Contents

General Policy and Practice

When did the Plan of Safe Care (POSC) officially go into effect?

County children and couth agencies (CCYA) have been engaged in Plans of Safe Care (POSC) for infants exposed to illegal substances for many years. The federal law changed in July of 2016 when the Comprehensive Addiction and Recovery Act (CARA) amendments to the Child Abuse Treatment and Prevention and Treatment Act (CAPTA) went into effect. In Pennsylvania, Act 54 which updated the Child Protective Services Law took effect in June of 2018 (Pennsylvania Plans of Safe Care Guidance, 2019).

What is a Plan of Safe Care (POSC) and how does it differ from other service plans?

A Plan of Safe Care is a document that lists and directs services and supports to provide for the safety and well-being of an infant affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder (FASD). One of the main ways in which it differs from other service plans is in the inclusion of services for both the affected infant and the family/caregiver, including substance use treatment services for the parent.

Where can I find the Pennsylvania Plan of Safe Care Guidance?

The Pennsylvania Plan of Safe Care Guidance is available on the KeepKidsSafe website here.

Are families mandated to participate in or follow Plans of Safe Care?

No, Plans of Safe Care are voluntary support plans for families raising infants affected by prenatal substance use.

If a pregnant person is willing, could a multidisciplinary team develop a Plan of Safe Care for a pregnant person before the baby is born?

Yes, the county children and youth agencies would not be included in the prenatal Plan of Safe Care, but as a best practice, health care providers and other professionals are encouraged to begin developing Plans of Safe Care in the prenatal period if the pregnant person agrees to the process.

Are there special considerations or protocols when a kinship caregiver is taking the child home?

Plans of Safe Care (POSC) are for the substance affected infant and their parents/ caregivers. If the kinship family is willing to participate in a POSC they will have access to the full array of services and supports offered to any other family/ caregiver.

What is being done to decrease stigma/ fear of involvement in the child welfare system?

Providing families with information about the required substance affected infant notification and voluntary Plan of Safe Care as soon as the health care provider or other involved professional (home

visiting, mental health provider, substance use counselor) suspects the infant may be substance affected can help to decrease the family's anxiety regarding the notification and increase participation in Plans of Safe Care.

Which agency is primarily responsible for overseeing the process?

It depends on the needs of the substance affected infant, family/ caregivers, and the presence or absence of safety/ risk concerns. In situations when the infant has been affected by illegal substance use the county child welfare agency should take the lead.

As a Health Care Provider, I have made SAI notifications to Childline but have not been invited to participate in the POSC meeting. What is the protocol?

As a state supervised county administered child welfare system each county has developed its own protocol for MDT meetings. In addition, when the substance affected infant (SAI) notification does not include information regarding the effects being displayed by the infant or indicates that there are no effects but that the infant and/or pregnant person tested positive for a substance the SAI indicator is removed from the notification. Currently, Plans of Safe Care are only required to be offered to families with infants that meet the commonwealth's definition of substance affected infant.

Is there funding attached to the work surrounding Plans of Safe Care?

The Department of Human Services, Office of Children, Youth and Families allocated funds to county children and youth agencies via a non-competitive two-year grant. Grant amounts were determined by county class size. The grant period began on 7/1/2021 and will end on 6/30/2023. Beginning in the 2023-2024 state fiscal year county children and youth agencies will be able to request funding via the needs-based program budget process.

Is there any funding or initiative to create a new notification process that does not get funneled through the Children and Youth system? I've heard patients express that the way the notification occurs felt punitive and not supportive.

Not at this time, providing families with information about the required substance affected infant notification and voluntary Plan of Safe Care as soon as the health care provider or other involved professional (home visiting, mental health provider, substance use counselor) suspects the infant may be substance affected helps to decrease the family's anxiety regarding the notification and increase participation in Plans of Safe Care

What are the expectations, if any, on engaging pregnant women prior to the baby's birth?

Standards of best practice encourage early and frequent discussions with pregnant people and their support system regarding the possible effects of prenatal substance exposure on the infant. Any professional working with a pregnant person whom they believe may be at risk of having a substance

affected infant are encouraged to discuss possible effects of substance exposure on the infant, let the person know of the mandatory substance affected infant (SAI) notification process, and encourage the pregnant person to participate in a Plan of Safe Care. The Plan of Safe Care can even be developed prior to the infant's birth. However, the SAI notification cannot be made to the Department of Human Services via ChildLine until after the birth of the infant and a health care provider determines, based on standards of professional practice, that the infant is affected by prenatal substance exposure.

Will there ever be a statewide template that would be for use across all counties?

As a county administered child welfare system Pennsylvania's Office of Children, Youth, and Families does not generate mandatory commonwealth wide templates. The Keep Kids Safe website provides resources including POSC templates submitted by county POSC teams for use by other agencies involved in POSC work.

Who is responsible for "hosting" the POSC?

Neither federal nor state statutes name an entity responsible for convening the initial MDT meeting. The Plan of Safe Care Guidance (2019) states, on page 20, that the initial multidisciplinary team (MDT) meeting should be convened by the health care provider making the required substance affected infant notification to ChildLine. Pandemic related restrictions in hospitals and staffing shortages have changed how the initial multidisciplinary team meeting is held. Currently, the process is determined differently in each county and often for each family.

Statutory Requirements

What does the law say about infants born substance exposed and Plans of Safe Care?

Federal law (the Child Abuse Prevention and Treatment Act) requires a Plan of Safe Care to be developed for every infant under one year of age born and identified as affected by substance use, withdrawal symptoms resulting from prenatal drug exposure or a fetal alcohol spectrum disorder.

State law (Act 54 of 2018) directs health care providers to immediately give notice or cause notice to be given to the Department of Human Services if the provider is involved in the delivery or care of a child under one year of age and the health care provider has determined, based on standards of professional practice, the child was born affected by substance use, withdrawal symptoms resulting from prenatal drug exposure or a Fetal Alcohol Spectrum Disorder. You may read Act 54 here.

My agency has worked with infants born affected by substances for years; what has changed in this law?

The most notable changes include the elimination of the word 'illegal' related to substance exposure, the inclusion of the parent/caregiver's needs in the Plan of Safe Care, the data required to be submitted to the federal government (increasing federal oversight), and the emphasis on the interdisciplinary nature of this work by ensuring Plans of Safe Care are not only the responsibility of the child welfare

system, but that the fields of Drug and Alcohol treatment, Early Intervention, Health, Mental Health and others are included in multidisciplinary teams and the development and implementation of Plans of Safe Care. The Departments of Health, Human Services and Drug and Alcohol Programs were required by Act 54 to develop interagency protocols regarding Plans of Safe Care.

