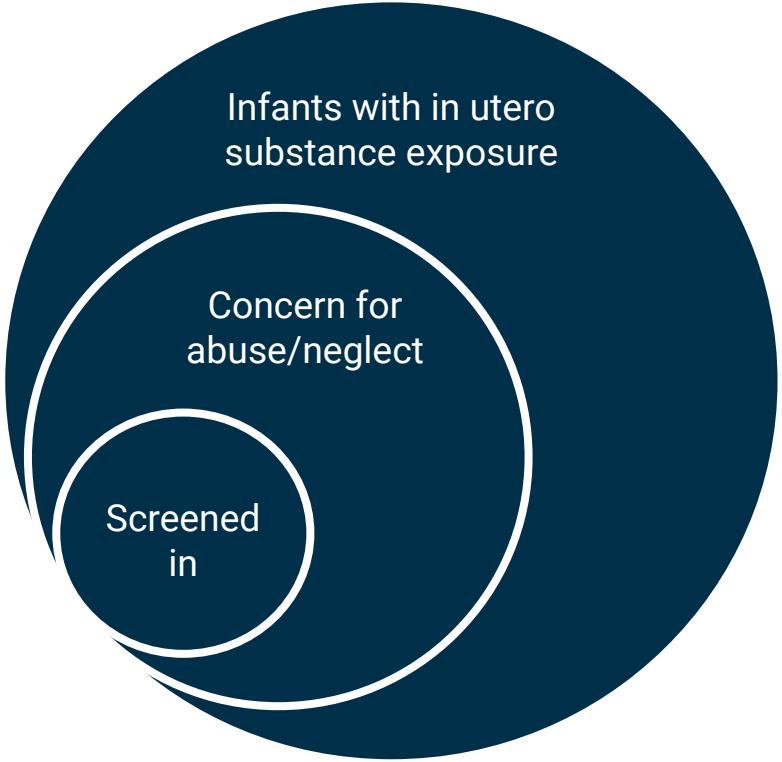
Plans of Safe Care:
Tips and Tricks for Clinic and Hospital-Based Implementation

Lauren Bruns, MD, FAAP
Assistant Professor of Pediatrics
University of Colorado School of Medicine
SuPPoRT Colorado Plans of Safe Care Work Group Co-Chair

Plans of Safe Care: Why we're here

Per the Administration for Children and Families (of US DHHS): "the development of a Plan of Safe Care is required whether or not the circumstances constitute child maltreatment under state law."



*graphic not representative of data

Some truths:

- We all want to do the best we can to support our patients and families impacted by SUD
- Providing trauma-informed, thorough, and complete collaborative care can be resource and time-intensive
- Time is a limited resource
- Change is hard!

It all starts with education!

- Acknowledge limitations and barriers
- Reduce stigma and bias
  - CPCQC RN training sessions in partnership with HardBeauty → piloting and then coming soon!
    - If interested, sign-up for the waitlist here!
- Mindfulness in how we speak and document
  - Words matter
- Engage provider groups/stakeholders
  - Clinic team meetings
  - Inpatient provider staff meetings (L&D, Peds/NICU)
  - LCSW and care management
  - County DHS caseworkers
  - We can help!

Opportunities for Engagement and Implementation

Prenatally

- Parents/caregivers
- FM/OB/CNM champions
- Ancillary support staff champions
- Behavioral health/SUD treatment champions

Birth Hospitalization

- Parents/caregivers
- FM/OB/CNM champions
- Nursery/NICU teams
- Pediatric provider champions
- M/B LCSW
- Care management

Post-Discharge

- Parents/caregivers
- FM/OB/CNM champions
- Ancillary support staff champions
- Behavioral health/SUD treatment champions
- Pediatric provider champions
- Community-based organizations

Prenatal Engagement

- Family-owned and initiated Plan of Safe Care
  - Benefits: gives pregnant person/family sense of ownership, allows for patient-advocacy, family can fill out pre-visit
  - Downsides: paper and everything that comes with that (MUST ensure that family understands document contains sensitive information → consider deleting MRN, DOB, and using only first names, etc)
- EMR-based Prenatal Plan of Safe Care
  - Benefits: accessible to healthcare based providers across specialities, easily updated at visits, secure
  - Downsides: time intensive, work-flow integration
    - Epic EMR template available
    - Consult visits → billing support

Birth Hospitalization Implementation

Education! Cooperation! Collaboration!

