



PROTOCOL TOOLKIT

Michigan Plan of Safe Care

A Guide to Supporting Infants
and Families Impacted by
Substance Use



Acknowledgments

This toolkit would not be possible without contributions from the Plan of Safe Care (POSC) Steering Committee, POSC Statewide Workgroup, POSC Technical Assistance Team, National Center on Substance Abuse and Child Welfare (NCSACW) and the continued efforts of the Governor's Task Force on Child Abuse and Neglect (GTFCAN).

The Michigan POSC Protocol was developed in collaboration between the Michigan Department of Health and Human Services (MDHHS) GTFCAN, other partners and subject matter experts who have done their best to use life-affirming language consistent with current standards.



Every effort has been made to ensure this document is accessible. If you are having any challenges preventing you from processing the information, please reach out to MDHHS-PlanofSafeCare@michigan.gov.

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GOVERNOR'S TASK FORCE ON CHILD ABUSE AND NEGLECT (GTFCAN)

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Table of Contents

Introduction	6
Background	7
Plan of Safe Care Legislation	9
Plan of Safe Care Protocol Development	11
Guiding Principles and Goals	13
Development Process	14
The 4 Ws for the Plan of Safe Care	15
What is a Plan of Safe Care?	15
Who Could Benefit from a Plan of Safe Care?	16
When Should a Plan of Safe Care be Initiated?	16
Who Should be Involved in Developing and Updating a Plan of Safe Care?	16
Implementation: eLearning Courses	18

Table of Contents - *Continued*

Implementation: Working with Families	19
POSC Workflows	19
Introduction to Families	25
Prenatal Period	26
Hospital Admission for Delivery	27
Postpartum (After Delivery and up to 12 Months)	29
Plan of Safe Care Implementation Scenarios	30
Implementation: Are You Ready?	39
Developing an Implementation Team	39
Implementation Readiness Checklist	41
Conclusion	43
Appendix	44
Plan of Safe Care Implementation Scenarios	46
Parents Sharing POSC with Their Support System	55
Talking Points for Discussing a POSC	55
Talking Points for Families Who Want or Ought to Share Their POSC with Providers	57
Additional Resources	65
National Resources	65
State and Local Resources	66

Introduction

A POSC is designed to address the needs of infants prenatally exposed to substances while providing support to parents and families. By offering tailored services to families affected by substance use during and after pregnancy, a POSC prioritizes the continuous health, development, safety and well-being of both the infant and their family members.

The State of Michigan Governor's Task Force on Child Abuse and Neglect, in collaboration with external partners and the Michigan Department of Health and Human Services (MDHHS), developed the POSC protocol, which received final approval in October 2022. The protocol aims to enhance the department's current POSC process, which is primarily facilitated by Children's Protective Services (CPS) case managers currently during active cases. The protocol expanded support for families, caregivers and guardians by creating opportunities for prenatal and community-held plans of safe care, in addition to the POSC traditionally developed by CPS case managers. The protocol includes a template to streamline sharing of information among multiple agencies. This template helps ensure those involved in the infant and family's care and all providers are updated and informed on how to support the family's needs.

This toolkit provides essential information and resources to equip care professionals to co-develop a POSC with families. Benefits of co-developing a POSC with the family include improved access to treatment for substance use, reduced mortality rates for individuals during pregnancy and postpartum, higher rates of keeping families together, promoting infant/parent bonding and attachment and providing comprehensive services to support the whole family.

Background

Substance use during pregnancy and parenting is a significant public health issue. Across the United States, substance use has adverse impacts on pregnant individuals, infants, parents and families. According to the Centers for Disease Control and Prevention:

In 2010...



4 out of every 1,000 infants born were diagnosed with Neonatal Abstinence Syndrome (NAS).

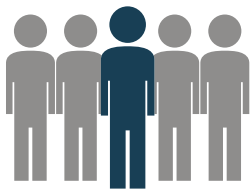
In 2017...



7.3 out of every 1,000 infants born were diagnosed with NAS.

Between 2010 and 2017:

- There was an 82% relative increase of infants diagnosed with NAS in the rate per 1,000 birth hospitalizations.
- The rates of infants diagnosed with NAS varied substantially across states from 1.3 to 53.5 per 1,000 hospital births.



One in Five

Twenty percent of parents report misuse of prescription opioids. Misuse is defined as getting opioids from a non-health care source or using them for a reason other than to relieve pain.¹

The data shows that substance use among families is increased and needs to be addressed. Care professionals should act as soon as possible, including during the prenatal period, to co-create a POSC with the pregnant individual. Developing a POSC in the prenatal period, rather than postpartum, has many benefits. Initiating a plan for support prenatally may reduce the adverse effects of substance exposure on the fetus, including the risk of still birth, low birth weight and physical, mental and behavioral problems. In addition, providing support prenatally may also decrease the risk of childhood maltreatment, entry into foster care and the risk of that child using substances in adolescence.

MDHHS and the Governor's Office recognized this pervasive public health issue and took action to reduce the number of pregnant individuals, infants and families impacted by substance use. Actions included updating the previous POSC process, creating the POSC protocol and developing educational resources (toolkit, eLearning courses, etc.) to equip care providers with the necessary knowledge and skills to co-create a POSC with the families they serve.

1 Haight, S. C., & C. (2018, August 9). Opioid Use Disorder Documented at Delivery Hospitalization. Centers for Disease Control and Prevention. doi.org/10.15585/mmwr.mm6731a1

Plan of Safe Care Legislation

A POSC addresses the health needs of the infant, the treatment needs of the birthing individual and the needs of other affected family members. [The Child Abuse Prevention and Treatment Act \(CAPTA\)](https://www.fda.gov/oc/ohrt/capta) (URL: [bit.ly/3NfyhJ8](https://www.fda.gov/oc/ohrt/capta)) was created in 1974 to bring a federal focus to prevention, identification and treatment of child abuse and neglect. Through CAPTA, states receive federal funding and guidance to improve their child welfare systems and conduct prevention activities. CAPTA has been amended multiple times to address the growing concerns over parental substance use. In 2003, CAPTA introduced a mandate requiring each state to have established policies and procedures that serve the needs of infants exposed to substances. These include making appropriate referrals to CPS and other relevant services, as well as developing a POSC specifically designed for the well-being of these infants.

CAPTA requires all states receiving grants to create a POSC protocol to:

- Address the health and substance use treatment needs of the pregnant or postpartum individual with substance use disorder.
- Address the physical, mental, behavioral and safety needs of the affected infant and other family members.
- Specify a department for monitoring the local provision of services in accordance with these requirements.

The [National Center on Substance Abuse and Child Welfare \(NCSACW\)](https://www.ncsacw.org/) website (URL: [bit.ly/4lkZREe](https://www.ncsacw.org/)) summarizes why plans of safe care are necessary:

“In 2016, the Comprehensive Addiction and Recovery Act modified child welfare legislation to expand POSC to include all infants affected by substance abuse, withdrawals symptoms or a fetal alcohol spectrum disorder and who require services be identified for the family/caregivers of these infants. The Administration for Children, Youth and Families, Children’s Bureau, which provides guidance related to POSC, has identified multi-system collaboration as a best practice to support affected infants and their families.”



