

Plans of Safe Care Frequently Asked Questions

General / Overview

What is a Plan of Safe Care and how does it differ from other service plans?

A Plan of Safe Care is a document that lists and directs services and supports to provide for the safety and well-being of an infant affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder (FASD). One of the main ways in which it differs from other service plans is in the inclusion of services for both the affected infant and the family/caregiver, including substance use treatment services for the parent.

What does the law say about infants born substance exposed and Plans of Safe Care?

Federal law (the Child Abuse Prevention and Treatment Act) requires a Plan of Safe Care be developed for every infant under one year of age born and identified as affected by substance use, withdrawal symptoms resulting from prenatal drug exposure or a fetal alcohol spectrum disorder.

State law (Act 54 of 2018) directs health care providers to immediately give notice or cause notice to be given to the Department of Human Services if the provider is involved in the delivery or care of a child under one year of age and the health care provider has determined, based on standards of professional practice, the child was born affected by substance use, withdrawal symptoms resulting from prenatal drug exposure or a Fetal Alcohol Spectrum Disorder. You may read Act 54 [here](#).

What does “up to one year of age” in the law mean?

“Up to one year of age” refers to the age of an infant/child who can be identified as substance exposed by a health care provider and for whom a notification to the Department of Human Services must be made; this includes newborn through the 11th month.

How is “affected by” defined?

Per Appendix C, Pennsylvania Definitions, of the Pennsylvania Plan of Safe Care Guidance, “affected by” is defined as an “infant with detectable physical, developmental, cognitive, or emotional delay or harm that is associated with maternal substance use or withdrawal, as assessed by a health care provider.”

When is the law effective? When should counties ensure their process and policies are in place for implementing Plans of Safe Care for licensing and inspection purposes?

Federal law changes were effective upon enactment on July 22, 2016; state law to ensure compliance with CAPTA was passed on June 18, 2018 and was effective October 1, 2018. For licensing and inspection purposes, county children and youth agencies should ensure policies and processes are updated and in place by January 1, 2020.

What efforts have been undertaken by the state agencies to ensure this information is disseminated widely so that practice can change?

The Departments of Health, Drug and Alcohol Programs, and Human Services convened an interdisciplinary workgroup in 2016 to ensure compliance with the changes to CAPTA and to develop a Pennsylvania policy agenda regarding infants born affected by substances from a comprehensive, public health approach. The Multidisciplinary Workgroup on Infants Born Substance Exposed (MDWISE) continues to meet and assist in the development of materials helpful for practitioners affected by this change in the law. The MDWISE assisted in the development of the Pennsylvania Plan of Safe Care Guidance, and is partnering with the Pennsylvania Perinatal Quality Collaborative, the Hospital and Health System Association of Pennsylvania, the Opioid Data Dashboard and other workgroups to ensure information regarding CAPTA and Act 54 is disseminated as widely as possible. The MDWISE also collaborated with the Governor's Institutes for Plans of Safe Care work sessions that took place in the spring and summer of 2019 to provide county level executive planning teams an opportunity to begin developing the policies and procedures needed on the county level to support this work.

My agency has worked with infants born affected by substances for years; what has changed in this law?

The most notable changes include the elimination of the word 'illegal' related to substance exposure, the inclusion of the parent/caregiver's needs in the Plan of Safe Care, the data required to be submitted to the federal government (increasing federal oversight), and the emphasis on the interdisciplinary nature of this work by ensuring Plans of Safe Care are not only the responsibility of the child welfare system, but that the fields of Drug and Alcohol treatment, Early Intervention, Health, Mental Health and others are included in multidisciplinary teams and the development and implementation of Plans of Safe Care. The Departments of Health, Human Services and Drug and Alcohol Programs were required by Act 54 to develop interagency protocols regarding Plans of Safe Care.

Where can I find materials from the 2019 Governor's Institutes on Plans of Safe Care work sessions?

You can find materials from those planning sessions [here](#).

