NH's Plans of Safe Care Guidance Document

This document provides general guidance about Plans of Safe Care (POSCs)[1] as well as answers to questions received from professionals related to Plans of Safe Care.

In compliance with federal law, NH law (RSA 132:10-e & 10-f) requires the development of a POSC "[w]hen an infant is born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure or a fetal alcohol spectrum disorder." If possible, it is recommended that the POSC be started prenatally and serve as a living document throughout the pregnancy and after birth.

This document was drafted in collaboration with the Perinatal Substance Exposure Task Force of the New Hampshire Governor's Commission on Alcohol and Other Drugs. For more information about Plans of Safe Care, visit the POSC webpage: https://nhcenterforexcellence.org/governors-commission/perinatal-substance-exposure-task-force/plans-of-safe-care-posc/

Questions about Plans of Safe Care may be emailed to: 2019POSC@gmail.com.

GENERAL POSC GUIDANCE	
1. What is a Plan of Safe Care? What is its purpose?	A Plan of Safe Care (POSC), developed collaboratively with the mother and other involved caregivers, reinforces existing supports and coordinates referrals to new services to help infants and families stay safe and connected when they leave the hospital.
2. Who needs a POSC?	A POSC must be developed for any infant exposed to drugs and/or alcohol prenatally.[2] One POSC is developed for both the mother and infant. Many providers may decide to develop POSCs with all new mothers and infants.
3. Who develops the POSC? When is it developed?	The POSC is developed by a health care provider and the mother and must be completed after an infant's birth before the mother's discharge. Best practices, however, support developing the POSC prenatally to serve as a living document throughout the pregnancy and after birth.
4. How will the POSC be shared?	The POSC must be given to the mother upon discharge from the hospital or birth center. Best practices for providers include encouraging the mother to share the POSC with the people, professionals and agencies who are currently supporting her, and those who will provide her with the new services or supports she needs to care for herself and her infant, including the mother and infant's other care providers. In addition, best practices include the hospital sharing the POSC with the infant's primary care provider along with the infant's other medical records. The POSC is not shared with DCYF unless a report of child abuse and/or neglect is made. When a provider reports child abuse and/or neglect, the POSC must be shared with DCYF.
5. What is the federal "notification" requirement? How is it different from a mandatory report?	Consistent with federal law, New Hampshire has a process for hospitals to notify officials when an infant is born with and identified as being affected by substance use or withdrawal symptoms resulting from prenatal drug exposure or Fetal Alcohol Spectrum Disorder. New

[1] All providers should consult with their own supervisors and compliance teams for more specific guidance in implementing Plans of Safe Care at their institution.

[2] New Hampshire's Plan of Safe Care development law for the protection of maternity and infancy, effective June 26, 2018, can be found at RSA 132:10-e and 10-f.