The 2016 Comprehensive Addiction and Recovery Act (CARA) and CAPTA amendments focused on improving well-being and safety of infants affected by prenatal substance exposure and their families or caregivers by:

- Including exposure to both legal and illegal substances as an indicator of need for a POSC.
- Specifying requirements for notification to CPS.
- Including the treatment needs of the family/caregiver in the POSC, rather than being solely focused on the infant's needs.
- Increasing data collection and monitoring requirements; states now need to report to the maximum extent possible:
 1. The number of infants identified as affected by substance use.
 2. The number of those infants for whom a POSC was developed.
 3. The number of those infants for whom a referral was made for appropriate services, including services for the affected family or caregiver.

Plan of Safe Care Protocol Development

The federal government does not provide standard or mandated POSC tools for states. Every state develops their own tailored policies and implementation plans to comply with legislation. Plans of safe care may look different and be implemented differently across states.

Traditionally, plans of safe care have been implemented by CPS during the postpartum period. With substance use increasing among pregnant individuals and families, the standardized protocol for plans of safe care identifies three fundamental practice changes.



Prenatal POSC

Identify substance use in the prenatal period to co-develop a POSC with families as early in the pregnancy as possible and actively address and maximize health outcomes for the infant and parent(s) and prevent family separation whenever possible.



Community-Held POSC

The new protocol allows for plans of safe care to be initiated not only by child welfare case managers but also by health care teams, Home Visiting, treatment providers and other agencies that engage with and support the family.

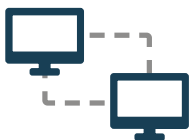


POSC Template

A standardized POSC template was developed to encompass the health and safety of infants, pregnant individuals and other caregivers or family members.



The POSC template has three primary benefits:



Creates
consistent information
across systems.



Improves
care coordination
between agencies.



Empowers
parents to advocate
for their needs.

To access and download the applicable template for your agency, visit the [Appendix](#).

Guiding Principles and Goals

The following goals and guiding principles informed Michigan's POSC Protocol:

- To collaborate across health and social service agencies and to address the infant's and parent's physical, social-emotional and safety needs.
- To develop an inclusive, family-centered approach that fosters a comprehensive understanding of substance use and its impact on infants, families and caregivers. The POSC will aim to meet the needs of each family member by building on their individual strengths and addressing their unique challenges.
- To establish a model of education for primary partners regarding substance use during the prenatal and postpartum stages of child development and potential risks to infants and their families and caregivers.
- To encourage collaboration and care coordination between relevant partners while maintaining privacy and confidentiality in the co-development and implementation of the POSC.
- To complete a risk assessment that is organized by the presence of protective factors that look at strengths and concerns of the parent(s), family members and caregivers as part of their engagement in recovery.
- To ensure legally sound and data-driven decision-making that includes a trauma-informed lens while maintaining family engagement.
- To offer support and services to an infant, parent(s), caregivers and other household members during the first year of an infant's life.



Development Process

In 2022-2023, tools were developed to support an understanding and application of a POSC in Michigan. These available resources include eLearning courses, this toolkit and additional documentation outlining the expectations of a POSC.

The following sections of this toolkit define and describe the POSC based on input and feedback from the steering committee. This document aims to guide health care teams, treatment providers, child welfare case managers, home visitors and other partners as they start implementing the POSC development process. This toolkit will continue to evolve according to the relevant policy or other changes affecting Michigan's POSC Protocol.

The 4 Ws for the Plan of Safe Care

What is a Plan of Safe Care?

A POSC is a tool co-developed with an individual who is pregnant with, or parenting, a baby that has been exposed to substances. A POSC may include addressing a family's basic needs, evaluating the social determinants of health, substance use recovery, treatment and many other services. The individual who is pregnant or parenting drives their plan, which should contain information about themselves, their baby, their family and their support network. Sharing this information can benefit the coordination of care and enable parents to advocate for their own needs and the needs of their baby.

The POSC serves as a tool to help the pregnant or parenting individual navigate care and services for themselves and their infant before and after delivery.

The POSC aims to have a positive impact on the family, with desired outcomes, including:

- Promoting substance use treatment and engaging in recovery.
- Ensuring children live in safe, stable and nurturing environments.
- Identifying and strengthening a family's support network.
- Keeping families together when possible.
- Safely reunifying families as quickly as possible if removal has occurred.

Who Could Benefit from a Plan of Safe Care?

A POSC exists for the benefit of pregnant or postpartum individuals who are using substances, medically administered or not, and their infants who are born exposed to substances. Plans of safe care can also benefit other caregivers, household members, family members and other support system members of the pregnant or parenting individual and their infant.

When Should a Plan of Safe Care be Initiated?

A POSC should be initiated and co-developed with a pregnant or parenting individual as soon as substance use is identified. Ideally, this would occur as early in the prenatal period as possible to allow for the most significant benefit. However, a POSC can be co-developed when the need is identified anytime during the pregnancy or within 12 months postpartum. These circumstances may include post-delivery at the hospital, during a CPS investigation or when a parenting individual engages in substance use treatment, Home Visiting or other supportive services.

Who Should be Involved in Developing and Updating a Plan of Safe Care?

A POSC is parent- and infant-centered with the goal of allowing families to lead with their own care and assist them in advocating for their needs. A POSC may be co-developed, in partnership with the pregnant or parenting individual, and by many types of health care or care providers, including evidence-based home visitors, Early On providers, prenatal, delivery and postpartum health care providers, substance use treatment providers, case managers, social workers and/or peer recovery support.

A pregnant or parenting individual must consent to a POSC before its development, and must also provide explicit informed consent prior to the POSC being shared with other providers. You can view the [Appendix](#) or a consent form used by MDHHS for sharing information between agencies as needed and agreed upon with the parent. [The consent form can be found here](#) (URL: bit.ly/4d8lAcX). Other agencies and partners should refer to internal procedures for their respective consent forms. To learn more about informed consent, please visit the [American College of Obstetrics and Gynecology website](#) (URL: bit.ly/3pdY5xv) and read Informed Consent and Shared Decision-Making in Obstetrics and Gynecology.

Figure 1: A POSC Can Be Initiated through a Variety of Health and Family Servicing Professionals.



There are many paths to initiating and sustaining a Plan of Safe Care (POSC)

There are **no requirements** for who must be involved in the development of a POSC, or with whom information must be shared. Individuals or families are encouraged to share their POSC with all their providers for optimal care collaboration. However, the POSC should only be shared with providers that the family or the pregnant/parenting individual has given explicit consent for it to be shared with.