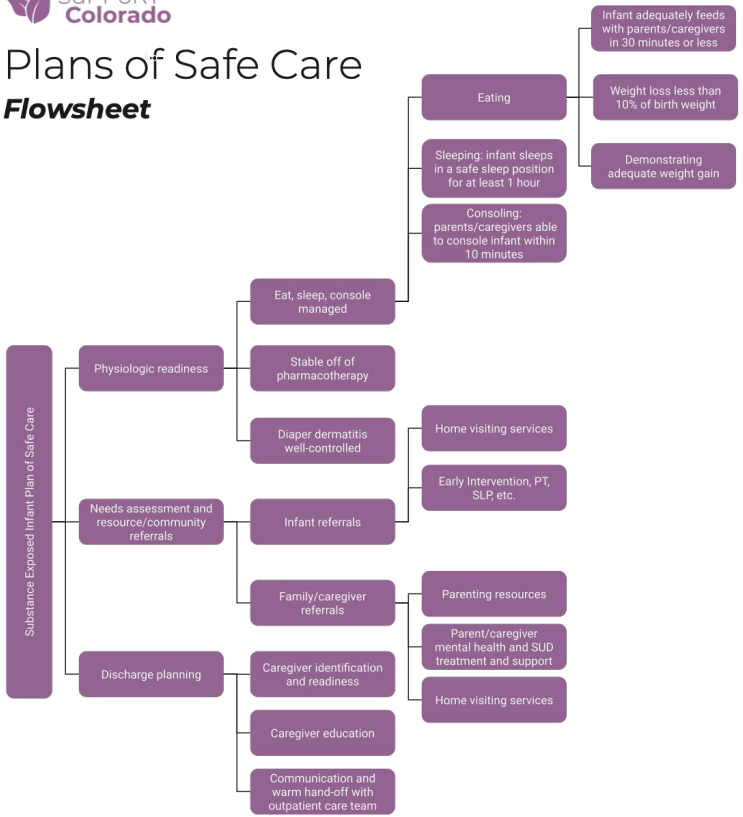
- Education on admission regarding birth hospitalization expectations
  - NOWS symptoms, ESC, feeding goals, indications for escalations in care, importance of family/caregiver engagement, 5 S's
  - Discharge readiness criteria
  - Plan of Safe Care development/updates
- Early involvement of unit LCSW and/or Care Management
  - Assessment/inventory of needs
  - Follow-up on previous referrals
  - Initiate new referrals
- Collaboration with birthing person's provider team
  - Addiction Medicine and Behavioral Health support, if indicated
  - Facilitating rooming-in
  - Ensuring access to MOUD dosing
- Involvement with DHS/CPS is NOT mandatory for infants with in utero substance exposure and a positive toxicology test alone does NOT require a DHS/CPS call

[Plans of Safe Care Best Practice Recommendations]