What does "up to one year of age" in the law mean?

"Up to one year of age" refers to the age of an infant/child who can be identified as substance exposed by a health care provider and for whom a notification to the Department of Human Services must be made; this includes newborn through the 11th month.

How is "affected by" defined?

The Pennsylvania Plan of Safe Care Guidance (2019), "affected by" is defined as an "infant with detectable physical, developmental, cognitive, or emotional delay or harm that is associated with maternal substance use or withdrawal, as assessed by a health care provider."

When is the law effective? When should counties ensure their process and policies are in place for implementing Plans of Safe Care for licensing and inspection purposes?

Federal law changes were effective upon enactment on July 22, 2016; state law to ensure compliance with CAPTA was passed on June 18, 2018, and was effective October 1, 2018. For licensing and inspection purposes, county children and youth agencies should ensure policies and processes are updated and in place by January 1, 2020.

Substance Affect Infant (SAI) Notifications

Who makes a notification that a baby has been born and identified as substance affected, displays withdrawals symptoms resulting from prenatal drug exposure or has been diagnosed with a fetal alcohol spectrum disorder?

The law requires a health care provider or their designee to make this notification; this may be a hospital social worker, registered nurse, discharge coordinator or other staff person as determined by the health care provider or health system.

Where do I make the notification?

You may call ChildLine at 1-800-932-0313 or use the online self-service portal at: http://www.compass.state.pa.us/cwis.

What happens once a make the notification?

Trained caseworkers at ChildLine will transmit the information to the appropriate county children and youth agency or other appropriate entity and a multidisciplinary team of professionals will be convened to assess the family for a Plan of Safe Care.

What if a pregnant person is taking a prescribed medication appropriately and the baby, while showing signs of withdrawal or other effects, will not be affected long term? Must I make a notification?

Yes, Plans of Safe Care are not only developed for infants who will be affected long-term. Any effect on the infant should result in a notification to ChildLine so that a multidisciplinary team can convene to support the family.

What if a pregnant person is taking a medication as prescribed by her doctor that may or may not affect the newborn at birth, but it is a legal medication and not an opioid, such as an SSRI or medication to prevent seizures? Must I make a notification if I detect an effect on the newborn?

Yes, legal and prescribed medications may also affect an infant exposed prenatally. A Plan of Safe Care is required for any infant born affected by substance use, withdrawal symptoms or FASD to ensure the ongoing health and safety of the infant and ongoing health and treatment needs of the parent.

What if I am aware that a pregnant person had used substances but her newborn baby does not show signs of withdrawal or otherwise of being affected by those drugs following birth? Must I make a notification?

No, under Act 54 and CAPTA, a health care provider is required to make a notification when the provider is involved in the delivery or care of a child under one year of age and the health care provider has determined, based on the standards of professional practice, the child was born affected by substances. However, if a health care provider has reasonable cause to suspect abuse or neglect of the infant or child, they still must make a referral to ChildLine as a mandated reporter. Notification of an infant born and identified as substance exposed does not replace Child Protective Services (CPS) or General Protective Services (GPS) referrals.

What if a pregnant person tests positive for substance use following delivery but her newborn baby does not show signs of withdrawal or otherwise of being affected by those drugs following birth? Must I make a notification?

No, under Act 54 and CAPTA, a health care provider is required to make a notification when an *effect on the infant is detected*. However, if a health care provider has reasonable cause to suspect abuse or neglect of the infant or child, they still must make a referral to ChildLine as a mandated reporter. Notification of an infant born and identified as substance exposed does not replace Child Protective Services (CPS) or General Protective Services (GPS) referrals.

What if a pregnant person is receiving medication assisted treatment (MAT) for opioid dependence and her baby tests positive for that substance but does not show signs of withdrawal? Must I make a notification?

No, a notification of an infant born and identified as affected by substances is *based on the* medical provider's detection of physical, developmental, cognitive, or emotional delay in the infant. However, if a health care provider has reasonable cause to suspect abuse or neglect of the infant or child, they still must make a referral to ChildLine as a mandated reporter. Notification of an infant born and identified as substance exposed does not replace Child Protective Services (CPS) or General Protective Services (GPS) referrals.

What if a delivering person admits to substance use but the baby does not exhibit any symptoms at birth? Must I make a notification?

No, under Act 54 and CAPTA, a health care provider is required to make a notification when an effect on the infant is detected. However, if a health care provider has reasonable cause to suspect abuse or neglect of the infant or child, they still must make a referral to ChildLine as a mandated reporter. Notification of an infant born and identified as substance exposed does not replace Child Protective Services (CPS) or General Protective Services (GPS) referrals.

Are notifications only required for illegal substances, such as heroin or cocaine?

No, notifications are required when an effect on the infant is detected due to the exposure to any substance, regardless of whether it is a legal or illegal substance, including alcohol.

Are notifications only required for opioid abuse?

No, notifications are required when an effect on the infant is detected due to exposure to any substance, opiate or non-opiate.

Are notifications required to be made when I know a pregnant woman is using substances?

No, under CAPTA and Act 54, a notification is required when a health care provider detects an effect on the infant following birth.

How will the notifications to Childline be categorized and disseminated?

ChildLine caseworkers will be trained to categorize notifications of an infant born and identified as affected by substance use as either Information Only notifications or a General Protective Services (GPS) referral, depending on the information provided. This information will be transmitted to the county children and youth agency and/or other appropriate entity in the family's county of residence so that the most appropriate entity can work with the family to develop a Plan of Safe Care. For example, for

Information Only notifications, this entity may be the medical provider or drug and alcohol treatment provider, and an assessment by child welfare may not occur.

If at any time the county children and youth agency obtain more information regarding the environment surrounding the family and believes the Information Only or GPS referral should be re-evaluated as a GPS or child protective services (CPS) referral, they can request that of ChildLine. *Note: until January 1, 2020, when the necessary changes are made to the Child Welfare Information System (CWIS), all notifications of an infant born and identified as affected by substance use, withdrawal symptoms related to prenatal drug exposure or FASD will be categorized as GPS referrals (this is a continuation of previous practice). This is to allow time for the necessary technical updates and changes to be implemented in the system. Following January 1, 2020, the ability of ChildLine caseworkers to classify a notification as Information Only or a GPS referral will be possible. Currently, the county agency can screen out the referral or refer the family for community services if there are no safety or well-being concerns for the child.

Does this process replace reporting suspected child abuse or neglect?

