Colorado Evaluation & Action Lab
UNIVERSITY OF DENVER
Using data to drive action

The Plans of Safe Care Pilot in the San Luis Valley

Findings from 1 Year of Serving Families

REPORT HIGHLIGHTS:

- **Plans of Safe Care (POSC)** are 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 4-year **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.
- This brief synthesizes the **seven key drivers of success** that were deployed during Year One of serving families with the POSC Framework.
- These seven drivers illustrate **opportunities to overcome common challenges** to coordinating care for families affected by prenatal substance use.
- A **Toolkit for Action** is included that can be used by partners for statewide learning and implementation.

AUTHORS:

Courtney L Everson, PhD

Sr. Project Director, Colorado Evaluation and Action Lab

Kelli Sutton, BS
Director of Behavioral Health Initiatives, Illuminate Colorado

Joanna Beletic, MA
Staff Researcher, Colorado Evaluation and Action Lab

With contributions from: Kathi Wells, Kempe Center; Becky Orsi-Hunt, Kempe Center; and Jillian Fabricius, Illuminate Colorado.

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For inquiries contact: Courtney L. Everson | admin@coloradolab.org | ColoradoLab.org

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Abstract

Substance use during pregnancy is a growing issue that demands data-informed, family-centered solutions. To align and accelerate Plans of Safe Care (POSC) progress, the Colorado Department of Human Services' Division of Child Welfare resourced a **4-year pilot** in the San Luis Valley (SLV), with potential for replication and scaling statewide. The Pilot runs from Federal Fiscal Year (FFY) 2023 to FFY26. FFY23 served as the planning year; FFY24 saw launch of the POSC Framework to build local capacity in the SLV; FFY25 marked the start of serving families; and FFY26 is the final implementation and evidence building year.

The **Pilot's goal** 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, a community-based approach to reduce stigma, and care coordination across providers to achieve family thriving.

This report synthesizes **seven key drivers of success** that have emerged in the first year of serving families with the POSC Framework. These seven drivers illustrate opportunities to overcome common challenges to serving families affected by prenatal substance use.

- Key Driver of Success 1: Building a no-wrong-door approach for families to engage with the POSC Framework.
- Key Driver of Success 2: Partnering with trusted supports in the community to serve as Specialized Providers.
- Key Driver of Success 3: Creating an attitude of shared responsibility across systems.
- Key Driver of Success 4: Co-designing workflows to center families—not systems.
- Key Driver of Success 5: Establishing a local intermediary for technical support to Specialized Providers and Entry Points.
- Key Driver of Success 6: Using evidence-based practices and data for learning.
- Key Driver of Success 7: Having responsive service providers across the San Luis Valley.

A **Toolkit for Action** is included that can be used by partners for statewide learning and implementation. This toolkit reflects leading tools used to deliver the POSC Framework that can help inform other local prevention and intervention efforts across Colorado when collaborating with families facing substance use during pregnancy.

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Acknowledgements

This research was supported by the Colorado Department of Human Services' (CDHS) Division of Child Welfare. The opinions expressed are those of the authors and do not represent the views of the State of Colorado, CDHS, local agency and community partners in the San Luis Valley (SLV), or the University of Denver. Policy and budget recommendations do not represent the budget or legislative agendas of state agencies, the Governor's Office, or other partners. Any requests for funding or statutory changes will be developed in collaboration with the Governor's Office and communicated to the legislature through the regular budget and legislative processes.

This Pilot is led by the Colorado Evaluation and Action Lab (Colorado Lab), in collaboration with Illuminate Colorado (Illuminate) 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
- **Technical support:** Kempe Center

Data Sources

The report was generated from information gathered through:

1. Before-Action Review in November 2024 and After-Action Review in June 2025.
2. Monthly Pilot team huddles with the Colorado Lab, CDHS, Illuminate, and the Kempe Center.
3. Fidelity measurement and qualitative data generated for the first and second 6-month periods of implementation (August 2024 to January 2025 and February 2025 to July 2025).
4. Monthly local implementation team meetings and site visits in the SLV.

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Introduction

The Colorado Department of Human Services' (CDHS) Division of Child Welfare (DCW) is resourcing a 4-year 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.

This report synthesizes key drivers of success deployed during the first year of POSC delivery in the San Luis Valley (SLV) to overcome common challenges to families' safety and health.

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. POSC are a requirement of the Child Abuse Prevention and Treatment Act (CAPTA). In Colorado, CDHS is responsible for meeting mandates around infants and families affected by prenatal substance use. States are given flexibility in implementing this CAPTA requirement, including the option for community partnership and POSC prenatal initiation. To align and accelerate POSC progress, DCW resourced a 4-year pilot in the SLV with potential for replication and scaling statewide. The Pilot design can be found here[3] and learnings from initial capacity building can be found here.[4] **This report focuses on findings from the first year of serving families.**

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 features of the POSC Framework are: 1) Prenatal POSC initiation, 2) Voluntary engagement by families, 3) Comprehensive service delivery and tracking, and 4) 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).

Specialized Providers are identified at community-based organizations and health care providers to receive referrals for a POSC, develop the POSC with families, and coordinate care for up to 1 year after birth. In the SLV, the Specialized Providers are the Area Health Education Center (AHEC), San Luis Valley Health, Valley-Wide Health Systems, Hard Beauty, and the Behavioral Health Group. Specialized Providers are trained, supported, and managed by the local catchment area intermediary, Illuminate Colorado (Illuminate). Entry Points are any one in the community—both formal systems and informal supports—that identify a family may benefit from a POSC and can make a referral to a Specialized Provider.

