NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

LISA J. PINO, M.A., J.D.
Executive Deputy Commissioner

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DHDTC DAL 21-12

Dear Hospital CEO/Birth Center Administrator:

In 2016, an amendment to the federal Comprehensive Addiction and Recovery Act (CARA) added new provisions to the Child Abuse Prevention and Treatment Act (CAPTA), which require the creation of **Plans of Safe Care (POSC)** to support the health and safety of newborns affected by substance use and their families or caregivers. The provisions also require states to **collect data** on the number of **substance affected** newborns. See 42 USC §§5106a(b)(2)(B)(iii) and 5106a(d)(18).

A POSC is a tool that can be used to support families impacted by substance use or taking medications to treat substance use disorders. The purpose of developing a POSC with a family is to ensure families are receiving comprehensive support, care, and treatment that meets their needs. Substance use **alone is not** an indicator of child abuse, maltreatment, or neglect and this has not changed. The CAPTA legislation provides guidance on the POSC and definition of "child abuse and neglect," which includes negligent treatment or maltreatment of a child. The related CARA amendments do **NOT** add substance use alone or substance use during pregnancy or at delivery as an indicator of child abuse or neglect.

The Department of Health (DOH), Office of Addiction Services and Supports (OASAS), and the Office of Children and Family Services (OCFS) have developed guidance on implementing these requirements. The DOH is also sending information to office and clinic-based healthcare providers through a "Dear Colleague" letter which can be found on the DOH CAPTA CARA webpage. Guidance from OASAS and OCFS to providers in their systems can be found on their respective websites.

Plans of Safe Care (POSC)
A POSC is a document which identifies how a provider, family, and community can support the safety and well-being of the newborn and person who gave birth. A POSC should be personalized and can address basic needs, identify support systems, and create linkages to necessary services and/or community-based organizations as appropriate. The DOH has developed a POSC template that can be used or adapted.

A POSC should be developed for pregnant individuals who:

- are diagnosed with a substance use disorder; or
- are receiving medication for addiction treatment (MAT) for a substance use disorder; or

- are under the care and supervision of a healthcare provider who has prescribed opioids.

Any healthcare or social services provider - obstetricians, gynecologists, nurse practitioners, physician assistants, midwives, doulas, primary care providers (PCP), licensed mental health or substance use treatment providers, OASAS certified providers, opioid treatment program (OTP) providers, social workers, case managers, credentialed alcoholism and substance abuse counselors (CASAC), hospital discharge planners, home visitors, certified peer recovery specialists/advocates -- can develop a POSC in collaboration with the pregnant person and/or family prenatally or post-delivery. Plans developed during the prenatal period may be specific to the pregnant person only or may also include anticipatory guidance, services or other supports that address the newborn's needs.

There is **no requirement** that child protective services be involved in the development of a POSC and there is **no reason** to inform child protective services that a family has a POSC. Furthermore, having a POSC or being referred to a provider to develop a POSC, **does not mean** that the pregnant or birthing individual will become involved in the child protective services system.

To make this most effective, healthcare and social service providers are encouraged to note the existence of the POSC in the pregnant person's electronic medical record (EMR) after obtaining the patient's specific consent (42 CFR Part 2 Cover Page and 42 CFR Part 2 Consent Form). Pregnant individuals are also encouraged to bring the POSC with them to the hospital or birth center. Discharge instructions for families impacted by substance use should include a reference to following the POSC. For pregnant or birthing individuals affected by substance use who do not have a POSC, or if the existing POSC does not include services for the newborn, the post-birth discharge plan serves as the start of a POSC and should include a warm linkage to appropriate community-based supports, healthcare or other providers to further develop the POSC. This is consistent with 10 NYCRR 405.9(f), which requires hospitals to link patients impacted by substance use to appropriate services at discharge. For more information about this requirement, please see DAL 18-13.

Warm linkages are a type of enhanced referral or connection that ensures the pregnant or birthing individual connects with the supportive services and is enrolled in care. Best facilitated through direct person to person contact, a warm linkage can help an individual feel confident in the referral source and make them more likely to enroll in that service. Hospitals and providers should be familiar with local community-based organizations and programs which can provide the necessary support for pregnant and birthing people in need of a POSC. Many of these programs can be found online sorted by region here: https://www.nyskwic.org/msnavigatorMap/.