SuPPoRT Colorado

Plans of Safe Care

Flowsheet



illuminate
Building Brighter Childhoods

Birth Hospitalization Implementation

EMR Based POSC

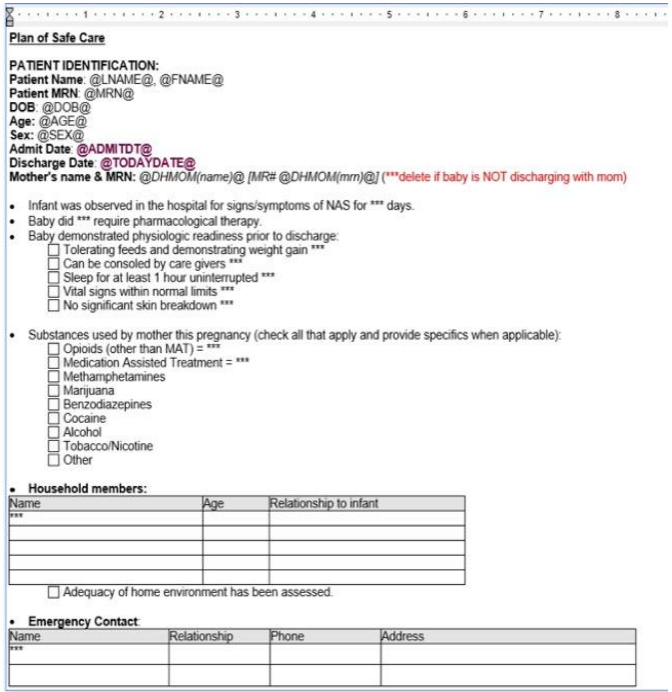
- Initiation at time of H&P documentation and frequently update throughout birth hospitalization
  - Problem based charting:
    - Consider using problem “Care Plan Discussed with Patient”
    - Ensure LCSW access to problem list → can usually be facilitated by clinic/hospital based EMR support specialists
  - Standard charting/documentation: Consider using a note template that may be shared during birth hospitalization → allows for updates by multiple providers during admission
- If family plans follow-up with clinic outside of healthcare system, consider faxing with H&P and DC summary and provide family a copy (ensure that family understands document contains sensitive information)

Paper Based POSC

- Don’t wait until the day of discharge!
- Consider development in a team-based setting (newborn provider, LCSW, RN, etc.)
- Ensure that family understands document contains sensitive information → consider deleting MRN, DOB, and using only first names, etc
- Consider sending a copy to medical records OR include as Media
- Encourage families to bring copy to follow-up appointments

Birth Hospitalization Implementation

EMR templates available!



Plan of Safe Care

PATIENT IDENTIFICATION:
Patient Name: @LNAME@, @FNAME@
Patient MRN: @MRN@
DOB: @DOB@
Age: @AGE@
Sex: @SEX@
Admit Date: **@ADMITDT@**
Discharge Date: **@TODAYDATE@**
Mother's name & MRN: *@DHMOM(name)@ [MR# @DHMOM(mrn)@]* (***delete if baby is NOT discharging with mom)

- Infant was observed in the hospital for signs/symptoms of NAS for *** days.
- Baby did *** require pharmacological therapy.
- Baby demonstrated physiologic readiness prior to discharge:
  - ☐ Tolerating feeds and demonstrating weight gain ***
  - ☐ Can be consoled by care givers ***
  - ☐ Sleep for at least 1 hour uninterrupted ***
  - ☐ Vital signs within normal limits ***
  - ☐ No significant skin breakdown ***

- Substances used by mother this pregnancy (check all that apply and provide specifics when applicable):
  - ☐ Opioids (other than MAT) = ***
  - ☐ Medication Assisted Treatment = ***
  - ☐ Methamphetamines
  - ☐ Marijuana
  - ☐ Benzodiazepines
  - ☐ Cocaine
  - ☐ Alcohol
  - ☐ Tobacco/Nicotine
  - ☐ Other