Implementation: eLearning Courses

Three eLearning courses with downloadable resources have been developed to provide training regarding what a POSC is, why they are important and the process for developing and maintaining a POSC alongside a family. Please check with your agency to determine the requirement to complete some or all of the modules. Follow this link to [create an account and access the courses quickly](https://bit.ly/3YK1YaP) (URL: bit.ly/3YK1YaP). **Nursing and social work continuing education credits have been applied for all three eLearning courses. To receive credit(s), complete a course and you will be emailed a printable certificate.**

Introduction

This brief section will provide an overview of the training structure, providing foundational information used throughout the following courses.

Course 1: Why?

This course will provide background information on why Michigan needs a POSC protocol, as well as explore the basics of substance use, trauma and other contributing factors, and look at the impact of substance use on families from a physiological and family integrity standpoint.

Course 2: What?

This course will examine the POSC protocol: how it was developed, what it includes and how it can be used to support families.

Course 3: How?

This course will explore the components of the successful implementation of a POSC, including how to co-develop a POSC, maintain family integrity and provide warm handoffs in care.

After these eLearning opportunities, you will have a comprehensive understanding of the POSC's purpose, value and process for development. If you would like to suggest further resources or need assistance, please email MDHHS-PlanofSafeCare@michigan.gov.

Implementation: Working with Families

POSC Workflows

As referenced earlier, a POSC can be co-developed with a family at any time that substance use is identified, including prenatally or up to a year (12 months) postpartum. In Michigan, recent updates to the POSC process affect those that co-develop the POSC with families, including health care providers, child welfare case managers, substance use treatment providers and home visitors.

The three key practice changes in Michigan's POSC process are:



Prenatal POSC

Co-develop a POSC with someone who uses substances as early as possible, ideally prenatally.



Community-Held POSC

Plans of Safe Care can be developed by providers outside of child welfare.



POSC Template

A standardized POSC document to provide consistent support and care coordination to families.

Recognizing when a POSC should be created is essential to connecting families with needed support services. To assist you, workflows demonstrating the POSC implementation process for each profession are available below.

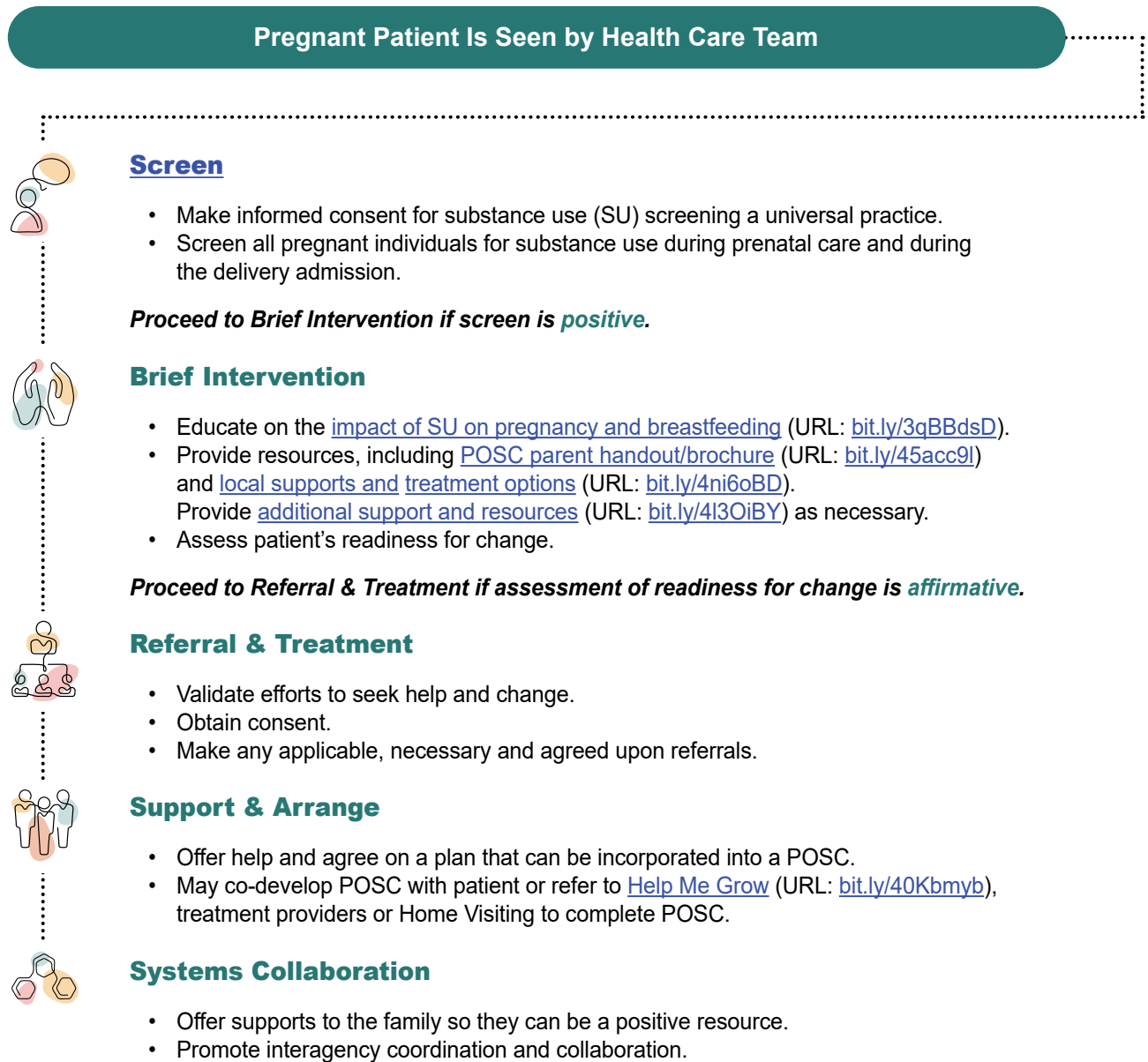
Figure 2a: Health Care Team POSC - Prenatal

Figure 2b: Health Care Team POSC - Delivery Admission of Parent and Infant

Pregnant Patient Is Seen by Health Care Team for Delivery Admission

Screen

- Make informed consent for screening a universal practice.
- Screen all consenting birth parents for SU at delivery, using validated screening tool.
- Review prenatal SU history.
- If no known prenatal care, rely on hospital protocol for testing.

*Proceed to Brief Intervention if screen indicates **SU** during pregnancy.*

Brief Intervention

- Educate on the [impact of SU on pregnancy and breastfeeding](https://bit.ly/3qBBdsD) (URL: bit.ly/3qBBdsD).
- Provide resources, including POSC parent handout/brochure, [local supports and treatment options](https://bit.ly/43R23eD) (URL: bit.ly/43R23eD).
- Assess patient's readiness for change.

*Proceed to Referral & Treatment if assessment of readiness for change is **affirmative**.*

Referral & Treatment

- Praise efforts to seek help and change.
- Obtain consent.
- Make any applicable, necessary and agreed upon referrals.