	Hampshire must then report annually to the federal Children's Bureau the aggregate number of infants born with prenatal drug and/or alcohol exposure for whom a POSC was created and referral(s) provided. New Hampshire's standard for notification and reporting is not the same as for provider mandatory reports of child abuse or neglect. Mandatory reporting is required under NH RSA 169-C:29 whenever anyone has a reason to suspect child abuse or neglect. The fact that an infant is born with prenatal exposure to drugs and/or alcohol does not itself require a mandatory report. So too, the fact that a provider develops a POSC with a mother does not necessarily mean the provider has a reason to suspect child abuse or neglect requiring a mandatory report. Notification and reporting are different processes with different standards.
6. How do providers notify the State about the birth of an infant exposed to drugs and/or alcohol?	Upon the infant's birth, the birthing center or hospital will answer the birth certificate worksheet questions about the infant's substance exposure. New Hampshire will then fulfill its federal data reporting requirements by aggregating data received and submitting de-identified data to the federal Children's Bureau on an annual basis.
7. Are hospitals required to make a mandatory report for all infants exposed prenatally to drugs and/or alcohol?	No. A provider may determine it is not necessary to make a report of child abuse and/or neglect to the Division for Children, Youth & Families (DCYF) even though a POSC is developed for the infant due to the infant's prenatal drug and/or alcohol exposure. For example, an infant exposed prenatally to drugs due to prescribed medication under a clinician's direction AND without any child safety concerns does not need to be reported to DCYF.
8. What happens to the POSC when a report of child abuse and/or neglect is made?	If providers make a report of child abuse and/or neglect, the POSC must be shared with DCYF according to New Hampshire's Plan of Safe Care development law (RSA 132:10-e and 10-f).
9. Does the POSC contain information protected by state and federal privacy laws?	The POSC does include private health information that identifies the mother and child and may be protected from disclosure by health and substance use disorder record confidentiality laws. However, the mother is encouraged to share this POSC with her existing and new services and supports, including the mother and infant's primary care providers. In addition, if a report of child abuse and/or neglect is made, the POSC must be shared with DCYF. Otherwise, the POSC should be treated like other patient information and shared consistent with privacy practices.
10. What types of services are included in the POSC?	A POSC may include referrals for both the infant and mother, and father (or other involved caregiver). Referrals for supports and services may include family resource centers, parenting support groups, home visiting, mental health counseling, substance use counseling, peer recovery coaching, medication assisted treatment, and Drug Court, as well as others.
11. What if a mother declines to participate in developing a POSC?	The healthcare provider should attempt to collaboratively develop a POSC with the mother. There will be times a mother will decline to participate. Absent child protection concerns, the refusal to develop a POSC does not itself warrant a mandatory report under NH RSA 169-C:29.

ADDITIONAL POSC GUIDANCE	
1. When will the POSC be "live" in every NH hospital?	The state law requiring the development of POSCs went into effect on June 26, 2018. NH DHHS has disseminated a letter regarding POSC requirements to all relevant parties. A POSC template, guidance document, implementation checklist and other resources are available on the Perinatal Substance Exposure Task Force web page.
2. What does state law require regarding Plans of Safe Care?	In compliance with federal law, NH law (RSA 132:10-e & f) requires that a Plan of Safe Care must be developed to support the infant and mother "[w]hen an infant is born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure or a fetal alcohol spectrum disorder." The health care provider is responsible for developing the Plan of Safe Care collaboratively with the parents or guardians and the department of health and human services, division of public health services, as appropriate, "to ensure the safety and well-being of the infant, to address the health and substance use treatment needs of the infant and affected family members or caregivers, and to ensure that appropriate referrals are made and services are delivered to the infant and affected family members or caregivers." The POSC must take into account whether the infant's prenatal exposure occurred as the result of medication assisted treatment or other prescribed medication, as well as whether the mother is or will be actively engaged in ongoing substance use disorder treatment following discharge that would mitigate future risk of harm to the infant. A copy of the POSC should be included in the instructions for the infant upon discharge. If possible, it is recommended that the POSC be started prenatally and serve as a living document throughout the pregnancy and after birth.
3. What is the definition of "affected" by substances?	The law does not specifically define "affected by." Some health care providers will interpret this requirement as applicable to any infant who has been exposed to substances in utero and experienced any detectable physical, developmental, cognitive, or other delay or harm as a result, including presenting with withdrawal symptoms. However, not all effects of substances – both illegal and legal - on the infant are detectable at birth. Health care providers are encouraged as a best practice, though not required by law, to develop a POSC with all new infants and mothers, whether exposed to substances or not, but especially for those infants that have been exposed to substances in-utero.
4. Is the POSC always developed by the health care provider or can a social service provider (e.g., home visitor) develop this plan?	By law, a POSC must be developed by the "health care provider" when an infant is born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure or fetal alcohol spectrum disorder. According to state-recommended best practices, the POSC should be started prenatally and serve as a living document, to be added to by any/all maternal-infant care providers, throughout the pregnancy and after birth. There is thus every reason to encourage all maternal-infant providers including social service providers (e.g., community health workers, social workers, home