- **Household members:**

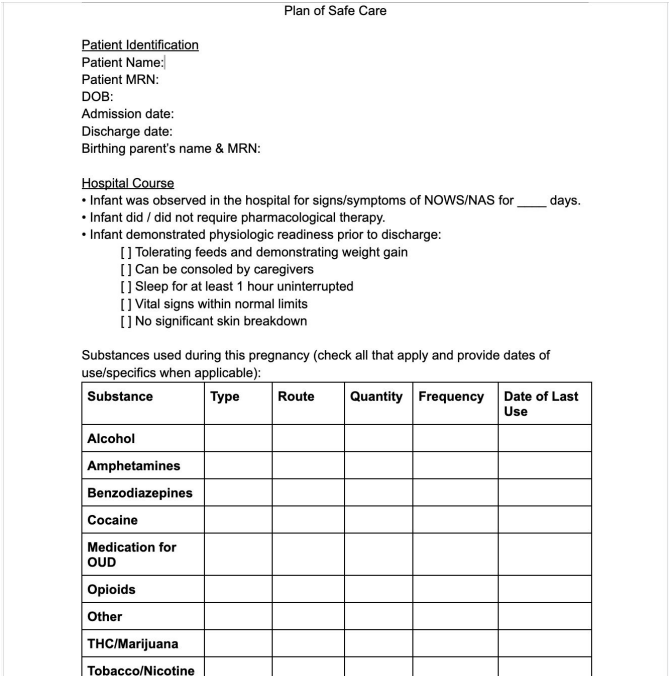
Name	Age	Relationship to infant
***		

☐ Adequacy of home environment has been assessed.

- **Emergency Contact**:

Name	Relationship	Phone	Address
***			

Paper-based templates available!



Plan of Safe Care

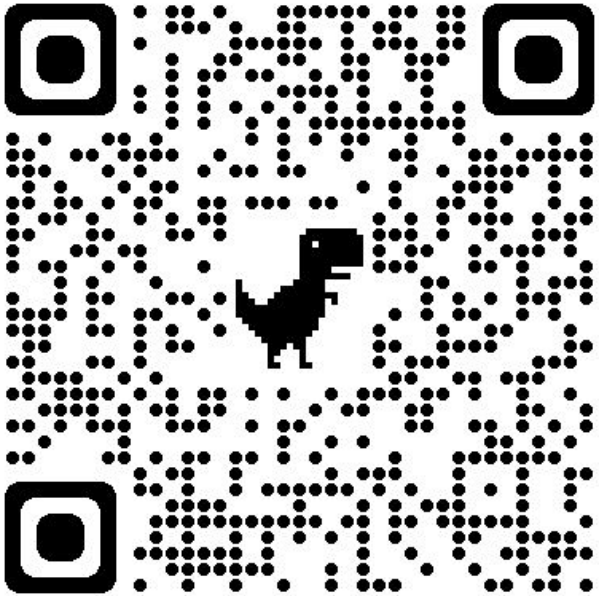
Patient Identification
Patient Name:
Patient MRN:
DOB:
Admission date:
Discharge date:
Birthing parent's name & MRN:

Hospital Course
• Infant was observed in the hospital for signs/symptoms of NOWS/NAS for ____ days.
• Infant did / did not require pharmacological therapy.
• Infant demonstrated physiologic readiness prior to discharge:
  [ ] Tolerating feeds and demonstrating weight gain
  [ ] Can be consoled by caregivers
  [ ] Sleep for at least 1 hour uninterrupted
  [ ] Vital signs within normal limits
  [ ] No significant skin breakdown

Substances used during this pregnancy (check all that apply and provide dates of use/specifics when applicable):

Substance	Type	Route	Quantity	Frequency	Date of Last Use
Alcohol					
Amphetamines					
Benzodiazepines					
Cocaine					
Medication for OUD					
Opioids					
Other					
THC/Marijuana					
Tobacco/Nicotine					

Want more help or support? Let us know!



Now what?

Epic Playground?

Post-discharge POSC and coordination with pediatric outpatient providers?

Discussion of barriers and challenges?

Review of what's to come?

Q&A?

Troubleshooting your EMR?

See It In Action!

Post-Discharge Implementation and Engagement

- DH Outpatient Pediatrician feedback
  - Pros:
    - Everything in one place
    - Easy to locate referrals, etc (especially for outpatient LCSW)
  - Cons:
    - Lengthy notes
    - Problem based charting versus templates
    - Lack of education/knowledge
- DRAFT of Post-Discharge POSC

Barriers and Challenges

- Fragmented care delivery systems
- Disconnect amongst providers, community organizations, DHS/CPS
- POSC mandate lies at the DHS/CPS level
  - Do we just call this a Family Support Plan?
- Lack of centralized POSC repository/database
- Bias, stigma, funding, time, education…all the usual suspects