



November 23, 2021

Dear Colleague,

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 hospitals and birth centers through a “Dear Administrator Letter” (DAL) 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 should coordinate with hospitals and birth centers to identify ways to share information and collaborate. 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. A sample of that consent form can be found on the NYS OASAS website: [42 CFR Part 2 Cover Page, 42 CFR Part 2 Consent Form](#). Pregnant individuals are also encouraged to bring the POSC with them to the hospital or birth center. Hospitals and birth centers will incorporate the POSC into discharge instructions. 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

Hospitals and birth centers are required to submit to the state on a quarterly basis **aggregate de-identified data** on three data points: (1) the number of newborns **affected** by substance use (as opposed to exposed), (2) the number of newborns affected by substance use who already have a POSC, and (3) the number of newborns affected by substance use for whom referrals were made for the POSC to be completed in the community after discharge. Please note (2) and (3) are subsets of (1), and the only newborns who should be included in (1) are those **affected by substance use**, as described in the following paragraph.

Newborns Affected by Substance Use

Only newborns who fall into one or more of the following groups will be included in the aggregate de-identified data submitted by hospitals and birth centers to the State.

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

Impact on Substance Use 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

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.

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 neglect**.

Effective Date

Hospitals and birth centers will be expected to begin submitting this data starting 60 days from the date of these letters. It would be beneficial for healthcare providers to follow the same timeline for beginning to develop POSC with their patients and families. 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.

A [flowchart](#) is attached to provide additional guidance in implementing these requirements. The DOH, in collaboration with OASAS, OCFS, associations, professional organizations, and community organizations, will be developing additional FAQs and guidance to assist providers in the implementation of these protocols. Questions regarding the new requirements will be helpful as we develop these materials; questions may be sent by email to POSC@health.ny.gov.

Sincerely,

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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