Approach

The report synthesizes learnings that emerged from: 1) a Before-Action Review (BAR) and an After-Action Review (AAR) using the Emergent Learning approach; 2) monthly Pilot team huddles among the Colorado Evaluation and Action Lab (Colorado Lab), Illuminate, the Kempe Center for the Prevention and Treatment of Child Abuse and Neglect (Kempe Center), and CDHS; 3) fidelity measurement and qualitative narratives for the first 6 months (August 2024 to January 2025) and second 6 months (February 2025 to July 2025) of serving families; and 4) monthly local implementation meetings and site visits with SLV partners.

- **Emergent Learning:** Emergent Learning[5] is a set of principles and practices that help people across a system think, learn, and adapt together in order to overcome complex challenges and achieve important social change goals. The methodology was applied to guide the discovery and synthesis process to identify (and adapt) to learnings in Year One of serving families. A BAR (November 2024) and AAR (June 2025) were conducted in accordance with the Emergent Learning approach. Participants included representatives from the Colorado Lab, Illuminate, the Kempe Center, and CDHS/DCW. Thematic qualitative analysis was applied to narratives that resulted from each review.
- **Monthly Pilot Huddles:** Monthly huddles between the Pilot team and CDHS took place to accelerate rapid learning and embed feedback loops between the Pilot team entities, the state partner, and local catchment area partners. Thematic analysis was applied to narrative evidence generated from these huddles.
- **Fidelity of Implementation:** 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. These fidelity indicators serve as a means for assessing implementation fidelity and program quality. Fidelity is measured periodically in the Pilot, to inform both continuous quality improvement (CQI) and for final evaluation results. Fidelity results were descriptively analyzed at the pilot level.
- **Local Implementation Meetings and Site Visits:** The catchment area intermediary facilitated monthly meetings with local implementation partners, including all specialized providers named in the Pilot as well as local child welfare partners. These meetings focused on implementation management and building in feedback loops for CQI. Monthly meetings were augmented by periodic in-person, multi-day site visit to accelerate technical assistance, training, and data collection. Thematic analysis was applied to narrative evidence generated from monthly meetings and site visits.

Together, results identified seven drivers of success that were deployed during Year One of serving families with the POSC Framework. These seven drivers illustrate opportunities to overcome common challenges to serving families affected by prenatal substance use. The goal of this report is to share these findings so that other partners across health and human services, judicial and legal, and community-based organizations can learn from the POSC Framework in real time and apply insights to their own localized efforts around caring for families affected by prenatal substance use.

Key Strategies Driving POSC Pilot Success

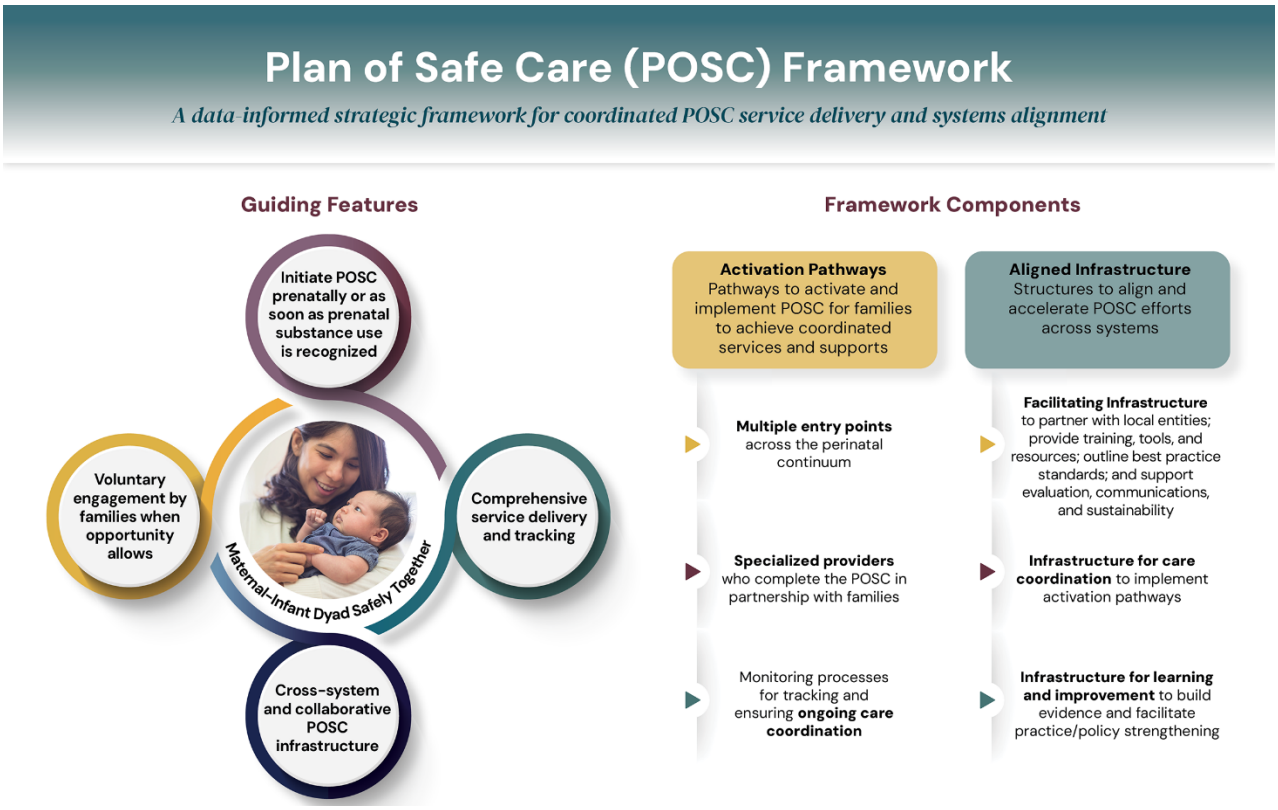
In the first year of service delivery in the SLV (August 2024 to July 2025), 23 families developed a POSC with a Specialized Provider.