Support & Arrange

- Offer help and agree on a plan that can be incorporated into a POSC.
- May co-develop POSC with patient or refer to [Help Me Grow](https://bit.ly/40Kbmyb) (URL: bit.ly/40Kbmyb), treatment providers or Home Visiting to complete POSC.

Systems Collaboration

- Offer supports to the family so they can be a positive resource.
- Promote interagency coordination and collaboration.

If infant exhibits signs of withdrawal or tests positive for substance(s):

Exposure Attributed to Medical Treatment

and no concerns for child abuse or neglect

Notification to Children's Protective Services (CPS) Centralized Intake Hotline

Health care provider to refer to [Help Me Grow](https://bit.ly/40Kbmyb) (URL: bit.ly/40Kbmyb), Home Visiting or other treatment provider for coordination and implementation of POSC. CPS-Centralized Intake to confirm notification is appropriate.

Exposure **NOT** Attributed to Medical Treatment

Referral to CPS-Centralized Intake

CPS-Centralized Intake will determine if the referral is screened out or screened in for investigation by CPS.

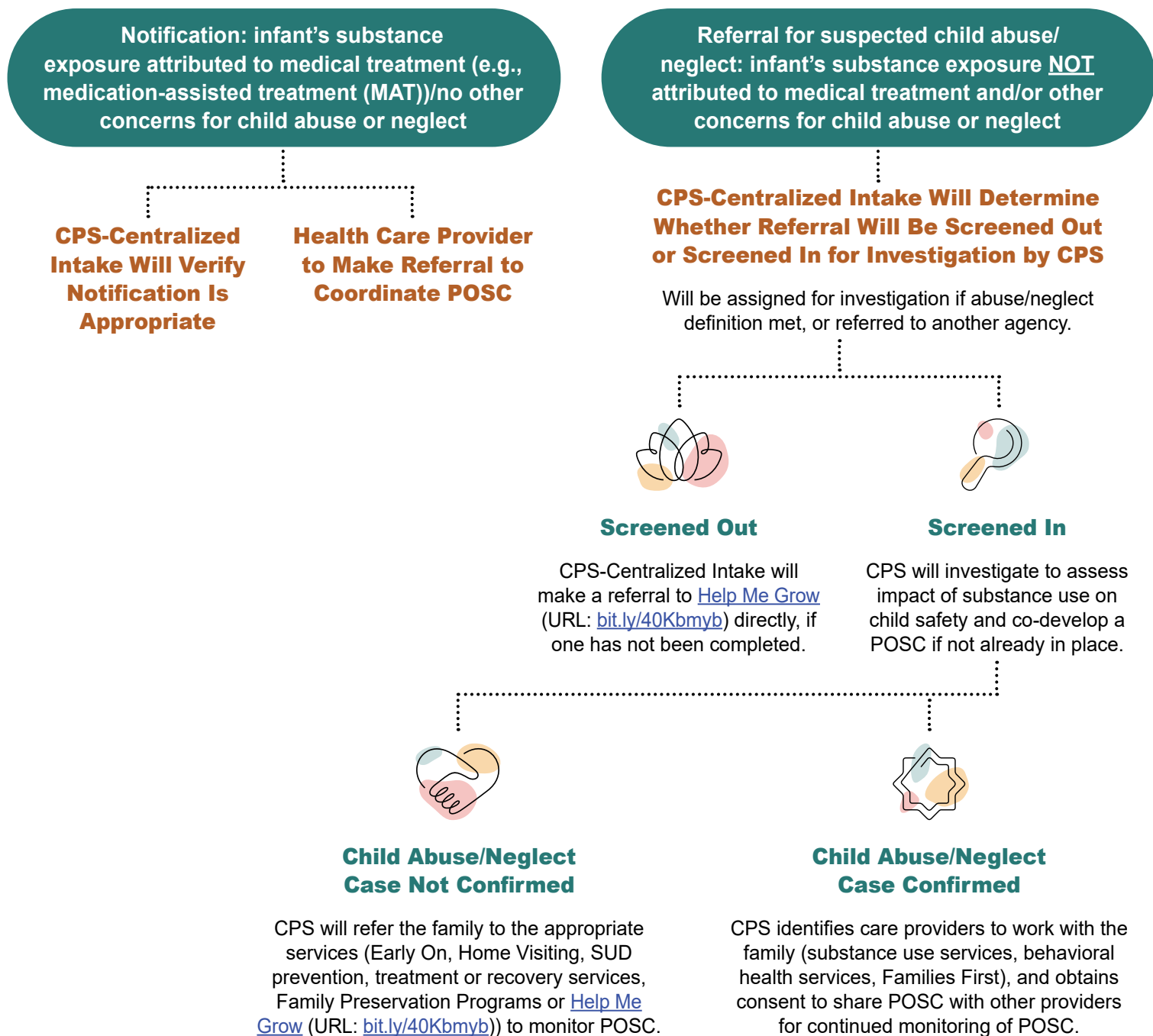
Figure 2c: Child Welfare POSC - Postpartum