No, if a mandated or permissive reporter has reasonable cause to suspect that a child is a victim of child abuse or neglect, they must still make a report to ChildLine to report those concerns and ensure an appropriate assessment or investigation takes place.

Does a notification of a child born affected by substance use constitute child abuse or neglect?

No, according to the law, the notification of an infant born and identified as affected by substance use, withdrawal symptoms resulting from prenatal substance exposure, or FASD does not constitute a report of suspected child abuse in and of itself.

Does this process replace "mandated reporting of infants" under the Pennsylvania Child Protective Services Law?

Yes, Act 54 reworks the Pennsylvania Child Protective Services Law Section 6386 to shift from "mandated reporting" to "notifications" for infants born substance exposed.

What if a baby is born without any symptoms or signs of withdrawal, but based on my knowledge of the pregnant person's drug use and other external environmental factors I have reasonable cause to suspect abuse or neglect of the infant?

You should make a referral to ChildLine at 1-800-932-0313 or at the self-service portal online at http://www.compass.state.pa.us/cwis.

If a baby is born across state or county lines, how will we ensure the notification is made to ChildLine?

CAPTA is a federal law; therefore, every state is required to ensure they have policies and procedures in place to comply. Pennsylvania will continue to receive notifications from neighboring state child protective services and other systems for concerns surrounding child well-being and safety, including notifications of infants born affected by substances.

Is there funding or an initiative to create a new notification process that does not get funneled through the Children and Youth system

Not currently. CAPTA requires the Department of Human Services be notified of all substance affected infants. Providing families with information about the required substance affected infant notification and voluntary POSC as soon as the health care provider or other involved professional (home visiting, mental health provider, substance use counselor) suspects the infant may be substance affected helps to decrease the family's anxiety regarding the notification and increase participation in Plans of Safe Care.

Is it mandated that all hospital Neonatal Intensive Care Units (NICUs) participate?

Pennsylvania Act 54 of 2018, (of the Child Protective Services Law) states “For the purpose of assessing a child and the child’s family for a Plan of Safe Care, a health care provider shall immediately give notice or cause notice to be given to the department (Human Services) if the provider is involved in the delivery or care of a child under one year of age and the health care prover has determine, based on standards of professional practice, the child was born affect by substance use or withdrawal symptoms resulting from prenatal drug exposure; or fetal alcohol spectrum disorder.”

Screening and Identification of Substance Affected Infants

What is the difference between universal screening and universal testing?

Screening is the determination of need for emergent care in the areas of withdrawal management, prenatal or psychiatric care. It is a short series of questions to identify the need for services and determine if further assessment is necessary. Screening is differentiated from testing in that testing involves biological samples such as blood, urine, meconium or umbilical cord.

Are medical staff required to test all newborns for substance exposure?

No, however, the Pennsylvania Department of Health recommends universal screening for all newborns.

Are medical staff required to test all delivering women for substance use?

No, however, Pennsylvania Department of Drug and Alcohol Programs recommends universal screening for all pregnant women. Screening should be inclusive of illicit drug, prescription drug, alcohol and tobacco use. All of these are risk factors that may impact infant and maternal health outcomes.

Are medical staff required to use specific screening tools?

No, however, both Pennsylvania Departments of Health and Drug and Alcohol Programs recommend that providers utilize an evidence-based, validated tool that meets the needs of the provider and the population served. No one tool is recommended or required.

What tools are available for to use for screening?

Some recommended screening tools, including the Institute for Health and Recovery's Integrated 5 P's Screening Tool, NTI Upstream's 4P's Plus©, ASSIST V3.0 (Alcohol, Smoking and Substance Involvement Screening Test), CAGE-AID (Cut Down, Annoyed, Guilty, Eye Opener Adapted to Include Drugs), and CRAFFT (Car, Relax, Alone, Forget, Family or Friends, Trouble) for adults and pregnant women. For newborns, Finnegan's Neonatal Abstinence Scoring Tool and the Lipsitz Tool are widely used.

Is there widespread prenatal drug testing available to obstetricians that is not cost prohibited? Are there grants or funds available for OBs to do prenatal drug testing for all women and not just those suspected of use?

The Department of Health recommends a public health, population-based approach, consistent with the American College of Obstetrics and Gynecologist (ACOG) recommendations, in which all pregnant people are screened for substance use. Screening is a short series of questions designed to determine risk, not to generate a formal diagnosis as per the Diagnostic and Statistical Manual of Mental Disorders (DSM), which is the standard classification of mental disorders used by mental health professionals in the United States, or to determine need for treatment. Screening is differentiated from testing in that testing involves biological samples such as blood, urine, meconium or umbilical cord. The department does not recommend universal testing of pregnant people.

Screening can vary across healthcare settings, why not a standard, recommended screening protocol (in pregnancy and infancy immediately after birth)?

Both Departments of Health and Drug and Alcohol Programs recommend that providers utilize an evidence-based (validated) tool that meets the needs of the provider and the population served. Several screening instruments for alcohol and other drug use have been validated for use during pregnancy. Other screening instruments that have been validated for screening of adult women, but not specifically for prenatal or antenatal screening. There is no consensus regarding which tool is best.

How can other substances besides alcohol and opiates be captured in the POSC process? It seems that only alcohol and opiates are identified as having a detectible effect on the infant.

Examples of newborn screening tools are listed in the POSC Guidance. Health care providers should use their professional judgment to identify universal screening practices and tools that cover a wide range of substance withdrawal.

Do you have a recommended best practice for determining "affected by"? Is consistency across birth centers in methods for identifying if an infant is affected by substances a goal? (i.e., is it ok for there to be different practices, including us of Finnegan score vs Eat, Sleep, Console vs cord testing?)

It is acceptable for hospitals to use a variety of methods to determine if an infant is affected by prenatal substance exposure. The Department of Health recommends a public health, population-based approach, consistent with the current practice of screening all newborns in Pennsylvania for metabolic, endocrine, hemoglobin, heart disease and hearing loss. Universal substance screening for newborns compared to targeted screening removes potential bias from practitioners and places the identification of withdrawal symptoms in the context of a medical condition.

Universal substance screening for newborns involves monitoring and assessing for signs consistent with withdrawal and scoring each newborn with specialized tools. The Modified 19 Finnegan's Neonatal Abstinence Scoring Tool is the most widely used tool due to its comprehensive nature and use for a wide range of substance withdrawal. The Lipsitz Tool was previously recommended by the American Academy of Pediatrics (AAP) due to its relatively simple metric and good sensitivity. Both tools are available in the public domain with versions modified to practice needs. It is important to note that both tools were developed for use in full-term infants. Currently, the AAP does not recommend a specific tool, but stresses that a chosen tool be used correctly by properly trained staff.