Where can I find the Pennsylvania Plan of Safe Care Guidance?

The Pennsylvania Plan of Safe Care Guidance is available on the KeepKidsSafe website [here](#).

My question isn't answered in the Guidance Document or these FAQs- who do I contact?

You may use the following resource account for questions related to Plans of Safe Care – it is accessible by all three state agencies: RA-PWPLANSOFSAFECARE@pa.gov.

Notifications

Who makes a notification that a baby has been born and identified as substance exposed, displays withdrawal symptoms resulting from prenatal drug exposure or has been diagnosed with a fetal alcohol spectrum disorder?

The law requires a health care provider or their designee to make this notification; this may be a hospital social worker, registered nurse, discharge coordinator or other staff person as determined by the health care provider or health system.

Where do I make the notification?

You may call ChildLine at 1-800-932-0313 or use the online self-service portal at: <http://www.compass.state.pa.us/cwis>.

What happens once I make the notification?

Trained caseworkers at ChildLine will transmit the information to the appropriate county children and youth agency or other appropriate entity and a multidisciplinary team of professionals will be convened to assess the family for a Plan of Safe Care.

What if I am aware that a pregnant woman had used substances but her newborn baby does not show signs of withdrawal or otherwise of being affected by those drugs following birth? Must I make a notification?

No; under Act 54 and CAPTA, a health care provider is required to make a notification when the provider is involved in the delivery or care of a child under one year of age and the health care provider has determined, based on the standards of professional practice, the child was born affected by substances. However, if a health care provider has reasonable cause to suspect abuse or neglect of the infant or child, they still must make a referral to ChildLine as a mandated reporter. Notification of an infant born and identified as substance exposed does not replace Child Protective Services (CPS) or General Protective Services (GPS) referrals.

What if a woman tests positive for substance use following delivery but her newborn baby does not show signs of withdrawal or otherwise of being affected by those drugs following birth? Must I make a notification?

No; under Act 54 and CAPTA, a health care provider is required to make a notification when an *effect on the infant is detected*. However, if a health care provider has reasonable cause to suspect abuse or neglect of the infant or child, they still must make a referral to ChildLine as a mandated reporter. Notification of an infant born and identified as substance exposed does not replace Child Protective Services (CPS) or General Protective Services (GPS) referrals.

What if a woman is receiving medication assisted treatment (MAT) for opioid dependence and her baby tests positive for that substance but does not show signs of withdrawal? Must I make a notification?

No; a notification of an infant born and identified as affected by substances is *based on the medical provider's detection of physical, developmental, cognitive, or emotional delay in the infant*.

However, if a health care provider has reasonable cause to suspect abuse or neglect of the infant or child, they still must make a referral to ChildLine as a mandated reporter. Notification of an infant born and identified as substance exposed does not replace Child Protective Services (CPS) or General Protective Services (GPS) referrals.

What if a delivering woman admits to substance use but the baby does not exhibit any symptoms at birth? Must I make a notification?

No; under Act 54 and CAPTA, a health care provider is required to make a notification when an effect on the infant is detected. However, if a health care provider has reasonable cause to suspect abuse or neglect of the infant or child, they still must make a referral to ChildLine as a mandated reporter. Notification of an infant born and identified as substance exposed does not replace Child Protective Services (CPS) or General Protective Services (GPS) referrals.

What if a woman is taking a prescribed medication appropriately and the baby, while showing signs of withdrawal or other effects, will not be affected long term? Must I make a notification?

Yes; Plans of Safe Care are not only developed for infants who will be affected long-term. Any effect on the infant should result in a notification to ChildLine so that a multidisciplinary team can convene to support the family.

Are notifications only required for illegal substances, such as heroin or cocaine?

No; notifications are required when an affect on the infant is detected due to the exposure to any substance, regardless of whether it is a legal or illegal substance, including alcohol.

Are notifications only required for opioid abuse?