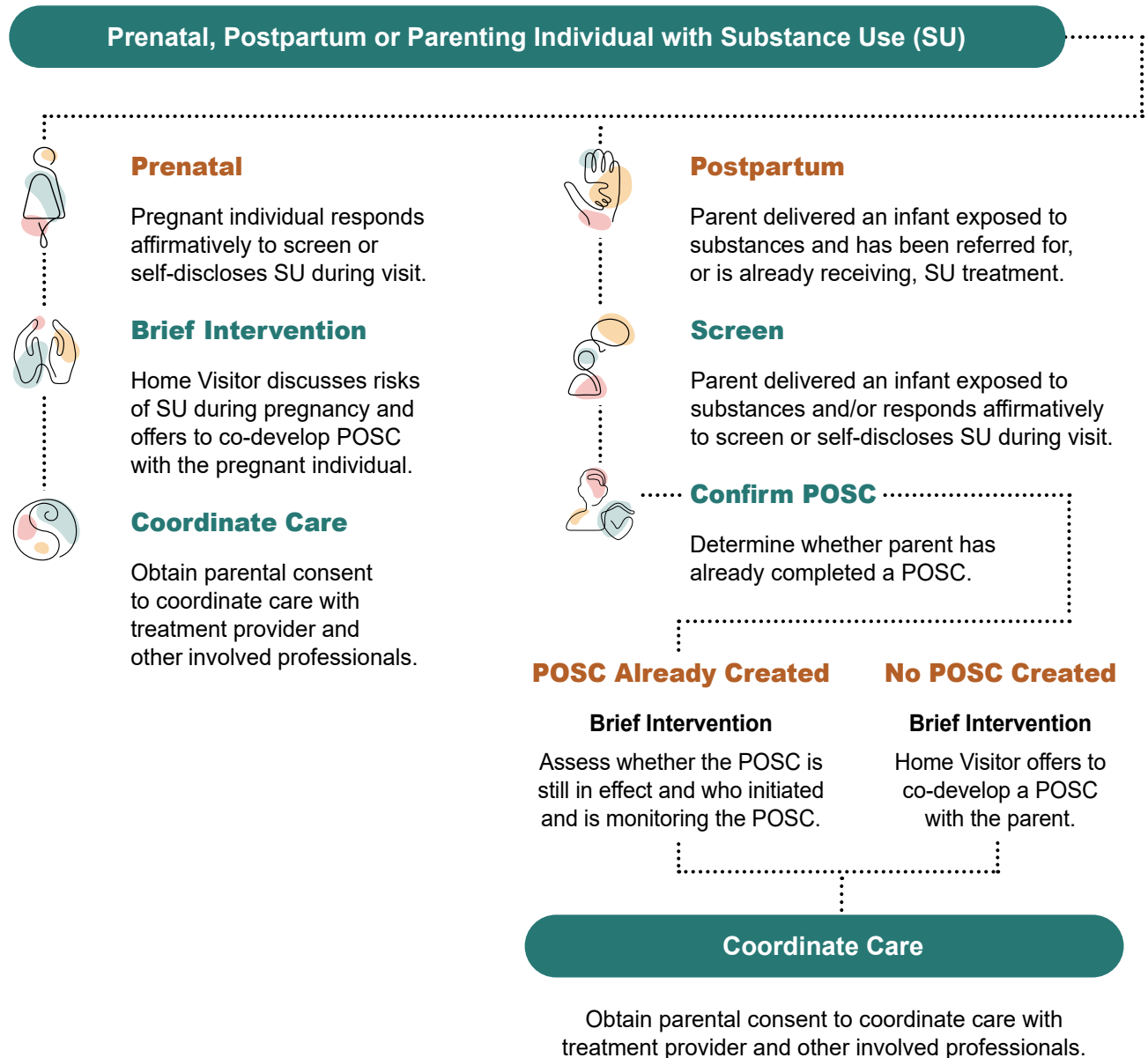
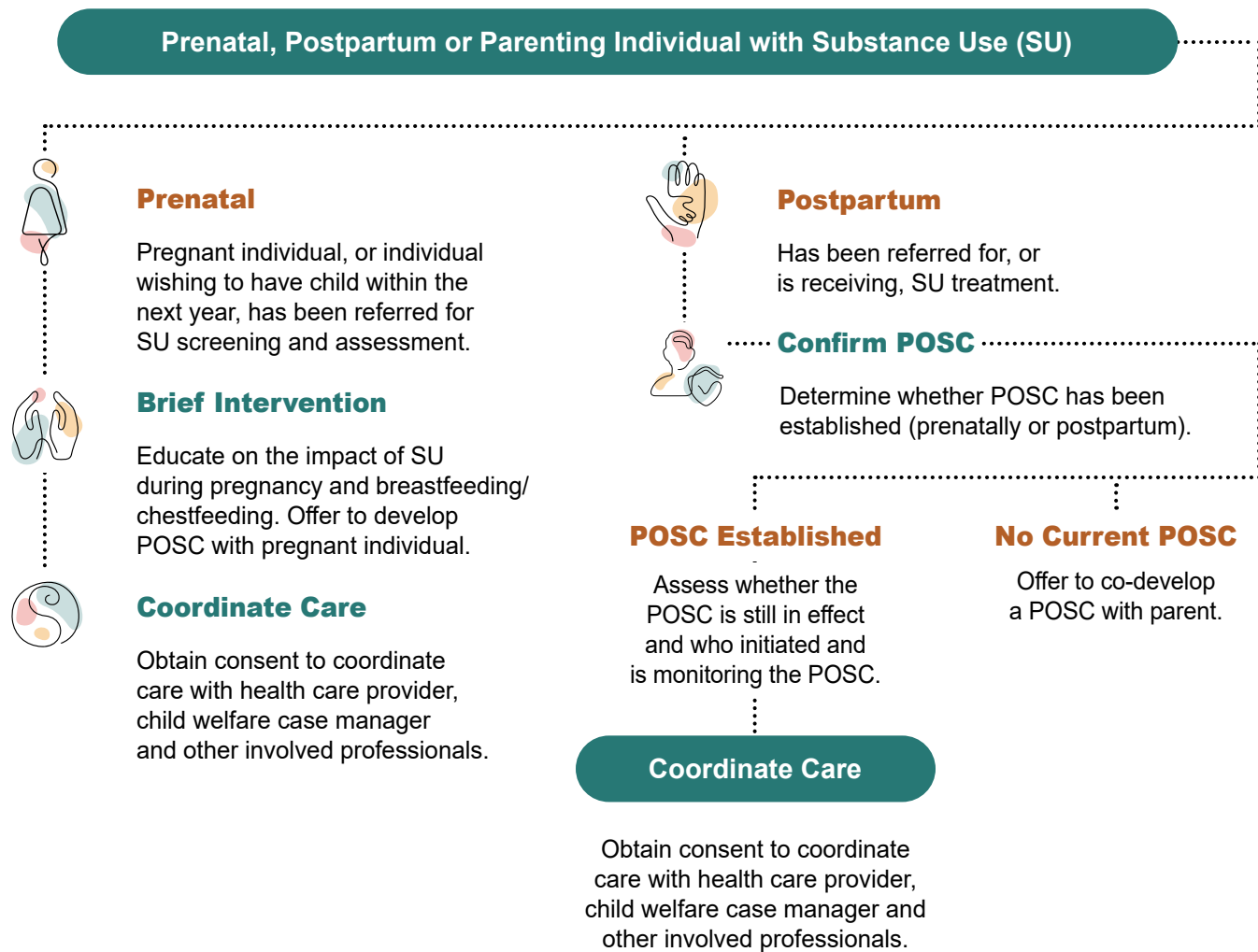
Figure 2d: Home Visitor, or other Community-Based Care Provider

Figure 2e: Treatment Provider POSC - Prenatal and Postpartum

The workflows help identify when a POSC should be initiated to support early identification and treatment. You can view a complete collection of how POSC implementation will affect your work area in the [Appendix](#) that includes the following graphics:

- **What's Different:** Health Care Team (Prenatal - OB/GYN, Midwife, Primary Care Provider (PCP), etc.).
 - **What's Different:** Delivery Admission.
 - **What's Different:** Child Welfare.
 - **What's Different:** Home Visiting.
 - **What's Different:** Treatment Providers.
 - **Home Visiting or Other Community-Based Care Provider:** Prenatal and Postpartum.
 - **Community Service Provider Handout:** Created to help providers understand a POSC.
-

Introduction to Families

The benefits of a POSC should be communicated clearly to a pregnant or parenting individual who uses substances. This guide provides resources to share with parents and families as you discuss a plan: see the [Appendix](#) for the **POSC Parent One-Pager**. You may use the content presented in these infographics as POSC talking points. Feel free to change the words so parents, caregivers and family members know the plan is for them and their health and well-being.