Individual Plan of Safe Care Development

What is required to be in a Plan of Safe Care?

CAPTA and Act 54 require a Plan of Safe Care to address the health of the infant and the health and substance use disorder treatment needs of the affected family or caregiver. The plan should also identify the most appropriate lead agency; assess the needs of the child, the child's parents, and immediate caregivers; and engage the child's parents and immediate caregivers to identify the need for access to treatment for any substance use disorder or other physical or behavioral health condition that may impact the safety, early childhood development, and well-being of the child.

Pennsylvania's Plan of Safe Care Guidance states that Plans of Safe Care should specify the agencies that are providing specific services, outline communication procedures among the family and provider team, and guide the coordination of services across various agencies with the family.

At what point do we include families in our planning process for Plans of Safe Care?

The family is a key member of the multidisciplinary team and should be the primary participants in the initial multidisciplinary team meeting and engaged throughout the development and implementation of the Plan of Safe Care.

In counties, who primarily oversees the process? Is it the county child welfare agency or is it more often Early Intervention (EI), a mental health provider, etc.?

It depends on the size and resources of the county. Many of the POSC Support Grant counties contract with a community-based provider to lead the POSC in instances when there isn't a need for further child welfare involvement. The Plan of Safe Care Guidance (2019) encourages the development of collaborative partnerships for coordinating and supporting a family-focused system that delivers prevention, EI, public health and community-based treatment services. The local county planning teams should regularly assess their membership to identify any potential gaps in agencies and organizations that provide services to impacted families and infants.

What should we do if a family does not want a Plan of Safe Care and does not want to engage the multidisciplinary team?

Counties should develop policies and protocols to follow when a family refuses to engage with the multidisciplinary team and/or the Plan of Safe Care. If there are safety concerns for a child, those concerns should be immediately reported to ChildLine.

Is it acceptable to have a multidisciplinary team meeting to develop a Plan of Safe Care after the infant is discharge from the hospital?

It depends. Per the law, the initial multidisciplinary team (MDT) meeting should be convened prior to the infant's discharge from the hospital if the health care provider determines the newborn to be affected by substances at birth. However, for infants identified as substance exposed after their discharge from the hospital, such as at a well-visit with the child's pediatrician, ChildLine must be notified immediately and the MDT must be convened within 72 hours of that notification, per the Pennsylvania Plan of Safe Care Guidance.

Who is responsible for bringing together the multidisciplinary team after an infant is identified and a notification is made to ChildLine?

For infants identified as at birth, the hospital social worker or other appropriate staff person, such as a patient care representative or discharge coordinator, should convene the initial MDT meeting. Hospitals should update their policies and procedures to determine the best way to comply with this law.

For infants identified as affected by substance use after their discharge from the hospital, such as through a well-child visit with their pediatrician or an appointment with the pregnant person's OB/GYN, the health care provider or appropriate staff will make the notification and a county children and youth

caseworker will be assigned to convene the initial MDT meeting. County children and youth agencies should update their policies and procedures to determine the best way to comply with this law.

In situations when the health care provider does not convene the MDT it is the responsibility of the county child welfare agency to do so.

What role should county children and youth agencies play? Is their involvement required?

Upon determination that an infant has been affected by substances, whether prenatally, at birth, or in the infant's first year, the health care provider is required to notify ChildLine, Pennsylvania's statewide hotline for reports of suspected child abuse and general protective services. Upon receipt of a substance affect infant notification ChildLine staff transmit the information to the appropriate county children and youth agency. The county children and youth agency will determine if there are additional safety concerns, for the infant, that require on-going involvement by the agency. If so, a general protective services case may be opened, and the Plan of Safe Care will be led by the county children and youth agency. If there are no additional safety concerns the Plan of Safe Care multidisciplinary team does not need to include child welfare.

If a county children and youth agency declines to be involved, how can the process be moved forward?

If the county children and youth agency determine there are no additional safety concerns, for the infant, the Plan of Safe Care multidisciplinary team does not need to include child welfare. Another agency may lead the Plan of Safe Care multidisciplinary team.

What role do state recommended evidence-based family support programs have in Plans of Safe Care?

Evidence-based family support programs can play an important role in supporting parents and caregivers after discharge from the hospital. Plans of Safe Care are individualized to meet the unique needs of each family. The multi-disciplinary team working with the substance affected infant and their family will determine which, if any programs are best suited to meet the presenting needs.

What role does a Family Center play in the Plans of Safe Care?

Family Centers can play an important role in supporting parents and caregivers after discharge from the hospital. Plans of Safe Care are individualized to meet the unique needs of each family. The multi-disciplinary team working with the SAI and their family will determine the best, if any role the family center, can play to meet the family's presenting needs.

Are there any special considerations or protocols when a kinship caregiver is taking the child home?

Plans of Safe Care are for the SAI and parents/ caregivers. If the kinship family is willing to participate in a POSC they will access to the full array of services and supports offered to any other family/ caregiver

Are the specific timeframes for working with a substance affected infant and their family?

Specific practices related to time frames and agencies identified to lead the Plan of Safe Care are determined at the county level on a case-by-case determination.

What are the principles/protocols for determining when POSC follow-up is complete?

Specific practices related to time frames and agencies identified to lead the Plan of Safe Care are determined at the county level on a case-by-case determination.

Multidisciplinary Teams (MDTs)

Who should be a part of a multidisciplinary team?

Each multidisciplinary team (MDT) should be unique to the infant and family's circumstances and needs. Potential members of the MDT include public, maternal and child health providers or staff; professional home visitors; substance use disorder prevention and treatment providers; mental health providers; public and private children and youth agency caseworkers or staff; Early Intervention (EI) staff; representatives from the court systems, local education agencies, managed care organization and private insurer care coordinators and hospital/medical providers, such as hospital social workers.

What if a child is identified as affected by substances after their discharge from the hospital? How soon must an MDT meet?

For infants identified as substance exposed after their discharge from the hospital, such as at a well-visit with the child's pediatrician, ChildLine must be notified immediately and the MDT should be convened within 72 hours of that notification, per the Pennsylvania Plan of Safe Care (POSC) Guidance.

Are MDTs required to meet in person? Can MDTs utilize conference calls or video calls?

MDTs are not required to meet in person; conference and video calling can be utilized when available.

Must the Plan of Safe Care be fully developed at the initial MDT meeting?