The POSC program is reaching families across the rural health context, with 57% residing in Alamosa and 43% residing in other SLV counties.

The POSC Framework has deployed seven key drivers of success to creatively overcome common barriers that impact families' safety and health when facing substance use in pregnancy.

These seven key drivers of success are organized within the POSC Framework's four guiding features, visualized in Figure 1.

Figure 1. A Framework for Coordinated Plan of Safe Care Service Delivery and Systems Alignment



Guiding Feature 1: Initiate POSC prenatally or as soon as prenatal substance use is recognized.

Key Driver of Success 1: Building a no-wrong-door approach for families to engage with the POSC Framework.

During Year One of serving families, a no-wrong-door approach was employed for families to learn about the benefits of POSC and if interested, complete a POSC with a trusted community support (see Key Driver 2). The no-wrong-door approach was made possible by outreaching to Entry Points that reflect the varied spaces and places families interact with—from street outreach to public benefit programs to local jails and substance use treatment providers.

Outreaching to Entry Points has taken multiple forms, including postcards advertising the POSC Pilot in the SLV, information sharing at gatherings such as the Neonatal Task Force Symposium, email communications, and one-on-one connections between Specialized Providers and Entry Points. The goal was to create surround sound for the Pilot and take a public health approach to ensure any family who may need the service knows how to access it.

Entry Points can make a referral to the program in multiple ways, including direct communication (email, text, phone call, warm hand-off with the family) to any Specialized Provider or by using an online Health Insurance Portability and Accountability Act (HIPAA)-secure referral.[6] Findings from Year One showed that referrals for a POSC need to be as simple as possible and allow multiple forms of consent, including verbal consent by a provider using a Release of Information form, as well as the ability for a family to self-refer. Based on these findings (see Key Driver 6), the HIPAA-secure referral migrated from Unite Us to REDCap.

In Year One, referrals for a POSC came from:

- Criminal justice and law enforcement
- Community-based supports
- County child welfare departments
- Health and medical care providers
- Self-referrals (referrals made by a family for themselves or their loved ones)

Challenge this strategy helps address: Families affected by prenatal substance use commonly have lower rates of prenatal care[7] and face multiple structural and cultural barriers to accessing services,[8, 9] including stigma. This means relying on any one system to reach families will result in less timely access to a POSC and many families will fall through the gap. A no-wrong-door approach helps address this by leveraging the spaces families occupy and the existing relationships they have in the community.

Guiding Feature 2: Voluntary engagement by families when opportunities allow.

Key Driver of Success 2: Partnering with trusted supports in the community to serve as Specialized Providers.

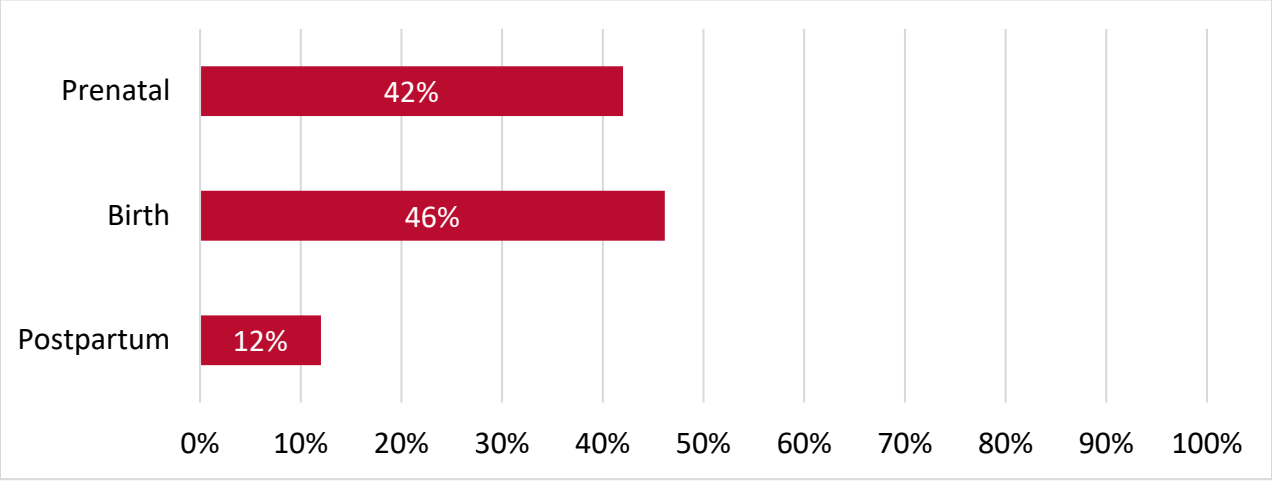
To improve family engagement, the Pilot has leveraged existing relationships and trust between Entry Points, Specialized Providers, and families. Strategies that have made this possible include:

- Embedding Specialized Providers across the SLV in both community and health care spaces that have demonstrable trust;
- Expanding and diversifying the types of Specialized Providers who can develop a POSC with a family, including use of peer specialists;
- Building relationships between Entry Points and Specialized Providers; and
- Grounding the implementation in research evidence to ensure decisions reflect the community's needs and context.