Prenatal Period

Early identification, screening and engagement with a pregnant individual who is using substances will allow the collaborative process to begin before the newborn's birth. Initiating a prenatal POSC is done by professionals involved in the prenatal period and co-developed with the pregnant individual. When available, we highly encourage the prenatal health care team to work closely with hospital peer navigators or Home Visiting programs to help facilitate the POSC process.

Care professionals should be aware of the impact of all forms of implicit and explicit biases impacting assessment, screening and care decisions with families who are impacted by substance use. You can learn more about these in the POSC eLearning courses.

Screening vs. Testing: What's the Difference?

These terms are often confused as synonyms when they are referring to different things.



Screening (Verbal or Written):

Initial assessment of prenatal substance use that identifies whether there may be or has been substance use and determines if there is a need for further risk assessment.



Testing:

Sample (urine/meconium/umbilical cord of newborn or urine/blood of birthing parent) evaluated for the presence of drugs and/or alcohol.

Substance Use Screening and Testing Best Practices:

- Screen all pregnant individuals for substance use at the first visit, every trimester and delivery.
- Educate on the impact of all forms of substance use, including alcohol, cannabis and illicit substances, on pregnancy and breastfeeding/chestfeeding.
- Ask about substance use before pregnancy awareness in addition to current use.
- Make informed consent for substance use screening and testing a universal practice.

Substance Use Screening: The purpose of universally using a validated screening tool is to reduce and prevent adverse outcomes, reduce bias, address risks early and connect with family when the patient needs support for the well-being of all family members. If screening is positive, providers should follow the POSC Workflows to provide support and treatment options to the pregnant or parenting individual. Please find a guide of evidence-based screening tools in the appendix of [Michigan's POSC Protocol](https://bit.ly/4eIUWAd) (URL: bit.ly/4eIUWAd).

During the prenatal phase, consider what available supports can be offered to the family so they can be a positive resource for the pregnant individual and infant. If there is no child welfare involvement, then the primary individual or organization that developed the POSC should work to encourage interagency coordination between organizations and the impacted individuals.

Hospital Admission for Delivery

Early identification, screening, engagement and referral of individuals who have just given birth, and for whom there are substance use concerns, will allow the collaborative process to begin prior to the newborn going home from the hospital.

A best practice is to create a communication protocol between applicable agencies that allows for timely information sharing and assessment of infants and families across multiple systems. Members of the health care team at the delivering hospital should ask parents if there is an existing POSC in place:

- If yes, ask if it needs to be updated, and if not, the delivering hospital should continue to use and support the current plan.
- If no, the health care team may offer to assist in the initial co-development of the POSC or refer the family to a home visitor or substance use treatment provider for co-development of the POSC for the birthing parent and infant(s) identified at the time of delivery.

Mandated Referrals and Notifications

A **referral* to CPS-Centralized Intake** is required if a mandated reporter knows, or has reasonable cause to suspect, that an infant has any amount of alcohol, a controlled substance or a metabolite of a controlled substance in the infant's body.

CPS will investigate referrals alleging that an infant was born exposed to substances not attributed to medical treatment when any of the following indicates exposure:

- A positive urine screen of the infant.
- A positive result from meconium testing.
- A positive result from umbilical cord tissue testing.
- A medical professional reports that the child has symptoms that indicate substance exposure.

A **notification to CPS-Centralized Intake** is required if the mandated reporter knows that the alcohol, controlled substance or metabolite, or the child's symptoms, are the result of medical treatment administered to the infant or the infant's parent. Medical marijuana, MAT and other prescribed medications are considered medical treatment.

If it is determined the infant's exposure is attributed to medical treatment, and a notification is made, the health care team should ensure a POSC is in place or make a referral to [Help Me Grow](https://www.me-grow.com) (URL: bit.ly/40Kbmyb), or any providers with whom the family has chosen to work, to facilitate co-development of a plan.

*** The terms referral and report are synonymous in the context of child welfare.**



Postpartum (After Delivery and up to 12 Months)

Continued screening, engagement and referral of an individual who has just given birth, and for whom there are substance use concerns, will allow the collaborative process to continue after the infant is discharged from the hospital.

During this time, it would be appropriate for a provider who is either working with the family already, or making initial contact with the family, to inquire about whether a POSC was developed, and if not, offer to co-develop one. If one was completed prenatally or during the birthing event or stay, then it would be appropriate for the provider to inquire about any possible updates needed to the POSC. Possible providers may include a Home Visiting program, Early On, substance use treatment program or a child welfare case manager.

Plan of Safe Care Implementation Scenarios

Preparing in advance for potential situations you may encounter can help you feel more prepared and capable of providing appropriate care to families. The following pages offer hypothetical scenarios of individuals impacted by substance use, and discussion prompts to aid in thinking through the role of a POSC in the care they receive. Each professional may encounter different circumstances based on their role. We have provided detailed examples from health care professionals, home visitors, child welfare case managers and treatment providers. Additional scenarios can be found in the [Appendix](#).

Health Care Team: Scenario One



Shanda is an 18-year-old pregnant individual who is currently in foster care. She is in substance use treatment where she receives methadone for her opioid use disorder. She is also regularly receiving prenatal care. Shanda has an open CPS case for neglect of her 3-year-old child related to her substance use. When Shanda delivered her baby, the baby did have symptoms of Neonatal Opiate Withdrawal Syndrome (NOWS) that did not require pharmacological intervention. Shanda reports having a stable home and support for her and her baby.

Questions to Consider

[For a Neonatal Intensive Care Unit (NICU) Health Care Provider]

- **What are the most immediate needs for Shanda, her newborn and other household members?**

As Shanda reports having a stable home and support for her and her baby, supports such as Home Visiting may provide continued connection for Shanda to arising needs postpartum, including a POSC. Shanda and her family will also benefit from safe sleep education.

- **Does this situation require a notification or referral to CPS-Centralized Intake? If yes, which one?**

This situation requires a notification to CPS-Centralized Intake because the infant has NOWS symptoms attributed to medical treatment of the parent.

- **What is the role of the health care team in relation to the POSC? Are you co-developing the POSC with Shanda, or referring to a different provider to co-develop the POSC?**

According to the policies and procedures of the health care team, the provider can offer help and agree on a plan that can be incorporated into a POSC. The provider may co-develop the POSC with Shanda or refer to a treatment provider or Home Visiting to complete the POSC. The SUD treatment provider might be in an excellent position to co-develop, or refer to [Help Me Grow](https://bit.ly/40Kbmyb) (URL: bit.ly/40Kbmyb) or any providers with whom Shanda has chosen to work, and support the POSC with Shanda.

- **Is a service referral necessary? If yes, who are you referring to?**

Referrals that are applicable, necessary and agreed upon by the patient may include, but are not limited to, substance use treatment providers, Home Visiting, additional health care providers, Women, Infants and Children (WIC), social work, etc.

Questions to Consider - *Continued*

[For a Neonatal Intensive Care Unit (NICU) Health Care Provider]

- **What does care coordination look like for this family? Who might the parent want to share the POSC with? Who might you (with consent) want to share the POSC with?**

With Shanda's consent, care coordination may include sharing the POSC with other supports and providers including, but not limited to, substance use treatment providers, other health care providers, including her infant's pediatrician, WIC, social work, behavioral health or Home Visiting.