No, the convening of the initial MDT meeting is the start of a Plan of Safe Care (or initial modification for those developed prenatally). It does not need to be fully developed within the initial meeting, as needs and resources will be identified for the family at subsequent meetings.

How is the lead for the Plan of Safe Care determined?

When determining who should receive a Plan of Safe Care, and who should take the lead on monitoring that the identified referrals are made and services received, consider the population with which you are working:

- Population 1: Women who are using legally prescribed medications, including opioids, for chronic pain or medication that can result in withdrawal symptoms and do not have a substance use disorder
- Population 2: Women who are receiving medication assisted treatment for an opioid use disorder and/or are actively engaged in treatment for a substance use disorder
- Population 3: Women who are misusing prescription drugs or are using other legal or illegal substances, may meet criteria for a substance use disorder, and are not actively engaged in a treatment program.

For the first two populations, the MDTs should determine who will be responsible for leading the creation and implementation of the Plan of Safe Care. If the use of MAT or engagement in treatment is relatively new, for the second population, the county children and youth agency may need to be

involved to help support a pregnant person's continued engagement in substance use treatment and that she is receiving the external support she needs. For the third population, the county children and youth agency should be responsible for the creation and implementation of the Plan of Safe Care.

Which county will be responsible to convene a MDT for a Plan of Safe Care if a baby is born in one county and transfers to another?

The MDT should be convened in the infant and family's county of residence.

Is there a universal template that must be utilized for all Plans of Safe Care?

No, counties are welcome to develop their own templates and forms for Plans of Safe Care. However, an example, in both pdf and word document form, can be found on the KeepKidsSafe website.

Can Plans of Safe Care be included in a Child Safety Plan, Family Service Plan, Hospital Discharge Plan or Substance Use Treatment Plan if it fulfills all the needs of the infant/family?

It depends; a Plan of Safe Care is unique from each of the above-mentioned service plans. Typically, this will mean that Plans of Safe Care should remain distinct documents. However, for situations in which the county children and youth agency is the lead and in which the family is already open for services, the agency may include the Plan of Safe Care as an addendum to the Family Service Plan, to avoid duplication of effort.

Must Plans of Safe Care be monitored for a specific amount of time?

No, there are no statutory requirements surrounding timeframes for monitoring plans of safe care. Each MDT should determine the appropriate intervals at which the team should meet to review the plan and the infant and family's continued need for services and supports. The frequency of meetings should be determined based on each individual case but should be at least monthly. These intervals will likely be more frequent at the onset of a plan and become less frequent as the plan is implemented.

Who determines when a Plan of Safe Care is no longer needed?

Consistent with the individualized nature of Plans of Safe Care, the MDT lead will continuously assess each individual situation to ensure all the needs of the family are being met.

Consensus among the involved entities is needed when determining that changes should be made to a plan or that a plan is no longer needed.

Are there any circumstances when the MDT can decide that a plan of safe care is not warranted?

Federal and state law requires a Plan of Safe Care to be offered to all identified substance affected infants and their families/ caregivers. Elements of the Plan of Safe Care are determined by the needs of the SAI and their family/ caregivers. The MDT can and should make suggestions regarding resources that will best meet the needs of the SAI and their family/ caregivers.

What can those who work with Kinship Caregivers do to be proactive with DOH concerns?

Kinship family members caring for substance affected infants are encouraged to participate in a Plan of Safe Care to support them and the infant. Kinship families are not required to make a report to the Department of Health but can and should report any concerns they have regarding the infant in their care to the infant's primary health care provider

Monitoring / Data Collection

Who is going to monitor that the Plans of Safe Care (POSC) are created and implemented?

On the statewide level, there is no definition of "monitoring" in federal law and CAPTA does not specify what the state level monitoring system must consist of. In guidance provided to states, the Administration for Children and Families has confirmed that a "state agency" is required to monitor the implementation of Plans of Safe Care. As a state-supervised, county-administered system, the county child welfare agency is considered a "state agency" and may both develop and monitor Plans of Safe Care. Other state agencies, such as the Departments of Health and Drug and Alcohol Programs, may also monitor Plans of Safe Care.

As discussed in the Pennsylvania Plan of Safe Care Guidance, multidisciplinary teams (MDTs) are responsible for monitoring the implementation of individual Plans of Safe Care. In particular, the designated lead for each MDT is tasked with ensuring the Plan of Safe Care is appropriately updated, edited as needed, and closed when necessary.

How will POSC be monitored and by whom?

When county children and youth agencies are the lead on a Plan of Safe Care the plan is to be included in the family's case chart. Pennsylvania Department of Human Services, Office of Children, Youth and Families licensing staff may ask to see the plan and will note if a plan was offered to the family /caregiver of a substance affected infant.

What data will be collected?

The Department of Human Services is required to submit the following data to the federal government on an annual basis:

- The number of infants identified as being affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or FASD;
- The number of infants for whom a plan of safe care was developed; and
- The number of infants for whom referrals were made for appropriate services, including services for the affected family or caregiver.

What will be required at licensing for child welfare agencies?

For Plans of Safe Care in which the local children and youth agency is the designated lead:

- County children and youth caseworkers and supervisors should keep record in the family's case file that includes the Plan of Safe Care; a list of the members of the MDT; proof of referrals to recommended services and supports, including contact information for the appropriate agencies; notes from regular MDT meetings; and any other documentation related to the Plan of Safe Care, including, but not limited to, release of information agreements and confidentiality agreements.
- The county agency is responsible for monitoring the implementation of Plans of Safe Care on an ongoing basis. This may take place during regular quality assurance activities such as case file reviews, supervision, peer reviews, etc.

During annual licensing inspections by the Department of Human Services, random sampling will be employed to assess overall agency compliance with the Pennsylvania Plan of Safe Care Guidance. Ten percent of case files pulled for review must include those for whom a Plan of Safe Care was created. The plan will be reviewed for compliance based on the Pennsylvania Plan of Safe Care Guidance. If agencies do not have the appropriate documentation regarding Plans of Safe Care in the case file for infants and families for whom a notification was made under section 6386 of the CPSL, a plan of correction will be required that outlines the agency's planned steps to remedy the violation and ensure future compliance.

How will the notifications to Childline be categorized and disseminated?