	visitors) who interface with pregnant women to participate in development of the POSC whenever possible and helpful to the family including during the pregnancy and after delivery.
5. Can anyone help a mother fill out the POSC?	Yes. Any member of the mother's and infant's care team, along with a co-parent or other caregiver may be involved in developing the POSC, depending on the mother's needs and as appropriate to the infant's care.
6. Is the POSC given to the mother in multiple ways?	Yes. At minimum, the mother should receive her own printed copy of the POSC at the time of her newborn's discharge (or sooner if the infant will be discharged with a caregiver other than the mother) as it was developed/finalized with the newborn's care team. If possible and if preferred by the mother, share the POSC with her electronically. According to NH law, "a copy of the POSC shall be included in the instructions for the infant upon discharge from the hospital or from the health care provider involved in the development of the POSC." Optimally, the POSC would be initiated and shared with the mother during the pregnancy so that she can share with her other providers and care agencies so they can help co-develop the POSC.
7. Does the hospital forward the developed POSC to the pediatric provider or is the mother responsible for sharing the plan?	The hospital should forward the POSC to the baby's pediatric care provider (i.e., pediatrician, family medicine provider) at the time of the newborn's discharge. The POSC must be included in the instructions for the infant upon discharge from the hospital, with a copy provided to the mother. The POSC may, however, contain information protected from disclosure by confidentiality laws and should be shared consistent with the provider's/hospital's privacy practices.
8. How would the POSC be approached if the infant's father, a grandparent, or a foster parent, is awarded custody or guardianship?	In the event that someone other than the birth mother has been awarded custody or guardianship of the infant, the POSC may be developed with the person who has custody, guardianship, or is otherwise permissibly involved in caring for the infant. In this scenario, it is very important that the mother's information be protected from disclosure by confidentiality laws and the hospital's privacy practices.
9. The POSC template requests information about the "father." Is this intended to apply to another custodial parent? Or the biological father? This is potentially discriminatory against same sex couples or non-biological second parents.	The POSC template can be modified to meet the needs of the parents. The template does include space to list other caregivers if relevant. The template is offered to assist healthcare providers with identifying key information that needs to be collected to meet federal/state requirements.
10. What is the best way to introduce creating a POSC?	Best practice suggests that the POSC be introduced early, often, and if possible, with all mothers to reduce stigma and help infants and families stay safe and connected during the pregnancy and after delivery. It is acknowledged that this may not be possible or felt needed in individualized settings and scenarios. However, a discussion about current supports, goals and other services and supports needed could help introduce the POSC with every pregnant woman. There are many effective ways to introduce the POSC using supportive, non-judgmental language. Some providers recommend using the title "Plan of Supportive Care" instead of "Plan of Safe Care" for the POSC document, to emphasize a non-judgmental approach to supporting mothers as crucial

	partners in their babies' care. Both terms can be used interchangeably to refer to the same POSC requirement.
11. When a woman delivers in NH but is not a NH resident, does the hospital utilize NH's POSC process, or that of the woman's state of residence?	If a woman delivers in NH, health care providers should follow NH's POSC process.
12. How does the POSC apply to incarcerated women?	NH's POSC process should be completed with incarcerated women. If the mother will not be caring for the infant due to her incarceration, the POSC may be developed alternatively with the infant's identified caregiver. The POSC should be a living document, however, and if necessary may be amended to account for the mother's incarceration or release.
13. How does the implementation of a POSC happen for a home birth and for free standing birth centers?	If the POSC was not already developed by the prenatal healthcare provider, it should be developed by the healthcare provider the mother sees at the time or immediately following the birth of the infant, as the case may be. As above, the mother should receive a printed copy of her infant's Plan of Safe Care prior to being discharged home.
14. What is the difference between a "Plan of Care" and a "Plan of Safe Care"? Is this going to remain named Plan of Safe Care or will it be changed?	The federally required "Plan of Safe Care" is different from the document that DCYF develops in its reporting process, which is often referred to as a "plan of care." This is not the same as a "Plan of Safe Care" as discussed throughout this document, which is developed collaboratively with the mother to reinforce existing supports and to coordinate referrals to new services to help infants and families stay safe and connected when they leave the hospital. The name "POSC" comes from the federal and state statute. Some providers recommend using the title "Plan of Supportive Care" instead of "Plan of Safe Care" for the POSC document, to emphasize a non-judgmental approach to supporting mothers as crucial partners in their babies' care. Both terms can be used interchangeably to refer to the same POSC requirement.
15. When a report is made to DCYF does the POSC need to be submitted to DCYF for substance-exposed newborns?	Yes. If providers make a report of suspected child abuse and/or neglect to DCYF, a copy of the POSC shall accompany the report according to New Hampshire law, RSA 132:10-f.
16. Is a hospital required to provide information regarding prescribed medications to DCYF?	Not necessarily. As noted, mandatory reporting is required under state law whenever anyone has a reason to suspect child abuse and/or neglect. The fact that an infant is born with prenatal exposure to prescribed medications, even in the setting of signs of withdrawal symptoms, does not itself require a mandatory report. If a report of child abuse or neglect is made, DCYF may ask about the infant's exposure to drugs or alcohol.
17. If a patient is solely using marijuana during her pregnancy but no other illicit substances, is a report to DCYF needed when the infant is born?	As noted, mandatory reporting is required whenever anyone has a reason to suspect child abuse and/or neglect. The fact an infant is born with prenatal exposure to marijuana should not itself require a mandatory report, unless the provider(s) has reason to suspect abuse or neglect.
18. If a family was reported for having marijuana but does not allow DCYF in their home what happens to the report?	DCYF has statutes, rules and policies that direct how the agency investigates reports of child abuse or neglect and maintains its records.