- **Who will provide ongoing support, monitoring and updating of the POSC as it pertains to the health and safety needs of Shanda, her infant and other household or family members?**

According to the policies and procedures of the health care team, the POSC may be updated and monitored by one or as many team members as needed. At the time a notification is made, CPS-Centralized Intake will inquire whether a POSC has been developed, or encourage the health care team to make a referral to [Help Me Grow](https://bit.ly/40Kbmyb) (URL: bit.ly/40Kbmyb) to facilitate co-development of a plan. If the POSC is shared with Shanda's foster care case manager, the foster care case manager can also offer support and monitoring of the POSC.

Home Visitor: Scenario One

Laine is a 22-year-old woman who has two children that are 2 and 3 years old, and is currently pregnant. She has been enrolled in your Home Visiting program for three months. However, during those three months, she has canceled and rescheduled home visits multiple times, so her intake paperwork could not be completed, including the substance use screening tool. She recently reached out to schedule a home visit at her new apartment. At the visit, she disclosed that she is 18 weeks pregnant. She acknowledges not yet receiving prenatal care and is concerned about having a positive drug test for opioid use. She describes that she has a strong support system in place and is currently working part-time at a local grocery store. Prior to finishing the visit, you support her in scheduling a visit with her prenatal care provider.

Questions to Consider

- **What are the most immediate needs for Laine? For family members?**

The most immediate supports for Laine and her family include a connection to prenatal care and substance use treatment. Laine will also benefit from a POSC as well as safe sleep education.

- **Does this situation require a notification or referral to CPS-Centralized Intake? If yes, which one?**

Not at this time. At the birth event, if the infant screens positive for opioids and Laine is receiving MAT, a notification is needed. If the infant screens positive and the exposure is not attributed to medical treatment, a referral to CPS-Centralized Intake is required.



- **What is the role of a home visitor in relation to the POSC? Are you co-developing the POSC with Laine, or referring to a different provider to co-develop the POSC?**

As the home visitor, you should co-develop the POSC with Laine. You must also ensure the POSC has all the referrals with the contact information in one place. You want to encourage Laine to call any of the identified agencies; however, if she is not comfortable doing so, support her in making the calls and provide warm handoffs when possible. You will continue to support her and follow-up on the POSC at every visit.

- **What does care coordination look like for this family? Who might the parent want to share the POSC with? Who might you (with consent) want to share the POSC with?**

Encourage Laine to share her POSC with her PCP, prenatal care provider and substance use treatment provider, as applicable. If CPS becomes involved after the birth of the baby, Laine should also be encouraged to share her POSC with the CPS case manager. With consent, you can share the POSC with any of these agencies if that is what Laine requests.

- **Who will provide ongoing support, monitoring and updating of the POSC as it pertains to the health and safety needs of Laine, her infant and other household or family members?**

Ongoing support will occur through the home visitor and substance use treatment provider. If CPS becomes involved postpartum, they may help provide ongoing support.

Child Welfare Case Manager: Scenario One

Ayana is the 20-year-old mother of a baby born three days ago. Ayana lives with her own mother and the father of her baby. The baby's meconium was positive for tetrahydrocannabinol (THC). Ayana received sporadic prenatal care and it is unknown if a POSC is in place. Ayana further reports she uses marijuana daily because it is legal and helps her relax. She has no intentions of stopping. She reports she has everything she needs to care for her daughter.

Questions to Consider

- **What are the most immediate needs for Ayana? Her newborn? Other household members?**

Identify whether a POSC has been implemented. If not, co-develop with family. Ayana and all household members should be educated regarding the safe use and storage of marijuana, including ensuring a capable caregiver is present should Ayana decide to use marijuana while caring for her child. Education surrounding safe sleep should occur. Alternatives to substance use as it pertains to relaxation should be discussed. Resources for substance abuse treatment should be provided. Despite the legality of recreational marijuana use, Ayana and other household members should be aware of treatment options in the event the marijuana use presents risk to the infant.

- **What is the role of a child welfare case manager in relation to the POSC? Are you co-developing the POSC with Ayana, or referring to a different provider to co-develop the POSC?**

The child welfare case manager should determine if there is an existing POSC. If one does not exist, the POSC should be co-developed with Ayana and the existing household members, as well as any other support individuals who might care for the infant. Coordination should occur with the infant's pediatrician as well as any providers referred to the family.

- **Is a service referral necessary? If yes, who are you referring to?**

A referral to Early On should be made based on the infant's exposure to substances. For additional support, the Home Visiting program should be discussed with the family, and a referral should be made if the family is interested in participating. Prevention-based services to address any of the family's needs should be referred to provide additional ongoing support.

- **What does care coordination look like for this family? Who might the parent want to share the POSC with? Who might you (with consent) want to share the POSC with?**

With Ayana's consent, the POSC should be shared with any health care provider who is working with Ayana and her baby, including her PCP and the baby's pediatrician. The POSC should also be shared with all other care providers involved with the family, including a substance use treatment provider if treatment is sought.

- **Who will provide ongoing support, monitoring and updating of the POSC as it pertains to the health and safety needs of Ayana, her infant and other household or family members?**

If child welfare involvement continues past the initial investigation stage, the assigned case manager should continue to assist with monitoring and updating the POSC. If child welfare involvement does not continue, monitoring and updating the POSC should be led by the family, medical providers, referred service providers and prevention-based service providers. The responsibility ultimately is that of Ayana and her family, but any referral-based services should continue to provide ongoing support in this area. Before child welfare involvement ceases, the case manager should ensure all appropriate entities are aware of the existence of the POSC, with the parent's consent.

Substance Use Treatment Team: Scenario One

Rashida is a 27-year-old Muslim mother of two children ages 4 and 7 years old. She is 30 weeks pregnant and has been enrolled in MAT for 3 years, following the delivery of her second child, and attends one-on-one counseling with a SUD therapist. Rashida states she is regularly engaged in prenatal care and has developed a delivery plan with her prenatal care provider. She is able to identify supports, including her mosque, neighbors and family members, and states she has everything in place to care for this child.

Questions to Provider

- **What are the most immediate needs for Rashida and her family?**

Rashida requires a plan for the continuation of MAT while she is in the hospital for labor and delivery, and when she is discharged home. Offer safe sleep education and resources and assess any barriers to implementing safe sleep practices. Connect Rashida to preventative resources as needed to mitigate any barriers.

- **Does this situation require a notification or referral to CPS-Centralized Intake? If yes, which one?**

Not at this time. At the birth event, if the infant screens positive for opioids and Rashida is receiving MAT, a notification is needed. If the infant screens positive and the exposure is not attributed to medical treatment, a referral to CPS-Centralized Intake is required.