This level of integration has allowed Entry Points and Specialized Providers to identify families that may benefit from a POSC sooner. Historically, families have been connected to needed supports and services *after* the birth event, often once a family is involved with child welfare. While the POSC Framework engages providers across the perinatal continuum, the aim is to develop a POSC prenatally or as soon as substance use is identified, to move services *upstream* so that protective factors are put in place early, giving maximum value to families.

In the first year of implementation (August 1, 2024, to July 31, 2025) 30 referrals were made for a POSC. Of those with a known perinatal period of initiation (26), 42% were initiated prenatally (Figure 2).

Figure 2. Rate of Referrals for a Plan of Safe Care by Perinatal Period



Challenge this strategy helps address: Families mistrust of systems is a documented chronic barrier to engagement.[10, 11, 12, 13] This is made especially true in a rapidly evolving federal and local landscape that is increasing confidentiality and safety concerns. Using Entry Points with an already established relationship with the family, alongside Specialized Providers that are trusted by the community and are skilled at rapport building, can help overcome these challenges and increase family engagement. Even so, distrust of systems remains a barrier to families choosing a POSC and requires ongoing attention to consistently improve engagement.

Guiding Feature 3: Cross-system and collaborative POSC infrastructure.

Key Driver of Success 3: Creating an attitude of shared responsibility across systems.

The Pilot has successfully engaged a varied array of systems and sectors to meet families where they are in their parenting and substance use journey. This has included health and medical care providers, child welfare caseworkers, community-based organizations, peer specialists and recovery supports, and criminal justice and law enforcement.

The POSC Framework identifies three essential sectors to moving POSC upstream and creating a community-based infrastructure, while also recognizing the necessary role of child welfare in fulfilling CAPTA requirements when safety concerns are present. These sectors are the birthing hospital(s), child welfare departments, and community-based providers**. In the first year of serving families, all essential sectors (100%) have been engaged in the Pilot.** This is evidenced by Memorandums of Understanding and Business Associate Agreements signed for participation in care coordination, as well as the complete (100%) onboarding, training, and participation of all essential sectors in implementation opportunities (e.g., symposium, monthly calls) and quality improvement activities (e.g., site visits, fidelity presentations).

"We strive to offer and engage all patients giving birth with the necessary support and resources. By creating a "village" for those delivering babies and their families, we aim to ensure a solid discharge plan to ensure a smooth journey beyond delivery. Incorporating Plans of Safe Care into the discharge process allows for an opportunity to incorporate additional resources to wrap around a family, providing additional advocacy, and includes handoffs to additional medical and community providers. This ensures that upon discharge, families know who to reach out to as they face struggles, with ease of mind that there is a safety net and path forward. This may start, but does not end, in Labor and Delivery at San Luis Valley Health."

- San Luis Valley Health

A key driver of success among Specialized Providers engagement with the POSC Framework is leadership at the organization. When leadership hold fluency and confidence in the POSC Framework, they are able to be a more effective champion for engagement, both inside and outside their organizations. Conversely, turnover poses a significant challenge, evidenced in the first half of pilot implementation. Once stability was achieved in staffing among Specialized Providers, greater effectiveness and efficiency was seen. Because turnover, attendance, and stability will invariably fluctuate, it is vital that each essential sector has a closed feedback loop so that any new information or insight is communicated internally regularly, regardless of who the essential sector representative is at a given activity.

Another key driver of success for collaborative ownership is intentional investment in relationship building across key sectors, especially between health care and community-based organizations, and the birthing hospital and child welfare. Through facilitation by the intermediary, improved linkages and shared mental models between these partners are being observed, which in turn supports more effective implementation of the activation pathways.

Building relationships is especially important in areas where distrust across systems is deep, as is true for some entities in the SLV. This is made even more challenging by partners' responsibility to notify the state about infants exposed prenatally (IESP) to substances and reporting safety concerns, where the rules and regulations are not always clearly understood by everyone. To help address, the Pilot team and DCW are seeking to improve training around child welfare laws and requirements for IESP notification and reporting.

Challenge this strategy helps address*:* POSC cannot be viewed as the responsibility of one system for three reasons: first, putting the onus on any one system is too rigid to respond to changing policy, funding, or best practice landscapes; second, families live in communities, not any one system, and thus need to have cross-cutting access to a POSC; and three, by definition, POSC require significant care coordination (see Key Driver 7) that is best achieved through collaboration across sectors. The POSC Framework aims to address this by creating workflows that take a holistic, cross-system approach to referral for a POSC, development of a POSC, and care coordination of needs identified within a POSC, as discussed in Key Driver 4, below.

Key Driver of Success 4: Co-designing workflows to center families—not systems.