Data Collection
Under the new federal provisions, hospitals and birth centers must collect and provide to the state **aggregate de-identified data** on substance use affected, as opposed to exposed newborns (see definition below). This information must be submitted quarterly and will be collected through the completion of an online survey instrument called the *New York State CAPTA Data Form to the Office of Children and Family Services (OCFS),* which can be found in the Health Commerce System (HCS) Health Electronic Response Data System (HERDS). The survey asks four questions about **newborns affected by substance use:**

1) The total number of substance use affected newborns discharged during the previous quarter
    a. The Race/Ethnicity of all newborns included in the total count for question number 1.
2) The total number of newborns discharged for whom a POSC was developed prior to hospital admission or during their hospital stay (i.e. prior to discharge)
3) The total number o newborns discharged for whom a referral was made for the POSC to completed in the community after discharge.

Please note that questions (2) and (3) are subsets of question (1) and should equal the total number provided in (1) when combined. Infants born in one quarter but discharged in another quarter should be included in the report for the quarter they are discharged from the facility.

Newborns Affected by Substance Use
Only newborns who fall into one or more of the following groups should be counted as "substance affected" and included in the total for the question (1) on the data collection form:

- **Newborns who display symptoms of substance withdrawal and have a positive toxicology screen**
- **Newborns who receive a diagnosis of Neonatal Abstinence Syndrome (NAS)/Neonatal Opioid Withdrawal Syndrome (NOWS)**
- **Newborns who receive a diagnosis of a Fetal Alcohol Spectrum Disorder (FASD).**

Impact on Screening and Toxicology
These federal provisions **do not** change recommended practices for substance use screening during pregnancy or delivery. The American College of Obstetricians and Gynecologists (ACOG) continues to recommend universal verbal screening for substance use during pregnancy; **they do not recommend toxicology testing during pregnancy and delivery, or for the newborn unless medically indicated**.

Toxicology testing should only be performed when medically indicated as part of the work up for the pregnant individual and infant to determine the appropriate medical treatment. ACOG recommends for biologic testing that,

> "Before performing any test on the pregnant individual or neonate, including screening for the presence of illicit substances, **informed consent** should be obtained from the pregnant person or parent. This consent should include the medical indication for the test, information regarding the right to refusal and the possible outcome of positive test results."[1]

Each hospital should develop policies and procedures for obtaining informed consent prior to substance use assessment, including whether consent will be obtained verbally or in writing. While a verbal consent may be sufficient for a verbal screening, written consent is recommended prior to toxicology testing. Suspicion of drug use, which can be influenced by implicit and explicit bias, is not a medical basis for toxicology testing. Research has shown that implicit bias can affect patient-physician interactions and relationships[2,3].

When there is **reasonable cause**, beyond substance use, to suspect a child is at risk of abuse or neglect, hospitals and birth centers should continue to follow existing policies and protocols for making a report to the Statewide Central Register for Child Abuse and Maltreatment (SCR). **Substance use alone**, whether disclosed through development of a POSC, self-report, screening, toxicology, medical record note, or newborn symptoms, **is not evidence of child abuse or neglect**.

Effective Date

While we understand that it will take time to fully implement this process, hospitals and birth centers will be expected to begin completing the de-identified CAPTA DATA Survey in HERDS starting 60 days from the date of this letter. Webinars and trainings will be offered during this time. To register for webinars and find supplemental information, please visit the NYSDOH CAPTA CARA website. Each of the webinars will be recorded and archived online. Once this is in effect, de-identified aggregate data should be submitted on a quarterly basis, no later than the 5th day of the month following the end of the quarter. The first quarter of CAPTA CARA data collection should begin 60 days after the final webinar on 12/21/2021. That data will be reported via the *New York State CAPTA Data Form to the Office of Children and Family Services (OCFS),* which can be found in the Health Commerce System (HCS) Health Electronic Response Data System (HERDS).

A flowchart is available online to provide additional guidance in implementing these requirements. The DOH, in collaboration with OASAS, OCFS, associations, professional organizations, and community organizations, will develop additional FAQs and further guidance to assist providers in the implementation of these protocols.

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[1] American College of Obstetricians and Gynecologists (2020). Opposition to Criminalization of Individuals During Pregnant and the Postpartum Period: Statement of Policy". Washington, DC: ACOG Board of Directors.

[2] Maina, I.W., Belton, T.D., Ginzberg, S., et al. (2018). A decade of studying implicit racial/ethnic bias in healthcare providers using the implicit association test. *Social science & medicine (1982)* 199, 219-229. doi:10.1016/j.socscimed.2017.05.009

[3] Hall, W.J., Chapman, M.V., Lee, K.M., et al. (2015). Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review. *American Journal of Public Health* (105), e60–e76. doi:10.2105/AJPH.2015.302903

Questions regarding the new requirements will be helpful as we develop these materials; questions may be sent by email to hospinfo@health.ny.gov.

Sincerely,

Marilyn A. Kacica, MD, MPH
Medical Director,
Division of Family Health

Stephanie Shulman, DrPH, MS
Director,
Division of Hospitals and
Diagnostic & Treatment Centers