No; notifications are required when an effect on the infant is detected due to exposure to any substance, opiate or non-opiate.

What if a mother is taking a medication as prescribed by her doctor that may or may not affect the newborn at birth, but it is a legal medication and not an opioid, such as an SSRI or medication to prevent seizures? Must I make a notification if I detect an effect on the newborn?

Yes. Legal and prescribed medications may also affect an infant exposed prenatally. A Plan of Safe Care is required for any infant born affected by substance use, withdrawal symptoms or FASD to ensure the ongoing health and safety of the infant and ongoing health and treatment needs of the parent.

Are notifications required to be made when I know a pregnant woman is using substances?

No; under CAPTA and Act 54, a notification is required when a health care provider detects an effect on the infant following birth.

If a pregnant mother is willing, could a multidisciplinary team develop a Plan of Safe Care for a pregnant mother, before the baby is born?

Yes. The county children and youth agencies would not be included in the prenatal Plan of Safe Care, but as a best practice, health care providers and other professionals are encouraged to begin developing Plans of Safe Care in the prenatal period if a mother is agreeable to the process.

How will the notifications to Childline be categorized and disseminated?

ChildLine caseworkers will be trained to categorize notifications of an infant born and identified as affected by substance use as either Information Only notifications or a General Protective Services (GPS) referral, depending on the information provided. This information will be transmitted to the county children and youth agency and/or other appropriate entity in the family's county of residence so that the most appropriate entity can work with the family to develop a Plan of Safe Care. For example, for Information Only notifications, this entity may be the medical provider or drug and alcohol treatment provider, and an assessment by child welfare may not occur.

If at any time the county children and youth agency obtains more information regarding the environment surrounding the family and believes the Information Only or GPS referral should be re-evaluated as a GPS or child protective services (CPS) referral, they can request that of ChildLine. *Note: until January 1, 2020 when the necessary changes are made to the Child Welfare Information System (CWIS), all notifications of an infant born and identified as affected by substance use, withdrawal symptoms related to prenatal drug exposure or FASD will be categorized as GPS referrals (this is a continuation of previous practice). This is to allow time for the necessary technical updates and changes to be implemented in the system. Following January 1, 2020, the ability of ChildLine caseworkers to classify a notification as Information Only or a GPS referral will be possible. Currently, the county agency has the ability to screen out the referral or refer the family for community services if there are no safety or well-being concerns for the child.

Does this process replace reporting suspected child abuse or neglect?

No; if a mandated or permissive reporter has reasonable cause to suspect that a child is a victim of child abuse or neglect, they must still make a report to ChildLine to report those concerns and ensure an appropriate assessment or investigation takes place.

Does a notification of a child born affected by substance use constitute child abuse or neglect?

No; according to the law, the notification of an infant born and identified as affected by substance use, withdrawal symptoms resulting from prenatal substance exposure, or FASD does not constitute a report of suspected child abuse in and of itself.

Does this process replace "mandated reporting of infants" under the Pennsylvania Child Protective Services Law?

Yes. Act 54 reworks the Pennsylvania Child Protective Services Law Section 6386 to shift from "mandated reporting" to "notifications" for infants born substance exposed.

What if a baby is born without any symptoms or signs of withdrawal, but based on my knowledge of the mother's drug use and other external environmental factors I have reasonable cause to suspect abuse or neglect of the infant?

You should make a referral to ChildLine at 1-800-932-0313 or at the self-service portal online at <http://www.compass.state.pa.us/cwis>.

If a baby is born across state or county lines, how will we ensure the notification is made to ChildLine?

CAPTA is a federal law; therefore, every state is required to ensure they have policies and procedures in place to be in compliance. Pennsylvania will continue to receive notifications from neighboring state child protective services and other systems for concerns surrounding child well-being and safety, including notifications of infants born affected by substances.

Screening and Identification

What is the difference between universal screening and universal testing?