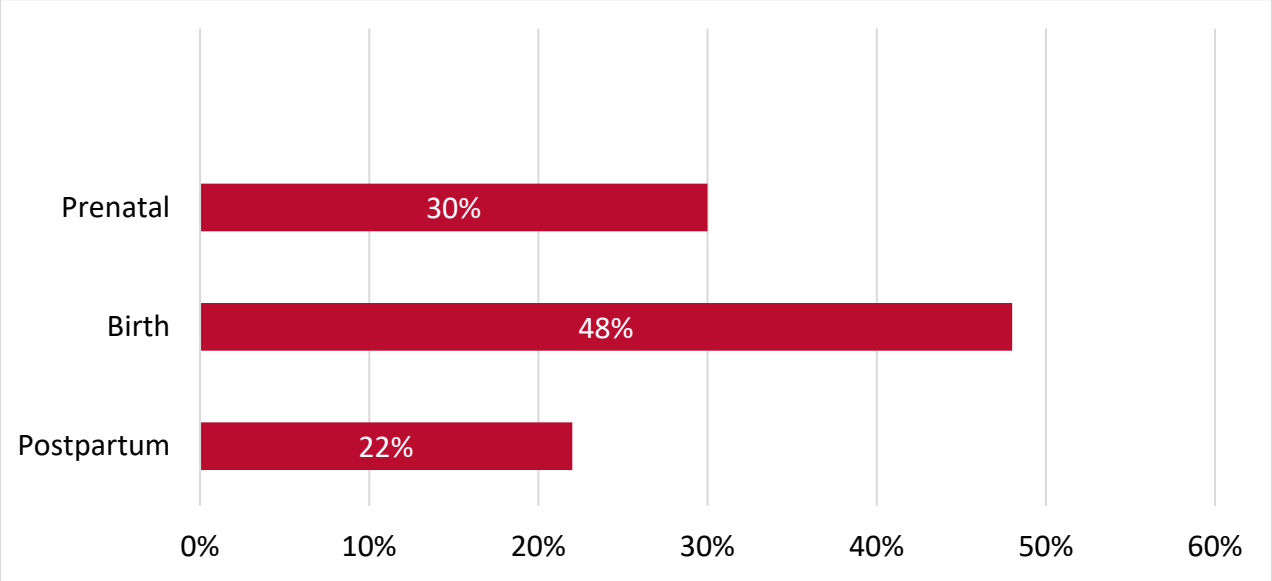
In the POSC Framework, two activation pathways are used, one is called the community-based activation pathway and one is called the child welfare activation pathway. The community-based pathway is for non-child welfare involved families and can be activated at any point in the perinatal period (prenatal, birth, or postpartum). The child welfare pathway is activated only after the birth of an infant and when a safety concern meeting Colorado's rules around abuse and neglect for IESPs is present. Both activation pathways reflect best practices in the literature on barriers and facilitators to POSC engagement and caring for families affected by prenatal substance use (see Key Driver 6). As such, the POSC Framework provides a template design for both activation pathways, and then local communities must adapt the design and create

community-specific workflows for implementation. This requires a co-design process *and* ongoing iteration, facilitated in the SLV by the catchment area intermediary.

As evidence of this, midway through the first year of serving families, Pilot partners identified that some Entry Points—anticipated to have a high level of engagement at launch—were not yet making active referrals. An example of this was substance use treatment providers, outpatient prenatal providers, and the local Family Resource Center. To help overcome this challenge, a plan for targeted outreach to underutilized Entry Points was developed, including communicating the unique role and responsibility of each player and translating how making a referral for a POSC is no different than other approaches in the public health toolkit, such as universal screening for postpartum depression and offering referrals for smoking cessation or allergy testing.

The workflows are designed to not only initiate a referral for a POSC, but to ensure that the POSC is completed and updated after the referral is made**.** In the first year of serving families, 77% (n = 23 of 30 referrals) of referrals resulted in a completed POSC. Figure 3 shows the rate of POSC developed by perinatal period.

Figure 3. Rate of Plans of Safe Care Developed by Perinatal Period



The goal in the POSC Framework is set at 70% completion, which means the Pilot is exceeding this goal. The 70% benchmark acknowledges that not all referrals for a POSC will result in a completed plan, for a number of reasons. This includes external, non-modifiable factors, such as a family moves out of the locale, the pregnancy results in a miscarriage, or a family was referred to the program to learn more, but they are not actively experiencing prenatal substance use and so may not be a good fit. This also includes more localized, modifiable factors, such as a family with unreliable contact methods (e.g., no phone), a family moving around because they have no safe place to go, or a family experiencing crisis and a high level of acuity with specific needs now (e.g.,

domestic violence/intimate partner violence). In these circumstances, a fully completed POSC may not be the most pressing need; it is imperative that Specialized Providers can appropriately triage level of acuity and connect the family to the right services at that moment. The family may come back to the provider to develop a POSC or may have their needs met in another way. Recognizing all connections to services and supports—however they manifest—as a success and using the POSC Framework in this way is imperative. This shows that the POSC Framework is driving culture change to enhance the care and response to families impacted by substance use prenatally, whether or not the POSC is developed, and that activation pathways serve this goal.

Challenge this strategy help address: Workflows that stay siloed within a single system fail to meet families where they are and will result in some families falling through the cracks. Further, each system has a unique niche and perinatal time period they may be working in. For example, hospital-based systems may primarily reach families at the birth event, while child welfare cannot legally get involved until after the birth event. To reach families upstream and in the spaces they variably occupy, workflows must reflect multiple points of activation and multiple sectors.

Key Driver of Success 5: Establishing a local intermediary for technical support to Specialized Providers and Entry Points.

