referrals; qualitative data from partners; internal tracking by intermediary	☐ All local birthing hospitals are engaged, at least three community-based organizations are engaged, all child welfare offices are engaged [2] ☐ At least one local birthing hospital is engaged, at least one community-based organization is engaged, at least one child welfare office is engaged [1] ☐ One of the three major sectors (birthing hospital, community-based, child welfare) are not engaged [0] ***Learning Indicators:*** *Are there other sectors that were not identified? What are the barriers to participation as an entry point and/or specialized provider? What entry points are most often engaged? Who within each sector is providing primary leadership?*	

Fidelity Item to Assess	Measurement and Data Source	Scoring Criterion	Score
Catchment area Specialized Providers and Child Welfare (essential sectors) are onboarded, trained, and participate in implementation support and continuous quality improvement activities. Entry points are offered opportunities to learn about the pilot and become active. **Note:** This fidelity item only applies to specialized providers as well as the specialized role of child welfare when required (i.e., when a family becomes involved in child welfare). Entry point data will be used only to answer learning indicators.	Measurement: Essential sectors consistently participate in required learning and improvement opportunities, as evidenced by attendance at required trainings, monthly calls, and site visits/symposium. Source for fidelity data: Internal tracking by catchment area intermediary; qualitative data from partners. Source for learning indicator data: Internal tracking by intermediary; qualitative data from partners.	☐ At least one representative from each essential sector attend >90% of required learning and improvement opportunities [2] ☐ At least one representative from each essential sector attend 60% to 90% of required learning and improvement opportunities [1] ☐ At least one representative from each essential sector attend <50% of required learning and improvement opportunities [0] ***Learning Indicators:*** *What are the barriers and facilitators to consistent use of tools and workflows? Who has most success in using pilot materials, and why? What are the barriers and/or facilitators to attending learning and improvement activities? Who has the most success in attending learning and improvement activities, and why? What are the emergent needs and asks? What are the best ways to reach entry points, and what hinders or helps their participation? How often do entry points participate in different opportunities?*	

Fidelity Item to Assess	Measurement and Data Source	Scoring Criterion	Score
Unite Us is being used to support a family's participation in a POSC. **Note:** This fidelity item only applies to specialized providers who have a Unite Us platform. It is anticipated that some families will agree to a POSC but will not agree to have their information stored in an electronic care coordination platform (i.e., Unite Us). To ensure this is not a barrier to care for families, a HIPAA-secure form will be developed that specialized providers will be asked to complete quarterly regarding any POSC referrals, development, and care coordination not logged in Unite Us due to family consent choices.	Measurement: POSC completed in Unite Us versus offline, of total referrals. Source for fidelity data: Unite Us; HIPAA-secure quarterly form completed by specialized providers. Source for learning indicator data: Unite Us; qualitative data from partners; HIPAA-secure quarterly form completed by specialized providers.	☐ Unite Us is being used for >90% of POSC participation [2] ☐ Unite Us is being used for 75% to 90% of POSC participation [1] ☐ Unite Us is being used for <75% of POSC participation [0] ***Learning Indicators:*** *What are the barriers to using Unite Us for POSC documentation and care coordination? What are the facilitators to using Unite Us for POSC documentation and care coordination?*	
		SUB-SCORE: • **MET = 5 to 6 points** • **APPROACHING = 3 to 4 points** • **NOT MET = 0 to 2 points**	**SUB-SCORE:** **/6**
Activation Pathways			
POSC are offered prenatally or as soon as prenatal substance use is recognized. **Note:** Anyone who is offered a POSC by an Entry Point and who consents to a referral to the POSC Program becomes the "known population." A family who is never identified as needing a POSC or declines a referral will not be counted in the "known population." All fidelity items are restricted to the known population.	Measurement: POSC referral is made, when, and by whom (e.g., at what perinatal cross-section is the POSC referral first made: prenatal and what trimester, at birth, postpartum and what month; by what sector is the referral made).	☐ >75% of POSC in the catchment area are referred prenatally [2] ☐ 50% to 75% of POSC in the catchment area are referred prenatally [1] ☐ <50% of POSC in the catchment area are referred prenatally [0]	

Fidelity Item to Assess	Measurement and Data Source	Scoring Criterion	Score
	Source for fidelity data: Unite Us; HIPAA-secure quarterly form completed by specialized providers. Source for learning indicator data: Unite Us; qualitative data from partners; HIPAA-secure quarterly form completed by specialized providers.	***Learning Indicators:*** *What is the breakdown by perinatal period? What sector and organizations drive the prenatal initiation rate? What facilitates prenatal initiation? What hinders prenatal initiation?*	
Of the known population, POSC are completed and updated after a referral is made.	Measurement: POSC are developed for the known population, including at what perinatal cross-section is POSC development completed; by what sector is the POSC completed; how often it is updated. Source for fidelity data: Unite Us; HIPAA-secure quarterly form completed by specialized providers Source for learning indicator data: Unite Us; qualitative data from partners; HIPAA-secure quarterly form completed by specialized providers.	☐ >75% of POSC referred in the catchment area are completed [2] ☐ 50% to 75% of POSC referred in the catchment area are completed [1] ☐ <50% of POSC referred in the catchment area are completed [0] ***Learning Indicators:*** *What is the breakdown by perinatal period? What sector and organizations drive the completion rate? Are we losing families between POSC referral and completion, and why?*	