Screening is the determination of need for emergent care in the areas of withdrawal management, prenatal or psychiatric care. It is a short series of questions to identify the need for services and determine if further assessment is necessary. Screening is differentiated from testing in that testing involves biological samples such as blood, urine, meconium or umbilical cord.

Are medical staff required to test all newborns for substance exposure?

No; however, DOH recommends universal screening for all newborns.

Are medical staff required to test all delivering women for substance use?

No; however, DDAP recommends universal screening for all pregnant women. Screening should be inclusive of illicit drug, prescription drug, alcohol and tobacco use. All of these are risk factors which may impact infant and maternal health outcomes.

Are medical staff required to use specific screening tools?

No; however, both DOH and DDAP recommend that providers utilize an evidence-based, validated tool that meets the needs of the provider and the population served. No one tool is recommended or required.

What tools are available for my staff to use in screening?

See Chapter 6 of the Pennsylvania Plan of Safe Care Guidance for some recommended screening tools, including the Institute for Health and Recovery's Integrated 5 P's Screening Tool, NTI Upstream's 4P's Plus©, ASSIST V3.0 (Alcohol, Smoking and Substance Involvement Screening Test), CAGE-AID (Cut Down, Annoyed, Guilty, Eye Opener Adapted to Include Drugs), and CRAFFT (Car, Relax, Alone, Forget, Family or Friends, Trouble) for adults and pregnant women. For newborns, Finnegan's Neonatal Abstinence Scoring Tool and the Lipsitz Tool are widely used.

Individual Plan of Safe Care Development

What is required to be in a Plan of Safe Care?

CAPTA and Act 54 require a Plan of Safe Care address the health of the infant and the health and substance use disorder treatment needs of the affected family or caregiver. The plan should also identify the most appropriate lead agency; assess the needs of the child, the child's parents, and immediate caregivers; and engage the child's parents and immediate caregivers in order to identify the need for access to treatment for any substance use disorder or other physical or behavioral health condition that may impact the safety, early childhood development, and well-being of the child.

Pennsylvania's Plan of Safe Care Guidance states that Plans of Safe Care should specify the agencies that are providing specific services, outline communication procedures among the family and provider team, and guide the coordination of services across various agencies with the family.

Are families mandated to participate in or follow Plans of Safe Care?

No; Plans of Safe Care are voluntary support plans for families raising infants affected by prenatal substance use.

At what point do we include families in our planning process for Plans of Safe Care?

The family is a key member of the multidisciplinary team and should be the primary participants in the initial multidisciplinary team meeting and engaged throughout the development and implementation of the Plan of Safe Care.

What should we do if a family does not want a Plan of Safe Care and does not want to engage the multidisciplinary team?

Counties should develop policies and protocols to follow when a family refuses to engage with the multidisciplinary team and/or the Plan of Safe Care. If there are safety concerns for a child, those concerns should be immediately reported to ChildLine.

Is it acceptable to have a multidisciplinary team meeting to develop a Plan of Safe Care after the infant's discharge from the hospital?

It depends. Per the law, the initial multidisciplinary team (MDT) meeting should be convened prior to the infant's discharge from the hospital if the health care provider determines the newborn to be affected by substances at birth. However, for infants identified as substance exposed after their discharge from the hospital, such as at a well-visit with the child's pediatrician, ChildLine must be notified immediately and the MDT must be convened within 72 hours of that notification, per the Pennsylvania Plan of Safe Care Guidance.

Who is responsible for bringing together the multidisciplinary team after an infant is identified and a notification is made to ChildLine?

For infants identified as substance exposed at birth, the hospital social worker or other appropriate staff person, such as a patient care representative or discharge coordinator, should convene

the initial MDT meeting. Hospitals should updates their policies and procedures to determine the best way to comply with this law.

For infants identified as affected by substance use after their discharge from the hospital, such as through a well-child visit with their pediatrician or an appointment with the mother's OB/GYN, the health care provider or appropriate staff will make the notification and a county children and youth caseworker will be assigned to convene the initial MDT meeting. County children and youth agencies should updates their policies and procedures to determine the best way to comply with this law.