Having a local intermediary tasked with design, implementation, and quality improvement support is proving an invaluable driver of success. The intermediary role provides the infrastructure needed to continue elevating conversations around POSC with diverse partners, providing technical assistance to troubleshoot problems in real time, identifying and delivering trainings that increase fluency of Specialized Providers and essential sector partners to effectively care for families affected by prenatal substance use, and facilitating quality improvement effort based on fidelity data and best practices from the research.

To drive success, the intermediary has:

- Delivered strong implementation materials that are responsive to varied needs.
- Developed a central POSC Pilot webpage for Pilot information.
- Designated a Senior Specialized Provider to serve as a centralized referral point, with the capacity to manage or delegate all referrals to ensure a coordinated and streamline effort as the “go-to” provider for Pilot fluency.
- Hosted monthly implementation meetings to review materials and workflow with Specialized Providers.
- Provided one-on-one support by Pilot intermediary to address emergent challenges and needs.
- Coordinated and supported facilitation of site visits to bring partners together for shared learning and relationship building.

- Brought statewide connections to the community that can support the work in the community and provide additional capacity and resources.
- Facilitated community understanding of statewide developments and conducted resource landscaping to inform opportunities in the SLV (i.e., recovery doula training, birth justice support, relevant child welfare trainings and supportive services).
- Provided onboarding and orientation support to new partners and new organizational staff when there was turnover.

Challenge this strategy helps address: POSC are more than a document. They require specialized skills to develop effectively, investment in rapport building and trust, and aligned training, such as Motivational Interviewing, for honest answers and continued connection. Currently in Colorado, POSC are being variably implemented and as a result, are having variable success. The lack of cohesion in implementing POSC across systems and communities means families don't know what to expect, other providers don't know what is available, and quality of care is inconsistent. A designated intermediary helps solve this challenge by ensuring comprehensive and consistent training, tools, and support. An intermediary can drive not only effectiveness in implementation of the POSC Framework, but also greater efficiencies and cost savings by having a go-to hub for communication and cross-locale, cross-system learning.

Key Driver of Success 6: Using evidence-based practices and data for learning.

Monitoring fidelity and measuring implementation progress is critical to within-Pilot strengthening and to readying the POSC Framework for long-term replicability. Fidelity refers to the extent to which the POSC Framework is being implemented as intended. It helps to answer questions of what happened and contributes to observed outcomes. During the first year of serving families, fidelity was measured twice: 1) families served between August 1, 2024, to January 31, 2025; and 2) families served between February 1, 2025, to July 31, 2025. Fidelity is being used to inform both quality improvement and to inform final evaluation results. Fidelity findings to date have been integrated across this brief.

The Pilot has seen several examples of how fidelity data and complementary qualitative data are driving quality improvement. For example, an initial Pilot goal was to innovate approaches to care coordination technology and explore the extent to which a social health information exchange (SHIE) approach could support the POSC Framework and its guiding features. To this end, the Pilot selected the HIPAA-secure Unite Us as a first test case for what was possible. Some benefits of this platform were identified, such as the opportunity to build towards tracking and ensuring closed loop referrals and having a central online form for referral to the POSC Pilot in the SLV that anyone could utilize, including a pregnant person who would like to initiate a POSC. However, Unite Us proved to be an inadequate SHIE, at large, and option in the SLV, specifically. The under-use was driven by a combination of fear of care technology systems (especially when new in relationship and given a changing federal landscape), the extra burden that comes with care technology systems (e.g., multiple layers of consent), and the importance of maintaining human touch, particularly in the relationship-based nature of rural health contexts. Of note, the value of

a care coordination system like Unite Us is the ability for multiple Specialized Providers, across agencies and working to implement the POSC Framework can collaborate and share information in real time. The challenge is that families may not trust all of the providers on the care team and want to rightfully limit their information. The tension of information sharing with information privacy is one that Unite Us was unable to adequately resolve, and no amount of scripting or support seemed to change that. Based on partner feedback and fidelity data, the decision was made to pivot away from Unite Us. Using data for learning allowed the Pilot team to pinpoint that a care coordination system is made up not only of the technology platform, but also of the people and pre-existing processes. As such, the decision was made to pivot away from Unite Us and to instead leverage REDCap for data collection and internal case management systems for care coordination.

What is REDCap?

REDCap, or Research Electronic Data Capture, is a secure, web-based application used to build and manage online surveys and databases for research studies. It is designed for public health and medical research with high levels of sensitive data.

Participation in the Consortium provides access to REDCap; for non-profits, this is free to join. Integration with hospital-based electronic health records is available through the Clinical Data Interoperability Services (CDIS).

REDCap is secure, including 21 Code of Federal Regulations (CFR) Part 11, Federal Information Security Modernization Act, HIPAA, and General Data Protection Regulation compliant, as well as enables 42 CFR Part 2 compliance.

Another example of using data for learning is in identifying Entry Points that are not contributing referrals at the rate expected. This has allowed the intermediary and Specialized Providers to come up with a targeted outreach plan to fill this gap. This includes an effort to engage healthcare providers—inpatient, outpatient, and emergency—with guidance on implementing a universal approach to offering a POSC and care coordination with a community-based organization or recovery coach/lived experience expert who are specially trained to support families impacted by perinatal substance use or pregnant people in recovery who are actively managing a recovery plan. There is a plan to leverage the expertise of Pilot partners to provide guidance on a universal approach and suggest a similar approach to other established public health strategies. This effort will aim to demonstrate the value to addressing perinatal substance use as a critical public health issue that warrants a coordinated and supportive health care response. Because of the infrastructure currently in place for care coordination from community organizations, this will lessen the burden of health care addressing it alone.