Fidelity Item to Assess	Measurement and Data Source	Scoring Criterion	Score
Through care coordination by Specialized Providers, services to which clients are referred are accepted and completed with client needs met.	Measurement: Service referrals end in a positive resolution. Source for fidelity data: Unite Us; HIPAA-secure quarterly form completed by specialized providers. Source for learning indicator data: Unite Us; qualitative data from partners; HIPAA-secure quarterly form completed by specialized providers.	☐ >75% of referrals made for services end in a positive resolution because client needs were met [2] ☐ 50% to 75% of referrals made for services end in a positive resolution because client needs were met [1] ☐ <50% of referrals made for services end in a positive resolution because client needs were met [0] ***Learning Indicators:*** *What are the barriers and/or facilitators to using services to meet needs? Which services are most likely to be used/completed? What family needs are most dominant in the POSC? Is the region equipped to meet identified needs?*	
		SUB-SCORE: ● **MET = 5 to 6 points** ● **APPROACHING = 3 to 4 points** ● **NOT MET = 0 to 2 points**	**SUB-SCORE:** **/6**
		TOTAL POINTS [12]	**/12**

Across all indicators and as data availability allows (i.e., sample sizes), a **data equity lens** will be taken to understand differences in fidelity being met for different socio-demographic characteristics, such as by race/ethnicity, parental age, county.

Appendix D: Data Sources

Four data sources will be used to answer the research questions posed:

1. Implementation data, collected by the Plan of Safe Care (POSC) intermediary
2. Care coordination data, collected through Unite Us
3. Outcomes data, using the Linked Information Network of Colorado (LINC) and/or Trails and/or Birthing Hospital Datasets and Unite Us
4. Qualitative data, collected from narratives of providers and families

Implementation Data

Data on implementation will be maintained by the catchment area intermediary. This will include:

- Training data (reach, coverage, satisfaction)
- Implementation support, including continuous quality improvement activities (reach, coverage, satisfaction)
- Memorandum of Understanding agreements (participation, meeting expectations)
- Perceptions and experiences of partners (activation pathways, tools, relationships)

Unite Us

Unite Us is a HIPAA-secure platform that enables care coordination. Administrative data from Unite Us will be accessed as part of the evidence-building process, including:

- Initiation of a POSC referral (when, by whom)
- Completion of a POSC (when, by whom)
- Referral to services (when, how, timeliness)
- Referral success (referrals made, referrals resolution)

Unite Us data will also facilitate identification of the leading social determinants of health (SDOH) facing families and the service array available to meet those needs. Unite Us will also help assess whether equitable access and outcomes are being achieved in the pilot area.

Piloting Unite Us for POSC in Colorado is a well-timed opportunity to accelerate progress in whole-person care. Colorado is heavily investing in a regional Social Health Information Exchange infrastructure[31] to improve care coordination and address SDOH. Use of Unite Us means the POSC pilot is positioned to inform this statewide build-out and help ensure the needs of families affected by prenatal substance use are included in the design.

Linked Information Network of Colorado or Trails Data

Tentative: To assess client- and system-level outcomes, we will explore linking data from Unite Us with other administrative data sources through LINC (http://lincolorado.org/). LINC is a public-private collaborative among the Colorado Lab and state and local data owners in Colorado that rely upon a data linking hub in the Governor's Office of Information Technology. LINC is available on a fee-for-service basis to link and de-identify data approved by the data owners for research and analytics. If using LINC proves feasible for the pilot, data will be linked at the level of the maternal-infant dyad and provided in a de-identified way to the evaluation lead for analysis. At a minimum, we will explore linking data from Unite Us to child welfare administrative data (Trails).

If using LINC proves not feasible, a data request to child welfare will be made to secure child welfare-related outcomes for POSC participants, and a data request to the local birthing hospital will be made to secure health-related outcomes data. Data from Unite Us will be used to assess outcomes of the pilot.

Qualitative Narratives

Throughout the pilot, qualitative methods will be used to assess acceptability, feasibility, and experiences of the POSC Framework. Ongoing touchpoints with local partners, facilitated by the intermediary, will provide real-time feedback loops that will be systematically tracked. In the final year, interviews, surveys, and focus groups will be conducted by the evaluation lead with entry points, specialized providers, and families. Narratives will be analyzed in comparison to the essential elements of the POSC Framework. Paired with administrative data, qualitative findings will enable a "numbers and narratives" approach to understanding POSC Framework success, challenges, and ability to scale.

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