Multidisciplinary Teams (MDTs)

Who should be a part of a multidisciplinary team?

Each multidisciplinary team (MDT) should be unique to the infant and family's circumstances and needs. Potential members of the MDT include: public, maternal and child health providers or staff; professional home visitors; substance use disorder prevention and treatment providers; mental health providers; public and private children and youth agency caseworkers or staff; Early Intervention (EI) staff; representatives from the court systems, local education agencies, managed care organization and private insurer care coordinators and hospital/medical providers, such as hospital social workers.

What if a child is identified as affected by substances after their discharge from the hospital? How soon must an MDT meet?

For infants identified as substance exposed after their discharge from the hospital, such as at a well-visit with the child's pediatrician, ChildLine must be notified immediately and the MDT must be convened within 72 hours of that notification, per the Pennsylvania Plan of Safe Care Guidance.

Are MDTs required to meet in person? Can MDTs utilize conference calls or video calls?

MDTs are not required to meet in person; conference and video calling can be utilized when available.

Must the Plan of Safe Care be fully developed at the initial MDT meeting?

No, the convening of the initial MDT meeting is the start of a Plan of Safe Care (or initial modification for those developed prenatally). It does not need to be fully developed within the initial meeting, as needs and resources will be identified for the family at subsequent meetings.

How do we determine the lead for the Plan of Safe Care?

When determining who should receive a Plan of Safe Care, and who should take the lead on monitoring that the identified referrals are made and services received, consider the population with which you are working:

- Population 1: Women who are using legally prescribed medications, including opioids, for chronic pain or medication that can result in withdrawal symptoms and do not have a substance use disorder;
- Population 2: Women who are receiving medication assisted treatment for an opioid use disorder and/or are actively engaged in treatment for a substance use disorder;
- Population 3: Women who are misusing prescription drugs or are using other legal or illegal substances, may meet criteria for a substance use disorder, and are not actively engaged in a treatment program.

For the first two populations, the MDTs should determine who will be responsible for leading the creation and implementation of the Plan of Safe Care. If the use of MAT or engagement in treatment is relatively new, for the second population, the county children and youth agency may need to be involved to help support the mother's continued engagement in substance use treatment and that she is

receiving the external support she needs. For the third population, the county children and youth agency should be responsible for the creation and implementation of the Plan of Safe Care.

What is the difference between my county planning team and a multidisciplinary team?

The local county planning team is responsible for developing the county protocols that will build on the Pennsylvania Plan of Safe Care Guidance and must adhere to the requirements of Act 54. The planning team should encourage the development of collaborative partnerships for coordinating and supporting a family-focused system that delivers prevention, Early Intervention, public health and community-based treatment services.

The multidisciplinary team (MDT) is the group of direct service professionals who interface with the mother/caregiver/family of an infant or child with a Plan of Safe Care to ensure the referral to and delivery of appropriate and needed services. The main purpose of the MDT is for multiple agencies to coordinate services to address the unique needs, situations, and experiences of each family member in order to best serve infants with substance exposure and their family.

Which county will be responsible to convene a MDT for a Plan of Safe Care if a baby is born in one county and transfers to another?

The MDT should be convened in the infant and family's county of residence.

Is there a universal template that must be utilized for all Plans of Safe Care?

No; counties are welcome to develop their own templates and forms for Plans of Safe Care. However, an example, in both pdf and word document form, can be found on the KeepKidsSafe website.

Can Plans of Safe Care be included in a Child Safety Plan, Family Service Plan, Hospital Discharge Plan or Substance Use Treatment Plan if it fulfills all the needs of the infant/family?

It depends; a Plan of Safe Care is unique from each of the above-mentioned service plans. Typically, this will mean that Plans of Safe Care should remain distinct documents.

