CAPTA CARA – Frequently Asked Questions

Prepared: 6/2/2022

CAPTA CARA – Implementation

1. *Question: Does this legislation apply to obstetric patients treated in the Emergency Department (ED), those who are admitted to the hospital, or both?*

   Any pregnant patient and/or newborn identified as impacted by substance use should be offered the opportunity to complete a Plan of Safe Care (POSC). This can be done by health care providers in any setting and/or at any point when providing care. This can also be done by home visitors, community health workers, and peer navigators, and should include friends or family members of individuals who may benefit from the creation of a POSC for them and their newborn.

   For data collection purposes, the NYS Office of Children & Family Services (OCFS) is responsible for oversight and is requesting data on substance affected newborns from all birthing facilities in New York State. All births at each facility and regardless of the unit/department where the birth took place should be captured via the CAPTA CARA survey, which is available on the Health Commerce System (HCS). See FAQs below in Data Collection/Reporting Section.

Toxicology Testing, including Consent

2. *Question: If a newborn/neonate is displaying medically indicated symptoms, do we need consent to test the baby? Or can we test without consent?*

   There is no specific NYS Public Health Law or regulation that governs toxicology testing for pregnant people and/or their newborns. With the exception of emergency situations, a patient would need to give **informed consent** (meaning the risks, benefits, etc. are explained to the patient) prior to procedures/testing and that consent must be documented in the patient's medical record. Requiring informed consent aligns with Public Health Law 2805-d, as well as 10 NYCRR 405.7(b)(9), which details the Patients' Bill of Rights.

   Informed consent to perform a toxicology test on a newborn should be obtained from a parent/guardian prior to testing unless part of emergency care. Obstetric and Neonatal staff should work with legal counsel at their birthing facility to develop policies and procedures outlining consent requirements for toxicology testing for pregnant/birthing people and/or their newborns. These policies should clarify whether verbal or written statements meet the requirement for informed consent.

3. *Question:* *If it is known that the pregnant/birthing person has used substances, illicit or prescribed during pregnancy, is that a medical indication for toxicology testing of the pregnant/birthing person?*

   Toxicology testing for substance use during pregnancy and/or delivery should only be done when medically indicated and/or necessary to treat the patient. The Department recommends that practitioners follow guidance from the American College of Obstetricians and Gynecology on verbal screening and toxicology testing for substance use during pregnancy/delivery. This guidance recommends that, prior to performing toxicology testing, providers obtain "informed consent including explanation of the medical indication for the test, information regarding the right to refusal, and the possibility of associated consequences for refusal and discussion of the possible outcome of positive test results."

   Informed consent should be a standard practice prior to testing unless providing care in an emergency situation. This requirement aligns with Public Health Law 2805-d, as well as 10 NYCRR 405.7(b)(9), which outlines the Patient's Bill of Rights. In order to operationalize this requirement, the Department recommends that providers work with legal counsel at their facility to develop policies and procedures on informed consent and toxicology testing for pregnant/parenting people and newborns.

4. *Question:* Are there approved medical indications for toxicology testing of the pregnant/birthing person and/or infant?

   Medical indications for toxicology testing should be determined by the clinical health care provider treating the pregnant person and/or the newborn. There are no published guidelines.

   Please note that medical indication and/or necessity of toxicology testing does not remove the requirement for obtaining informed consent prior to testing. See above for information on informed consent.

5. *Question:* *What if the pregnant/birthing person declined toxicology testing on the newborn but the pregnant/birthing person has a history of substance abuse, and the newborn develops symptoms of withdrawal?*

   Toxicology testing of newborns should only be conducted when medically necessary to provide adequate care to the newborn. Therefore, the provider needs to decide if toxicology testing is necessary for the treatment and care of the newborn. Newborns should not be subjected to unnecessary toxicology testing to confirm suspected drug use in a parent/birthing person who has refused to give consent for their own toxicology testing.

   Outside of emergency situations, informed consent should be obtained prior to performing toxicology testing on newborns.

6. *Question: If the pregnant/birthing person refuses to verbally agree to or to sign a consent for toxicology testing of themself or their infant, can it be done without a consent if there is a documented medical indication for the pregnant/birthing person and/or the infant?*

   Outside of emergency situations, informed consent, either verbal or written as described above, must be obtained prior to performing a medical test/procedure. This expectation is based on Public Health Law 2805-d, as well as 10 NYCRR 405.7 (b)(9), which outlines the Patient Bill of Rights. The Department recommends that providers work with legal counsel at birthing facilities to develop policies and procedures on toxicology testing and informed consent for pregnant/birthing people and newborns that address the requirement for informed consent.