ChildLine caseworkers will be trained to categorize notifications of an infant born and identified as affected by substance use as either Information Only notifications or a General Protective Services (GPS)

referral, depending on the information provided. This information will be transmitted to the county of residence for the pregnant person and infant. If at any time the county children and youth agency obtain more information regarding the environment surrounding the family and believe the Information Only or GPS referral should be re-evaluated to a GPS or child protective services (CPS) referral, they can request that of ChildLine. *Note: until January 1, 2020, when the necessary changes are made to the Child Welfare Information System (CWIS), all notifications of an infant born and identified as affected by substance use, withdrawal symptoms related to prenatal drug exposure, or FASD will be categorized as GPS referrals (this is a continuation of previous practice). This is to allow time for the necessary technical updates and changes to be implemented in the system. Following January 1, 2020, the ability of ChildLine caseworkers to classify a notification as Information Only or a GPS referral will be possible. Currently, the county agency can screen out the referral or refer the family for community services if there are no safety or well-being concerns for the child.

Dissemination protocols for notifications of infants born affected by substances where child welfare does not need to be involved are still under development between the Departments of Health, Human Services and Drug and Alcohol Programs.

How are hospitals required to document Plans of Safe Care?

Under Act 54 of 2018, health care providers are required to notify the Department of Human Services of a child born affected by substances up to one year of age for the purpose of assessing the family for a Plan of Safe Care. The act does not require health care providers to participate in the development a Plan of Safe Care. However, the Departments of Health, Human Services, and Drug and Alcohol Programs encourage health care providers to initiate a meeting of the multidisciplinary team to develop of a Plan of Safe Care when an infant is born affected by substances.

How should we properly document refusals to participate in Plans of Safe Care?

Participation in a Plan of Safe care is voluntary for families. County Child Welfare agencies should simply note in the case file (when there is a general protective services case with a substance affected infant) that a Plan of Safe Care was offered to the family/ caregiver.

How effective is the Plan of Safe Care?

As a state supervised, county administered child welfare system information related to individual Plans of Safe Care is housed at the county level. The ability to track notifications on substance affected infants was added to the Child Welfare Information System (CWISE) in October 2020. This allows the commonwealth to track the number of notifications and the number of Plans of Safe Care for substance affected infants with a general protective service case.

The Role of Early Intervention (EI) Services

What role does Early Intervention have in Plans of Safe Care?

EI leaders should participate on local county planning teams in collaboration with other local systems that support pregnant and parenting families and their infants impacted by prenatal substance exposure, including alcohol. Early Interventionists or Service Coordinators may play a role on an individual child/family's multi-disciplinary team to develop/update a POSC.

Are infants who have been exposed to substances prenatally automatically eligible for Early Intervention based on diagnosis?

No, this diagnosis alone does not qualify an infant for Early Intervention service. They are eligible for screening and at-risk tracking.

Can/should Early Intervention participate in a Plan of Safe Care team for/with a pregnant person?

No, the county Early Intervention coordinator should be part of the county administrative planning group to develop procedures for Plan of Safe Care, but Early Intervention and Children and Youth Services do not have a role until the infant is born, other than to ensure all other partner agencies that may participate in a Plan of Safe Care with a pregnant mother (like home visiting) know about Early Intervention and how to engage/refer to Early Intervention once the child is born.

Can/should Early Intervention be on a Plan of Safe Care team while the infant affected by prenatal substance exposure is still in the hospital?

Yes, but service coordination is the only Early Intervention service that can be provided while the infant is still in the hospital, 30 days or less prior to discharge for planning.

Can/should Early Intervention complete eligibility evaluations while the infant is still in the hospital?

No, Infant/Toddler Service Coordination is the only Early Intervention service that can take place in the hospital, 30 days prior to discharge. The hospital should be able to provide information on the infant as part of the Plan of Safe Care that can be used to help determine if the infant is eligible for Early Intervention service. All infants affected by prenatal substance exposure are eligible for Infant/Toddler Early Intervention screening and tracking.

How long can an infant who was exposed to substances prenatally remain in Early Intervention tracking?

Until the child's third birthday.

How do we ensure all infants with prenatal substance exposure are referred to Early Intervention?

Each EI program must have a comprehensive child find system, in collaboration with the local interagency coordinating councils, in place to ensure all at-risk children and infants and toddlers with disabilities are identified, located, and screened or evaluated in their geographic area responsible. EI leaders should ensure referrals are made within 2 working days after a child has been identified from hospitals (prenatal and postnatal care facilities) and physicians. See EI state regulations for more detail: Title 55 PA Code §4226.24. On a state level the DHS and DOH have a data sharing agreement in which infants diagnosed with NAS are checked to see if they have been referred to EI within 6 months of diagnosis.

If an infant does not qualify for EI at an early evaluation, how do we ensure that they are reengaged in the later months, when the infant is more likely to display signs of delay?

Infants who are prenatally substance exposed are eligible for at-risk screening and tracking if not eligible for IFSP services. Programs contact families regularly, at least once every 3 months, and use a standardized screening tool, Ages and Stages Questionnaire (ASQ) and if any concerns move to evaluation and service quickly. See EI state regulations for more detail: Title 55 PA Code §4226.26. Tracking system.

Should there be team follow-up meetings for everyone involved? How can we keep the client engaged in early intervention programs?

Yes, the frequency at which the multi-disciplinary teams come together to develop and monitor these Plans of Safe Care will differ based on the identified needs, risk factors and current situations of each family. Use the other members of the team to collaborate in planning how to keep families engaged in services.

Health Care Providers/Hospitals

What is the Department of Health's (DOH) role in the Plans of Safe Care (POSC)? Does the medical community alert the DOH when there is someone who meets these criteria?

The Department of Health works with health care providers through external and internal partnerships to increase awareness of Plans of Safe Care. The department is responsible for providing education and resources to hospitals and health care providers on notification requirements and plan development for infants born affected by substances. Health care providers notify the Department of Human Services upon identification of an infant or child up to one year who is affected by substances.

Is the medical community receiving training from the state regarding POSC reporting? What training has the medical community been offered by/through the Department of Health regarding Plans of Safe Care?

The Department of Health along with the Departments of Human Services and Drug and Alcohol Programs are exploring training opportunities for health care providers, hospitals, and health systems on Plans of Safe Care and notification of infants born affected by substances.

What steps can be taken when the medical community will not work with POSC? How to better engage the social workers and staff at the Hospital and Doctor's offices? How to effectively work with the medical community?

The Department of Health encourages health care providers to participate in the development of Plans of Safe Care. In 2022, the Departments of Health, Human Services, and Drug and Alcohol Programs are exploring training opportunities for health care providers, hospitals, and health systems. The goal of the trainings would be to increase awareness and understanding of the notification process and Plans of Safe Care.

Are obstetricians expected to make referrals to Plans of Safe Care prior to birth of the baby if the pregnant person is testing positive or obstetrician can readily see that the pregnant person is impacted by substance use, or the pregnant person admits substance use?