19. How does RSA 169-C:12-e, which establishes a “rebuttable presumption of harm,” impact reporting?	It doesn’t. This NH provision of law makes “[e]vidence of a custodial parent's opioid drug abuse or opioid drug dependence” a rebuttable presumption of harm to the child for purposes of a court proceeding. However, this “presumption” can be rebutted by evidence of the parent's compliance with treatment for such use or dependence. This means a judge may assume a custodial parent misusing opioids is harming the child unless the parent is in treatment. This language applies not to the standard for making a report of abuse or neglect, but to an active legal case once allegations of abuse or neglect have already been made.
20. Does "prenatal drug exposure" in RSA 132:10-e include tobacco/nicotine exposure?	The law requires that a POSC be developed for infants affected by substance use or withdrawal symptoms resulting from prenatal drug exposure (either legal or illegal) or fetal alcohol spectrum disorder. The law does not specifically exclude nicotine exposure. It is recommended that a POSC be developed for any infant exposed to substances in the pregnancy. Hospitals may individualize the POSC to their own setting, as appropriate, regarding referrals to supports and services and interventions provided.
21. How do hospitals decide who to test for exposure to substances?	Universal prenatal screening, using validated screening questionnaires, brief intervention and referral to treatment using the “SBIRT” approach is recommended in pregnancy to identify women who use substances. Generally, hospitals adopt their own drug testing policies, which are then reviewed with the patient.
22**.** Who is responsible for monitoring and what will the monitoring consist of to meet the federal law (CAPTA/CARA) requirement that each state “monitor referrals and service delivery”?	The state is responsible for monitoring the implementation of POSCs. At present, the hospital is required to complete the NH Division of Vital Records Administration Situational Surveillance: Births Document, which includes two questions associated with the infant’s birth. Currently, the state does not have a mechanism in place through the birth certificate surveillance questions to monitor the development of POSCs for substance-exposed newborns.
23. What is the plan to make sure healthcare providers know about the federal/state POSC requirements?	NH DHHS has disseminated a letter regarding POSC requirements to all relevant parties. The NH Perinatal Substance Exposure Task Force and the Northern New England Perinatal Quality Improvement Network (NNEPQIN) have been providing ongoing education to providers about the POSC implementation process. A web page for the Perinatal Substance Exposure Task Force provides information and education regarding POSCs.
24. Is the POSC template final and do hospitals have permission to use this template? What is the plan to keep the POSC template up to date? Will the template be electronic?	The POSC template was finalized in July 2019 and can be used by any entity. The current template can be found on the Perinatal Substance Exposure Task Force’s POSC web page. The template is available as a Word document and as a fillable PDF form. The POSC template may be modified as necessary and was developed to foster compliance with the federal and state law, and to optimize the usefulness of the tool for supportive patient care.