However, for situations in which the county children and youth agency is the lead and in which the family is already open for services, the agency may include the Plan of Safe Care as an addendum to the Family Service Plan, to avoid duplication of effort.

Must Plans of Safe Care be monitored for a specific amount of time?

No; there are no statutory requirements surrounding timeframes for monitoring plans of safe care. Each MDT should determine the appropriate intervals at which the team should meet to review the plan and the infant and family's continued need for services and supports. The frequency of meetings should be determined based on each individual case but should be at least monthly. These intervals will likely be more frequent at the onset of a plan and become less frequent as the plan is implemented.

Who determines when a Plan of Safe Care is no longer needed?

Consistent with the individualized nature of Plans of Safe Care, the MDT lead will continuously assess each individual situation in order to ensure all of the needs of the family are being met. Consensus among the involved entities is needed when determining that changes should be made to a plan or that a plan is no longer needed.

Monitoring / Data

Who is going to monitor that the Plans of Safe Care are created and implemented?

On the statewide level, there is no definition of “monitoring” in federal law and CAPTA does not specify what the state level monitoring system must consist of. In guidance provided to states, the Administration for Children and Families has confirmed that a “state agency” is required to monitor the implementation of Plans of Safe Care. As a state-supervised, county-administered system, the county child welfare agency is considered a “state agency” and may both develop and monitor Plans of Safe Care. Other state agencies, such as the Department of Health and Department of Drug and Alcohol Programs, may also monitor Plans of Safe Care.

As discussed in Chapter 10 of the Pennsylvania Plan of Safe Care Guidance Document, multidisciplinary teams (MDTs) are responsible for monitoring the implementation of individual Plans of Safe Care. In particular, the designated lead for each MDT, as discussed in Chapter 8 of the Guidance Document, is tasked with ensuring the Plan of Safe Care is appropriately updated, edited as needed, and closed when necessary.

What data will be collected?

The Department of Human Services is required to submit the following data to the federal government on an annual basis:

- The number of infants identified as being affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or FASD;
- The number of infants for whom a plan of safe care was developed; and
- The number of infants for whom referrals were made for appropriate services, including services for the affected family or caregiver.

What will be required at licensing for child welfare agencies?

For Plans of Safe Care in which the local children and youth agency is the designated lead:

- County children and youth caseworkers and supervisors should keep record in the family’s case file that includes the Plan of Safe Care; a list of the members of the MDT; proof of referrals to recommended services and supports, including contact information for the appropriate agencies; notes from regular MDT meetings; and any other documentation related to the Plan of Safe Care, including, but not limited to, release of information agreements and confidentiality agreements.
- The county agency is responsible for monitoring the implementation of Plans of Safe Care on an ongoing-basis. This may take place during regular quality assurance activities such as case file reviews, supervision, peer reviews, etc.

During annual licensing inspections by the Department of Human Services, random sampling will be employed to assess overall agency compliance with the Pennsylvania Plan of Safe Care Guidance. Ten percent of case files pulled for review must include those for whom a Plan of Safe Care was created. The plan will be reviewed for compliance based on the Pennsylvania Plan of Safe Care Guidance Document. If agencies do not have the appropriate documentation regarding Plans of Safe Care in the case file for infants and families for whom a notification was made under section 6386 of the CPSL, a plan of

correction will be required that outlines the agency's planned steps to remedy the violation and ensure future compliance.

How will the notifications to Childline be categorized and disseminated?

ChildLine caseworkers will be trained to categorize notifications of an infant born and identified as affected by substance use as either Information Only notifications or a General Protective Services (GPS) referral, depending on the information provided. This information will be transmitted to the county of residence for the mother and infant. If at any time the county children and youth agency obtains more information regarding the environment surrounding the family and believe the Information Only or GPS referral should be re-evaluated to a GPS or child protective services (CPS) referral, they can request that of ChildLine. *Note: until January 1, 2020 when the necessary changes are made to the Child Welfare Information System (CWIS), all notifications of an infant born and identified as affected by substance use, withdrawal symptoms related to prenatal drug exposure, or FASD will be categorized as GPS referrals (this is a continuation of previous practice). This is to allow time for the necessary technical updates and changes to be implemented in the system. Following January 1, 2020, the ability of ChildLine caseworkers to classify a notification as Information Only or a GPS referral will be possible. Currently, the county agency has the ability to screen out the referral or refer the family for community services if there are no safety or well-being concerns for the child.