To clarify the notification to ChildLine is for a substance affected infant. This notification triggers the Plan of Safe Care process. A notification to ChildLine and subsequent development of a Plan of Safe Care is dependent on the effect of substances on the infant, therefore a substance affected infant notification to Childline cannot be made prior to the infant's birth. However, health care providers are mandated reports in the Commonwealth. If the pregnant person has other children in the home and an obstetrician or any professional involved in the care /treatment of the pregnant person has concerns for the safety of the children in the home, they are required to report such concerns to the Department of Human Services via ChildLine**.**

Is there a recommended best practice for determining "affected by"? Is consistency across birth centers in method for identifying if an infant is affected by substances a goal? (i.e., is it ok for there to be different practices, including us of Finnegan score vs Eat, Sleep, Console vs cord testing?)

Plans of Safe Care should be developed for families with an infant born affected by substances. Currently, Pennsylvania defines affected by as an "infant with detectable physical, developmental, cognitive, or emotional delay or harm that is associated with maternal substance use or withdrawal, as assessed by a health care provider."

The Department of Health recommends a public health, population-based approach, consistent with the current practice of screening all newborns in Pennsylvania for metabolic, endocrine, hemoglobin, heart

disease and hearing loss. Universal substance screening for newborns compared to targeted screening removes potential bias from practitioners and places the identification of withdrawal symptoms in the context of a medical condition.

Universal substance screening for newborns involves monitoring and assessing for signs consistent with withdrawal and scoring each newborn with specialized tools. The Modified 19 Finnegan's Neonatal Abstinence Scoring Tool is the most widely used tool due to its comprehensive nature and use for a wide range of substance withdrawal. The Lipsitz Tool was previously recommended by the American Academy of Pediatrics (AAP) due to its relatively simple metric and good sensitivity. Both tools are available in the public domain with versions modified to practice needs. It is important to note that both tools were developed for use in full-term infants. Currently, the AAP does not recommend a specific tool, but stresses that a chosen tool be used correctly by properly trained staff.

How do I know how to identify at-risk children? What children should be referred for a Plans of Safe Care family/child? Are the requirements/eligibility per medical facility? Which children should be referred for a Plans of Safe Care family/child? Are the requirements/eligibility per medical facility?

Any infant up to one year of age who was prenatally exposed to substances (for example alcohol or prescription opioid pain medication) or illegal (heroin) can display symptoms related to that exposure.

Some families come in for a meeting and the infant didn't even test positive for any substance and family circumstances don't really seem to warrant a referral. What training are hospital maternity departments receiving?

The Department of Health along with the Departments of Human Services and Drug and Alcohol Programs are exploring training opportunities for health care providers, hospitals, and health systems on Plans of Safe Care and notification of infants born affected by substances.

Drug and Alcohol/Substance Use Disorder and Mental Health Providers

What should the role of a Drug and Alcohol (D&A) specialist be?

It is important to remember that clinical and case management services are two separate activities. If the Drug and Alcohol (D&A) Specialist has the training to provide case management services, then connecting the family to necessary services such as treatment services or recovery support services should be done based on the individual and family needs. The Department of Drug and Alcohol Programs is strongly encouraging Single County Authorities to work with the family unit to address substance use needs. POSC is designed to be a team approach and therefore staff working directly with the family can be part of the POSC team.

Can D&A open up monies for all counties for a Certified Recovery Specialists CRS or something similar for help in this community?

Each Single County Authority (SCAs) is responsible for establishing a plan on how they can best provide services to residents in their area. Some SCAs have Certified Recovery Specialists (CRS)/ Certified Family Recovery Specialists (CFSR) that work at the SCA while others contract with local providers for CRS/CFRS services. As funds are made available, SCAs are permitted to request funding from the Department of Drug and Alcohol Programs (DDAP) for additional services. Also, when funding is available, DDAP posts various grant initiative funding opportunities for services such as recovery supports and pregnancy services.

What is role of D & A in follow-up when mom leaves the hospital?

The POSC team should discuss the most appropriate course of action for each member of the team. All families are different therefore the follow-up for each family will vary based on the family's needs.

How much information is going out to DA providers? Is the information informing them of their roles as a member of POSC?

Each Single County Authority (SCA) is responsible for taking part in the POSC Team. If the SCA chooses to pass this function to a contracted provider to fulfill the role as a POSC Team member, then the SCA would inform the provider of their obligations.

We have heard concerns from substance use treatment providers about effectively engaging with individuals about plans of safe care--things like being positioned to support individuals and not families; losing client trust or the person disengaging from treatment when potential child welfare involvement is raised. Can you speak to these concerns?

Use of techniques such as Motivational Interviewing (MI) is a valuable tool that can be used to engage clients and families. All case management staff hired 7/1/2020 are required to have training on MI. When used effectively, MI techniques are designed to build the client's self-confidence and trust in themselves, increase participation in recovery and empower the client to make better choices. One of the main goals of POSC is to educate and engage the family on resources that are available to assist them and reduce any potential safety concerns.

How do you support work within Fetal Alcohol with POSC?

Pennsylvania's Child Protective Services Law requires that a notification be made to DHS via ChildLine when a health care provider has been involved in the delivery or care of a child under one year of age and the health care provider has determined, based on standards of professional practice, the child was born affected by substance use or withdrawal symptoms resulting from prenatal drug exposure or FASD. When a child has been identified as affected by a substance, the POSC team would meet to discuss the needs of the child and family. Conversations around specific needs such as FASD, can be discussed by the team and a plan developed to assist the family.

How can DDAP and home visiting services (Nurse-Family Partnership) better connect to provide referrals and additional support of at-risk, pregnant women?

Local Single County Authorities (SCA) often work with community partners to deliver services to targeted populations. Pregnant women who inject drugs and pregnant people who use substances are consider priority populations at DDAP. Contacting your local SCA to discuss options for collaborations and to gain a better understanding of the Nurse Family Partnership program is encouraged.

How often are drug and alcohol programs seeing or engaging with women prenatally?

There are multiple points of entry to access substance use disorder services. Self-referrals, criminal justice referrals and warm handoff connections in emergency departments tend to be where most prenatal women are seen by Single County Authorities.

What should the role of the Single County Authority be if treatment providers are already engaged with the family?

Single County Authorities (SCAs) can offer case management services to families regardless of the entity that is funding treatment. Many SCAs also have recovery support services that can be available to individuals and families in various stages of recovery.

What is being done to decrease stigma?