Pilot partners have been invited to attend all-provider and all-nursing staff monthly meetings to provide guidance on the approach to implementing POSC upstream. This also includes leveraging a new partnership between the Senior Specialized Provider for the Pilot (AHEC) and one of the

substance use treatment providers in the SLV that offers a wide range of recovery services. While this treatment provider has been critical to the success of implementing the POSC Framework as a referral provider, the Pilot partners also see an opportunity to explore how the provider could also be an Entry Point and support early initiation of a POSC with a family who could benefit. Local partners have also identified other organizations to outreach and plan to utilize already existing events or meetings to connect and share updates on POSC implementation and discuss how to enhance partnerships, optimize success, and build capacity.

In addition to building evidence from within-Pilot data, it is imperative that POSC efforts are driven by existing evidence. In the Pilot, a leading strategy has been to design the POSC Framework from a combination of Colorado specific data[14] and national literature on barriers, facilitators, and best practices in caring for families affected by prenatal substance use. Existing research evidence not only informed initial design but is regularly updated and consulted to inform challenges and opportunities within the activation pathways.

Challenge this strategy helps address: Too often, data are used for compliance or to punish, or data are only used at the end to demonstrate "the big" outcomes on everyone's minds. This approach misses opportunities to learn from data to strengthen implementation, risks continuing with a resource-intensive activity or tool that is not meeting needs, and is not consistent with Colorado's Steps to Building Evidence.[15] Having a reliable and valid data collection system, measuring fidelity early and often, and having a lead skilled in evidence building and evidence use helps to advance evidence-based practice and track opportunities for data-informed policy and practice in Colorado.

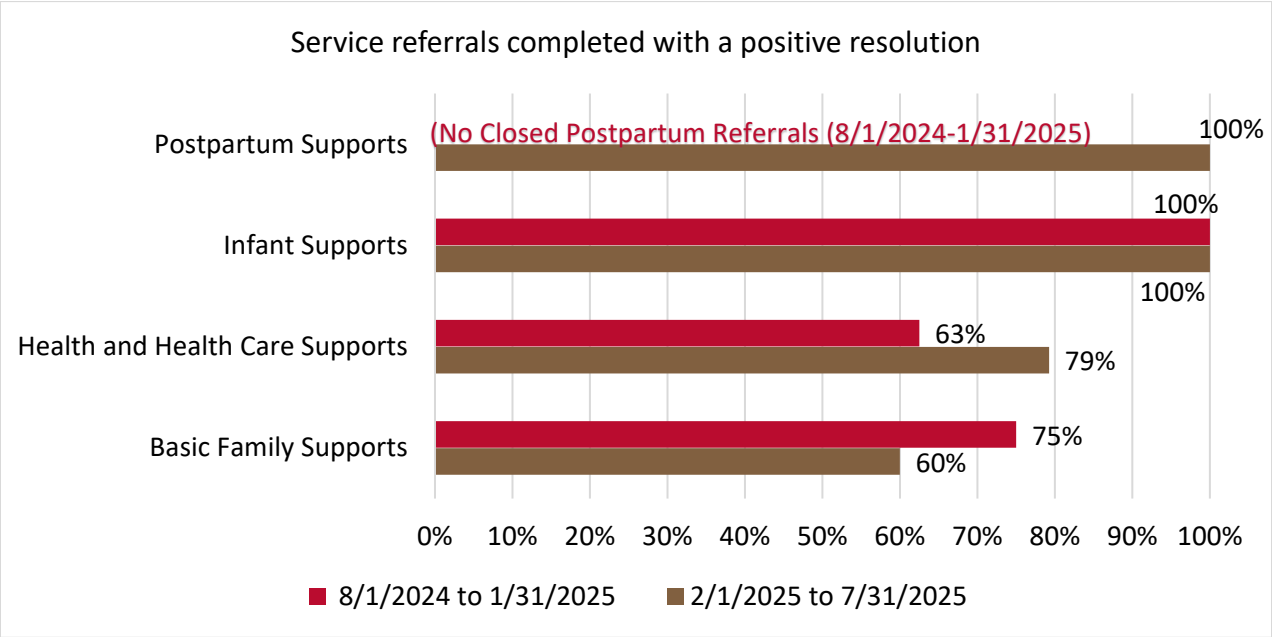
Guiding Feature 4: Comprehensive service delivery and tracking.

Key Driver of Success 7: Having responsive service providers across the San Luis Valley.

Families with a POSC are being connected with wraparound services and support at a promising rate. **Two hundred and eighty four (284) service referrals were made during the 12 months of serving families. Of those for which a there is a known resolution[i] (n = 209), 78% were closed with a positive resolution.** Positive resolutions of service referrals depend on factors such as availability of service in the local area, responsiveness of the service provider, and trust by the client and good rapport between client and service provider. Figure 4 displays the rate of successful completion for referrals with a known resolution by referral type for the first 6 months of families served (August 1, 2024, to January 31, 2025) and the second 6 months of families served (February 1, 2025, to July 31, 2025).

[i] Known resolution means the referral has happened and the status of the referral is known. Some referrals were still in progress at the time of reporting.