Dissemination protocols for notifications of infants born affected by substances where child welfare does not need to be involved are still under development between the Departments of Health, Human Services and Drug and Alcohol Programs.

Confidentiality Questions

How can we share information with the multidisciplinary team?

Information can be shared among planning team members with signed consent from the client. Each member of the multidisciplinary team is bound by state and/or federal confidentiality regulations related to their respective discipline.

How does 4 PA Code §255.5, related to disclosure of client-oriented information, affect this work and the ability for an MDT to collaborate?

With signed consent by the client, information can be shared with the multidisciplinary team within the confines of state and federal substance use disorder confidentiality regulations. According to 4 PA Code §255.5, individuals such as judges, probation or parole officers, insurance companies, health or hospital plan or governmental officials are restricted to the following information about a client in treatment for substance use disorder:

- (1) Whether the client is or is not in treatment.
- (2) The prognosis of the client.
- (3) The nature of the project.
- (4) A brief description of the progress of the client.
- (5) A short statement as to whether the client has relapsed into drug or alcohol use, and the frequency of such relapse.

Thus, when releasing information to MDT members, consideration should be given to the roles of the members on the teams. Importantly, there are no limitations on the types of information that an MDT can provide to a client's treating physicians.

The limitations on release of information detailed in 4 PA Code 255.5 do not preclude other entities such as mental health, Early Intervention, or hospital staff from releasing additional information. Those entities are bound by their own confidentiality and privacy regulations and should refer to them for guidance.

How do we share information if a client does not consent?

When consent is not obtained by the client, the multidisciplinary planning team should develop a process to assess the needs and safety of the client and family members without disclosing client identifying information to members of the multidisciplinary team.

Other

Is there funding attached to the work surrounding Plans of Safe Care?

The Departments of Health, Human Services and Drug and Alcohol Programs are working together to identify opportunities for funding to support this work.

Are infants who have been exposed to substances prenatally automatically eligible for Early Intervention based on diagnosis?

No, this diagnosis alone does not qualify an infant for Early Intervention service. They are eligible for screening and at-risk tracking.

Can/should Early Intervention participate on a Plan of Safe Care team for/with a pregnant mother?

No, the county Early Intervention coordinator should be part of the county administrative planning group to develop procedures on Plan of Safe Care, but Early Intervention and Children and Youth Services do not have a role until the infant is born, other than to ensure all other partner agencies that may participate in a Plan of Safe Care with a pregnant mother (like home visiting) know about Early Intervention and how to engage/refer to Early Intervention once the child is born.

Can/should Early Intervention be on a Plan of Safe Care team while the infant affected by prenatal substance exposure is still in the hospital?

Yes, but service coordination is the only Early Intervention service that can be provided while the infant is still in the hospital, 30 days or less prior to discharge for planning.

Can/should Early Intervention complete eligibility evaluations while the infant is still in the hospital?

No, Infant/Toddler Service Coordination is the only Early Intervention service that can take place in the hospital, 30 days prior to discharge. The hospital should be able to provide information on the infant as part of the Plan of Safe Care that can be used to help determine if the infant is eligible for Early Intervention service. All infants affected by prenatal substance exposure are eligible for Infant/Toddler Early Intervention screening and tracking.

How long can an infant who was exposed to substances prenatally remain in Early Intervention tracking?

Until the child's third birthday.

Will additional training be available for county planning teams?

Yes! Please plan to attend the Winter 2019 Technical Assistance sessions across the state.