Act 54 amended Pennsylvania's Child Protective Services Law and requires that notification be made to the Pennsylvania Department of Human Services via ChildLine when a health care provider has been involved in the delivery or care for a child under one year of age and the health care provider has determined, based on standards of professional practice, the child was born affected by substance use, withdrawal symptoms resulting from prenatal drug exposure or FASD. While notification of substance affected infants does not, by law, constitute a report of child abuse it is the role of the county child welfare agency to determine if there are additional safety concerns that require on-going involvement by the agency. The information only notification may be later recategorized as a higher priority general protective services or child protective services referral if additional concerns are identified during the initial meeting or after the county children and youth agency reviews the initial notification (Pennsylvania Plans of Safe Care Guidance, 2019).

Providing families with information about the required substance affected infant notification and voluntary Plan of Safe Care as soon as the health care provider or other involved professional (home visiting, mental health provider, substance use counselor) suspects the infant may be substance affected helps to decrease the family's anxiety regarding the notification and increase participation in Plans of Safe Care.

Is there a list available of all the current DDAP licensed residential treatment programs for pregnant persons/ persons with dependent children in Pennsylvania, and if so where can it be accessed?

There has been a large fluctuation in PW residential services in the commonwealth. Contact DDAP's Division of Treatment for the most recent information.

What role should mental health providers take in POSC?

Mental health services are vital to a successful POSC. The Office of Mental Health and Substance Abuse Services is a partner at the state level, and county Plan of Safe Care Teams are encouraged to include professionals from local mental health agencies and county MH/IDD.

Confidentiality Questions

How can we share information with the multidisciplinary team?

Information can be shared among planning team members with signed consent from the client. Each member of the multidisciplinary team is bound by state and/or federal confidentiality regulations related to their respective discipline.

How does 4 PA Code §255.5, related to disclosure of client-oriented information, affect this work and the ability of a MDT to collaborate?

With signed consent by the client, information can be shared with the multidisciplinary team within the confines of state and federal substance use disorder confidentiality regulations. According to *4 PA Code §255.5*, individuals such as judges, probation or parole officers, insurance companies, health or hospital plan or governmental officials are restricted to the following information about a client in treatment for substance use disorder:

(1) Whether the client is or is not in treatment.

(2) The prognosis of the client.

(3) The nature of the project.

(4) A brief description of the progress of the client.

(5) A short statement as to whether the client has relapsed into drug or alcohol use, and the frequency of such relapse.

Thus, when releasing information to MDT members, consideration should be given to the roles of the members of the teams. Importantly, there are no limitations on the types of information that an MDT can provide to a client's treating physicians.

The limitations on release of information detailed in 4 PA Code 255.5 do not preclude other entities such as mental health, Early Intervention, or hospital staff from releasing additional information. Those

entities are bound by their own confidentiality and privacy regulations and should refer to them for guidance.

How do we share information if a client does not consent?

When consent is not obtained by the client, the multidisciplinary planning team should develop a process to assess the needs and safety of the client and family members without disclosing client identifying information to members of the multidisciplinary team.

How can you make it easier for D&A facilities to communicate with community partners and vice versa, as privacy regulations are extremely restrictive, and we cannot communicate with other agencies without a client's consent?

Each county has a POSC team. Local Single County Authorities (SCA) and contracted SUD providers are part of the POSC team. Client consent is required to share information with other team members. Engagement strategies can be used by all team members to educate individuals and family members that the POSC team is designed to assist infants and caregivers to get the treatment/recovery supports they need.

Collaboration between community-based providers and county agencies

What efforts have been undertaken by the state agencies to ensure this information is disseminated widely so that practice can change?

The Departments of Health, Drug and Alcohol Programs, and Human Services convened an interdisciplinary workgroup in 2016 to ensure compliance with the changes to CAPTA and to develop a Pennsylvania policy agenda regarding infants born affected by substances from a comprehensive, public health approach. The Multidisciplinary Workgroup on Infants Born Substance Exposed (MDWISE) continues to meet and assist in the development of materials helpful for practitioners affected by this change in the law. The MDWISE assisted in the development of the Pennsylvania Plan of Safe Care Guidance, and is partnering with the Pennsylvania Perinatal Quality Collaborative, the Hospital and Health System Association of Pennsylvania, the Opioid Data Dashboard and other workgroups to ensure information regarding CAPTA and Act 54 is disseminated as widely as possible.

How can we help the medical community make appropriate referrals even if the child does not meet the level of care for Plans of Safe Care?

Plan of Safe Care County Planning Teams can provide education to health care providers regarding the definition of Substance Affected Infant and the process for notifying the Department of Human Services of a Substance Affected Infant via ChildLine.

A notification to ChildLine and subsequent development of a Plan of Safe Care is dependent on the effect of substances on the infant, therefore a referral for a Plan of Safe Care is not required during the prenatal period. Affected by is defined as “infant with detectable physical, developmental, cognitive, or

emotional delay or harm that is associated with maternal substance use or withdrawal, as assessed by a health care provider." While it is best practice to offer a Plan of Safe Care to a family during pregnancy, it is not required by Act 54 of 2018.

What can those who work with Kinship Caregivers do to be proactive with Department of Health concerns?

Kinship family members caring for substance affected infants are encouraged to participate in a Plan of Safe Care to support them and the infant. Kinship families are not required to make a report to the Department of Health but can and should report any concerns they have regarding the infant in their care to the infant's primary health care provider.

What role do state recommended evidence-based family support programs have in Plans of Safe Care?

Evidence-based family support programs can play an important role in supporting parents and caregivers after discharge from the hospital. Plans of Safe Care are individualized to meet the unique needs of each family. The multi-disciplinary team working with the SAI and their family will determine which, if any programs are best suited to meet the presenting needs.

What role does a Family Center play in the Plans of Safe Care?

Family Centers can play an important role in supporting parents and caregivers after discharge from the hospital. Plans of Safe Care are individualized to meet the unique needs of each family. The multi-disciplinary team working with the SAI and their family will determine the best, if any role the family center, can play to meet the family's presenting needs.

How can the state Infant/ Early Childhood Mental Health Consultation (IECMHC) program connect with county partners about supporting the infants' caregivers in the child's early childhood education/childcare setting as a part of a POSC?

The Plan of Safe Care Guidance includes social/ emotional development in the definition of 'affected by'. IECMHC can contact the county child welfare agency to obtain the name of the POSC contact person and/or contact information for community-based agencies engaged in POSC work.

My question is not answered in the Plan of Safe Care Guidance these FAQs - who do I contact?

Email questions related to Plans of Safe Care to the following resource account:
RA-PWPLANSOFSAFECARE@pa.gov