Figure 4. Service Referrals Completed with a Positive Resolution



These findings show that families have multiple and varied needs, ranging from health care supports (39%) like mental health services; to concrete supports (28%) like the Women, Infants, and Children (WIC) program; to infant supports (18%) like access to baby items; to postpartum supports (15%) like information on postpartum depression and baby milestones/ development information. Data also show the extent of needs is high among these families, with an average of 12.34 referrals for outside services and supports per POSC developed.

> *"POSC is so important in providing a platform for pregnant clients to be empowered to make healthy decisions for themselves and their babies. It is a positive way to give voice, advance self-advocacy, and support self-determination to navigate one's own life journey without undue external interference."*
>
> **- SLV AHEC**

To drive success, Specialized Providers—with support from the intermediary—have worked to establish direct relationships with organizations best positioned to assist with leading referral needs. This includes a direct relationship with the peer recovery organization Hard Beauty. Hard Beauty Recovery Coaches are trained to complete a POSC and provide ongoing care coordination, or a POSC can include a referral to Hard Beauty for coaching support and additional peer services. Similarly, the Senior Specialized Provider agency, SLV AHEC, has recovery doula services, as well as the American Indian Center where families can receive culturally responsive services. Specialized Providers have built direct relationships with providers who specialized in Medication for Opioid Use Disorder or Medication Assisted Treatment or have

these services within their own organization ensuring easy and timely access to care. The local intermediary has developed a spreadsheet with key contacts to facilitate connections and to increase understanding of what peers offer.

As the Pilot moves into the final year, there is an anticipated need for continued advocacy for robust service arrays in high priority areas, particularly given anticipated shifts in how the region may be (ill)equipped to meet family needs in a supportive way (e.g., health care insurance).

Challenge this strategy helps address: National research[16] shows that POSC are most effective as a tool for care coordination and when used this way, can help prevent removals from the home for families who do become involved in child welfare. By using the POSC to identify needs (of the infant, caregiver, and family on the whole) and then coordinating care through Specialized Providers around those needs, referrals to services are more effectively and efficiently achieved. Care coordination around a POSC also acknowledges that needs change from the prenatal period to postpartum period and go beyond just substance use treatment. By having Specialized Providers that can meet families where they are in their journey and coordinate care up to 1 year after birth, the POSC can remain a living document that is responsive and agile.

Implications and Considerations

The POSC Pilot in the SLV is actively serving families and will continue to build evidence for the POSC Framework through Federal Fiscal Year 2026. As such, policy, practice, data, and funding recommendations will not be made until the end of the Pilot period. Based on findings to date, implications for continued implementation of the POSC Framework—and opportunities for statewide consideration—are summarized below.

- **Policy:** Consider what governmental agency is best suited to hold responsibility for IESPs in Colorado. While CDHS is currently tasked as the Title IV-E agency, the Colorado Department of Public Health and Environment may be better positioned to advance a public heath approach to POSC that emphasizes universal reach and a community-based infrastructure.
- **Practice:** Continue iteration of activation pathways and target outreach and relationship building among underutilized Entry Points and Specialized Providers best positioned to support families, both within and outside of child welfare. Use a public health universal prevention approach to referring for a POSC, whether or not substance use is directly identified. Establish a state intermediary for technical support.
    - Continue to build out opportunities for community awareness of recovery services offered, how to access supportive services, and bring awareness to community events that support prevention, recovery, and treatment.
    - Build capacity for the SLV to provide a comprehensive array of services for families, including specific supports for pregnant and parenting individuals and culturally responsive services. Elevate awareness of this service network to enhance referral pathways and support greater engagement in POSC.

- **Data:** Discontinue use of Unite Us based on partner feedback and launch use of RedCAP for data collection, alongside internal case management systems of Specialized Providers for care coordination. This enables cohesive evidence building while reducing care burden on providers by enabling them to use their own systems and consent processes with families. Establish an evidence-building hub to coordinate data collection, synthesis, and actionability across POSC efforts.
- **Funding:** Consider adding POSC as a Z13 screening International Classification of Diseases (ICD)-10 code and use to develop the POSC and identify initial needs. Leverage Current Procedural Terminology codes for case management (CM) in conjunction with a specific ICD-10-CM diagnosis code that reflects the underlying condition or reason for CM to support funding for POSC care coordination.

POSC Toolkit for Action

The catchment area intermediary has developed a public toolkit with current POSC Framework materials to support shared learning towards statewide implementation and cohesion.

The toolkit can be accessed on Illuminate Colorado's POSC webpage and includes:

- (Pilot Executive Summary) Coordinating Care and Support for Families Affected by Prenatal Substance Use: Developing a Data-Informed Strategic Framework for Plans of Safe Care
- (Data Executive Summary) Coordinating Care and Support for Families Affected by Prenatal Substance Use: Early Learnings from the Plans of Safe Care Pilot in the San Luis Valley
- (Outreach Material) Plan of Safe Care Referral Postcard in the SLV
- (Workflow) Community-Based Activation Pathway (SLV example)
- (Workflow) Child Welfare Activation Pathway (SLV example)
- (Consent Forms) Participant HIPPA/Part 2 Release- Adult; Participant HIPPA/Part 2 Release- Child, Participant Consent Plan of Safe Care Pilot Program
- (Training Materials) Plan of Safe Care Tools for Child Welfare
- (Tools) Plan of Safe Care Statewide Templates and Guidance

Endnotes

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