7. *Question: Is there any time where testing without consent is indicated?*

   Toxicology testing, of either a pregnant person and/or a newborn should only be done after receiving informed consent from either the patient and/or their parent/guardian. An exception to this requirement is when providing care in an emergency situation.

8. *Question: With regards to marijuana use, when would a toxicology test be appropriate? If a pregnant/birthing person disclosed prior cannabis use, but stopped during pregnancy is a toxicology testing suggested?*

   Toxicology testing for substance use during pregnancy and/or delivery should only be done when medically indicated and/or necessary to treat the patient.

9. *Question: Does a verbal screening for substance use of a pregnant/birthing person require informed consent?*

   Providers should work with legal counsel at their respective facilities to determine informed consent requirements.

10. *Question: The NYSDOH website has several verbal screening tools (CAGE-AID, CRAFFT, Audit, DAST and others). Is one screening preferred and should the same screening be used within an organization?*

    The Department of Health does not recommend one verbal screening tool over another. Organizations should decide whether the use of the same screening tool is beneficial.

Plans of Safe Care

11. *Question: If a patient completes a POSC but does not consent to it being put in the medical record how should the document be stored in the hospital?*

    If a patient is willing to complete a Plan of Safe Care (POSC) but does not complete the 42 CFR Part 2 form (see https://www.health.ny.gov/prevention/captacara/#what_is_a_plan_of_safe_care) and consent to have that POSC shared, the POSC must not be included in their medical record and staff should not note the existence of the POSC in the record (as the patient has not consented to share information on substance use). The Department recommends that providers assisting the pregnant/birthing person provide them a hard copy of the POSC so the patient has a copy and can bring it with them to future appointments if desired.

12. <u>Question</u>: *Does POSC consent need to be obtained on both baby and pregnant/birthing person since we will be placing it in both charts?*

    A patient must complete the necessary consent form in order to disclose information on substance use, which includes the existence or sharing of a Plan of Safe Care (POSC). This form must be completed for both the parent and newborn to be included in both charts.

13. <u>Question</u>: *Which substances or class of substances are defined in a substance use disorder?*

    Healthcare providers treating patients must make a clinical determination whether an individual meets the criteria to be diagnosed with a substance use disorder. If the provider determines a patient has a substance use disorder, they should be offered a Plan of Safe Care (POSC). A POSC may be a useful tool for many pregnant individuals in need of additional supports and can be offered to patients when a provider, community health worker, case coordinator, etc. deems it necessary or appropriate. For more information on developing a Plan of Safe Care please go to the <u>NYSDOH CAPTA CARA website</u>.

14. <u>Question</u>: *What if the pregnant/birthing person refuses consent to include the plan of safe care in the medical record? Does that mean it doesn't exist/not available - for the purposes of data collection?*

    If the patient does not complete the 42 CFR Part 2 Consent form (see https://www.health.ny.gov/prevention/captacara/#what_is_a_plan_of_safe_care) and does not want the POSC shared in their medical record, we recommend providing the patient a hard copy of the POSC so that they may bring the plan with them at delivery should they change their mind. If, at delivery, they choose to bring the POSC and then consent to have it shared you may do so at that point. If the POSC is completed it should be counted in the CAPTA CARA Data Collection Survey.

15. <u>Question</u>: *If there is already a POSC developed in the outpatient/ambulatory setting, should we create another one? Or should we review/update the previous POSC? How do we handoff POSCs between the outpatient to inpatient settings and vice versa?*

    If a patient is admitted for delivery and already has a Plan of Safe Care (POSC) developed and has consented to share it, you do not have to create a new POSC. Following delivery, facilities and providers should update the existing POSC to reflect their evolving needs and the additional needs of the newborn. Once updated (or created) the patient must consent to having the new/updated POSC included in their medical record and shared with other providers. They should complete the 42 CFR Part 2 Form which is available on the NYSDOH website here: https://www.health.ny.gov/prevention/captacara/#what_is_a_plan_of_safe_care

Diagnosing Newborns affected with Neonatal Abstinence Syndrome (NAS), Neonatal Opioid Withdrawal Syndrome (NOWS) and/or Fetal alcohol spectrum disorder (FASD)

16. *Question*: *Can you provide information about diagnosing newborns with Neonatal Abstinence Syndrome (NAS)?*

    Diagnosing a newborn with Neonatal Abstinence Syndrome (NAS), also known as Neonatal Opioid Withdrawal Syndrome (NOWS), is a clinical determination that should be made by healthcare providers at a birthing facility. That diagnosis may be based on various factors which may or may not include results from biological testing (e.g., toxicology testing).

    For additional information on Neonatal Abstinence Syndrome/Neonatal Opioid Withdrawal Syndrome (NOWS):
    - Standardizing the Clinical Definition of Opioid Withdrawal in the Neonate from The Journal of Pediatrics
    - Prenatal Opioid and Substance Exposure – CDC
    - About Opioid Use During Pregnancy – CDC

17. *Question*: *Can you provide information about diagnosing newborns with Fetal Alcohol Spectrum Disorder (FASD)? This is rarely diagnosed in the neonatal period as there are many developmental issues that can help with diagnosis.*

    Diagnosing a newborn with Fetal Alcohol Spectrum Disorder (FASD) is a clinical determination that should be made by a healthcare provider at a birthing facility. The Department defers to the clinical judgement of providers in diagnosing and treating newborns.

    The Department does not expect or recommend that providers or birthing facilities change the process to diagnose or treat newborn.
    For additional information on Fetal Alcohol Spectrum Disorder (FASD):
    - Fetal Alcohol Spectrum Disorders (FASD) – CDC

Mandated Reporting

18. *Question*: *Can Child Protective Services (CPS) request a toxicology testing report for a baby based on a report they receive relating to something other than substance use?*
    Providers and birthing facilities are expected to follow all state and federal laws regarding the release of medical information (including the results of verbal and/or biologic testing for substance use in pregnancy and/or substance exposure of a newborn). Providers and birthing facilities should have policies and procedures outlining the circumstances upon which medical information can be shared with local child welfare and/or law enforcement authorities as part of investigations into allegations of child maltreatment.

19. *Question*: *What if a pregnant/birthing person refuses to complete a POSC? Or does not follow through with a referral? Or does not consent to have it shared? Would this be a case for referral to the SCR as we would not be able to complete referrals to agencies nor confirm that mother was compliant with referrals?*

    Mandated Reporters are obligated to report suspected cases of child abuse or maltreatment when acting in their official role or capacity. Information on those requirements can be found at the NYS Office of Children & Family Services website here: Home | Child Protective Services | OCFS (ny.gov)

Failure to complete a POSC, refusal to consent to share a POSC, or the inability of providers to confirm compliance with referrals listed in a POSC alone may not be cause to suspect child abuse or maltreatment.

Each case/patient should be assessed or considered based on the individual circumstances of the case and the professional judgement of the mandates reporter(s) working in a professional capacity with that child/family. The Department of Health recommends that when making determinations about reporting, especially related to substance use, providers consider whether the individual was prescribed the substance and whether they are in treatment, and all associated circumstances before determining whether a call to the Statewide Center Register of Child Abuse and Maltreatment (SCR) should be made. If the individual is in a medical assistance treatment program or under the care and supervision of the doctor who prescribed the drugs, and are taking as prescribed, there is not a need to make a report to the SCR, unless there are other concerns about the individual's ability to care for the child.

20. Question: *What are the criteria for making a SCR Report?*

    Can you clarify the current guidance, which states: "When there is ***reasonable cause****, beyond substance use, to suspect a child is at risk of abuse or maltreatment, hospitals and birth centers should continue to follow existing policies and protocols for making a report to the Statewide Central Register of Child Abuse and Maltreatment (SCR)?* ***Substance use alone****, whether disclosed through development of a POSC, self-report, screening, toxicology* ***is not evidence of child maltreatment****."*

    Given the many variables involved in making determinations about if and when a mandated reporter should call the Statewide Central Register of Child Abuse and Maltreatment (SCR) to report a suspected case of child abuse/maltreatment there is no standard process/algorithm that can be utilized. The expectations and obligations outlined by the NYS Office of Children & Family Services (OCFS) can be found online here: https://www.ocfs.ny.gov/programs/cps/

    The Department of Health recommends that all mandated reporters carefully consider the holistic circumstances of each situation when making determinations on reporting to the child welfare system, especially if the only concern identified is substance use.

21. Question: *How is "reasonable cause" defined as an indication to contact Child Protective Services (CPS)?*

    Requirements and/or expectations to report cases of child abuse and/or maltreatment are outlined by the NYS Office of Children & Family Services (OCFS) as part of the NYS Mandated Reporter Law. Further information on those requirements can be found online here: https://www.ocfs.ny.gov/programs/cps/

Collection of CAPTA CARA Information on Newborns who are Substance Affected

22. <u>Question</u>: *Our team had a question regarding infants who may be experiencing abstinence symptoms secondary to a mother taking an SSRI, for example. The infant will have a diagnosis of NASIs this an infant that needs to be included in the data capture?*

    If an infant meets the medical definition of Neonatal Abstinence Syndrome (NAS), Neonatal Opioid Withdrawal Syndrome (NOWS) and/or Fetal alcohol spectrum disorder (FASD) as diagnosed by a clinical provider, that infant should be included in the data submitted for CAPTA CARA data survey.

23. <u>Question</u>: *How is "Newborns who display symptoms of substance withdrawal and have a positive toxicology test" defined for the purposes of reporting data for CAPTA CARA.*

    For the purposes of collecting and sharing information as required by CAPTA CARA, birthing facilities must report on newborns who are "substance affected" which includes those infants who "display withdrawal symptoms and have a positive toxicology test." A positive toxicology test would include the presence of any substance known to negatively impact fetal development or health. Determining whether a newborn is displaying symptoms of withdrawal is a clinical decision that should be made by the health care providers treating the newborn. If a newborn's chart includes a positive toxicology test and documentation of withdrawal symptoms as assessed by a health care provider, the newborn should be included in the data submitted for CAPTA CARA data survey.

    If a newborn is diagnosed with NAS/NOWS by a healthcare provider, that infant should be included in the CAPTA CARA data collection and reporting. This would include infants who receive this diagnosis and are treated through Eat, Sleep Console, and/or medication therapy.

    If a newborn meets the diagnosis criteria for FASD as determined by a health care provider, they should be included in the CAPTA CARA data survey.

24. <u>Question</u>: *When does the CAPTA CARA reporting requirement go into effect?*

    Birthing facilities are expected to submit quarterly data via the "NYS CAPTA CARA Data to OCFS" on the 15th of the month following the end of each quarter. The first quarter of data collected was Quarter 1 2022 (January 1, 2022 - March 31, 2022) which will be due via the CAPTA CARA HERDS survey by April 15, 2022.

    Future data submissions will be due on the 15th of the month following the end of the quarter.

    Quarter 1: Jan – March due April 15

    Quarter 2: April – June due July 15

    Quarter 3: July – September due October 15

    Quarter 4: October – December due January 15

25. <u>Question</u>: *For an infant's race/ethnicity - How is this defined? Mother and fathers' self-reported races combined, or what the mother designates infant's race as? What if only mother available and not father? Any additional guidance on this would be appreciated.*

    Birthing facilities should continue to collect race/ethnicity data for infants using their current process and definitions. There is no need to update or modify your existing data collection process for CAPTA CARA data collection.

26. <u>Question</u>: *Should infants exposed to cannabis/THC be counted in the CAPTA CARA data survey?*

    If an infant meets the definition of substance affected, which includes a positive toxicology test and documentation of withdrawal symptoms as assessed by a health care provider, the newborn should be included in the data submitted for CAPTA CARA. If the infant only has a positive toxicology test result but does not display symptoms of withdrawal, they should not be included in the CAPTA CARA data survey.

Adoption

27. <u>Question</u>: *If a baby is put up for adoption: Should the birthing person still be able to consent for the baby, as their parental rights are not usually terminated immediately after the baby is born? Who is the POSC performed with? The birthing person and support person? The adoptive parent if known and their support person? Both? Are we consenting the adoptive parents for POSC if completed with them?*

    Given the many different circumstances under which an infant may be placed for adoption and/or circumstances related to gestational surrogacy, the Department does not have uniform guidance on this issue. It is recommended that health care providers work with legal counsel at their birthing facility to develop policies/procedures related to Plans of Safe Care (POSC) development and consent.