- **What is the role of a treatment provider in relation to the POSC? Are you co-developing the POSC with Rashida, or referring to a different provider to co-develop the POSC?**

Rashida's substance use treatment provider can provide her with a POSC handout and co-develop a POSC with her if one does not already exist. If a POSC has already been developed, the treatment provider should review it with Rashida to see if there are any necessary updates. The POSC should include a plan that Rashida will have access to her MAT when in-hospital for her delivery, that her other children are well supported and that her cultural and religious needs are being met.

- **Is a service referral necessary? If yes, who are you referring to?**

No referrals are necessary at this time. A peer recovery coach may be helpful to Rashida and could be offered.

- **What does care coordination look like for this family? Who might the parent want to share the POSC with? Who might you (with consent) want to share the POSC with?**

The POSC should be shared with any health care provider who is working with Rashida, including her prenatal care provider and MAT provider. The POSC should also be shared with all other care providers involved with the family. Rashida may also choose to share her POSC with members of her mosque for additional support.

- **Who will provide ongoing support, monitoring and updating of the POSC as it pertains to the health and safety needs of Rashida, her infant and other household or family members?**

Rashida's MAT provider should assist Rashida and any other applicable care provider in updating the POSC as needed.

Implementation: Are You Ready?

Care providers should consider the logistic and functional needs their team has to create Plans of Safe Care and support families they serve. Below are tools to assist care providers in preparing and implementing the POSC protocol. Michigan's POSC Template (see [Appendix](#)) is available to use and adjust for your team's specific needs.

Developing an Implementation Team

The successful co-development of a POSC with families requires that care providers have a system for care coordination and interagency collaboration. This system can be designed and refined by developing an Implementation Team.

The team should consist of key partners including, but not limited to:



Front Office/Client-Facing Staff



Administration



Support Staff



Human Resources/Training



Direct Care Staff

Questions to Ask

With an Implementation Team gathered, share past experiences with a POSC, what practices are in place today and what may need to change. Develop a list of questions that address the considerations for implementation, such as:

Who?

- Who will receive a POSC and how will they be identified?
- What *section* of the POSC is each care provider responsible for? (May be provider-specific.)
- Who is responsible for helping clients/patients *develop or initiate* their POSC?
- Who is responsible for helping patients *update/review* their POSC?

Documentation?

- What specific documents and information will be provided?
- Where will this information be stored?
- How and where should providers document initiation and updates to the POSC?

When?

- When is the POSC started with clients/patients?
- How often and when is the POSC updated/reviewed?
- When will you meet as a team to reflect upon implementation? (*Include date/time of first follow-up meeting; any ongoing meetings to discuss implementation.*)

Challenges/Solutions?

- What policies or workflows need to be developed or updated before implementation?
- How to identify if a POSC has already been initiated?
- What are some anticipated challenges to co-creating a POSC with families?
- What are some potential solutions to address those challenges?

Refer to the [Appendix](#) to view a template for implementation questions that you can use.

Implementation Readiness Checklist

The below checklist can be used to prepare for a successful implementation.

Are You Ready?

- All staff that may be involved in the co-creation, updating or support of a POSC should complete the three POSC eLearning trainings:



Course 1

Why?



Course 2

What?



Course 3

How?

- An Implementation Team meets to discuss the workflow process for POSC development.
- An Implementation Team develops a POSC Implementation Guide for their staff involved with the Plans of Safe Care.
- Staff have access to POSC protocol and agency-specific template.
- Initial implementation/trial period will be: _____ to _____
(a short period of time, such as one week or one month for an initial trial period).
- Follow-up meeting to discuss trial period is scheduled for: _____.
- Ongoing meetings are scheduled for ongoing review, implementation reflection and revision of processes, as needed.



Developing POSC Training as an Educational Requirement

Your organization may wish to start by amending training policies to require all new hires and existing staff to complete the POSC eLearnings.

POSC eLearning training is a series of three courses that provide background information on the need for a POSC, the components of a successful POSC, and direction on successful implementation and collaboration with the teams involved in development and monitoring of a POSC.

Conclusion

The goal of a POSC is to strengthen the family, support a healthy pregnancy and keep child(ren) safely at home. This toolkit includes scenarios, workflows, definitions and links to many resources to help you better support pregnant and parenting individuals with co-developing a POSC. Families should feel empowered to take ownership of the plan and advocate for their unique needs.

To ensure you are prepared to provide support for Michigan's pregnant and parenting individuals and their families, please take the following steps:



Review Toolkit

Read this document and note the changes for Michigan's POSC.



Complete e-Learning Courses

Review resource links and determine which tools you can use.



Share Knowledge

Identify opportunities and share the information in this toolkit.

By taking these actions, care providers can expand their expertise and practical knowledge in supporting families impacted by substance use. Health care providers, case managers, home visitors, treatment providers and other care providers have a tremendous opportunity to support significant positive changes in the lives of Michigan families. Through the implementation of plans of safe care, care providers can co-develop solutions for and with families.

Appendix

AIM Safety Bundle: Care for Pregnant and Postpartum Individuals with Substance Use Disorder

[AIM Safety Bundle: Care for Pregnant and Postpartum People with Substance Use Disorder](https://bit.ly/3MMbiWz) (URL: bit.ly/3MMbiWz)

Authorization to Release Confidential Information

[Authorization to Release Confidential Information](https://bit.ly/4e2X2Vt) (URL: bit.ly/4e2X2Vt)

Michigan's POSC Protocol

[Michigan's POSC Protocol](https://bit.ly/4eIUWAd) (URL: bit.ly/4eIUWAd)

POSC General Template

[POSC General Template](https://bit.ly/42MFKJn) (URL: bit.ly/42MFKJn)

POSC Maternal Infant Health Program (MIHP) Template

[POSC MIHP Template](https://bit.ly/3O05itN) (URL: bit.ly/3O05itN)

Form 1: Implementation Questions

These questions are a starting point when preparing to implement a POSC protocol in your work setting.

Question	Response
Who will receive a POSC and how will they be identified?	
What <i>section</i> of the POSC is each care provider responsible for? (May be provider-specific.)	
Who is responsible for helping clients/patients <i>develop or initiate</i> their POSC?	
Who is responsible for helping patients <i>update/review</i> their POSC?	
When is the POSC started with clients/patients?	
How often and when is the POSC updated/reviewed?	
When will you meet as a team to reflect upon implementation? (<i>Include date/time of first follow-up meeting; any ongoing meetings to discuss implementation.</i>)	
What specific documents and information will be provided?	
Where will this information be stored?	
How and where should providers document initiation and updates to the POSC?	
What policies or workflows need to be developed or updated before implementation?	
Determine if a POSC has already been initiated.	
What are some anticipated challenges to co-creating a POSC with families?	
What are some potential solutions to address those challenges?	

Plan of Safe Care Implementation Scenarios

Preparing in advance for potential situations you may encounter can help you feel more prepared and capable of providing appropriate care to families. Below are additional hypothetical situations of families who are impacted by substance use, and discussion prompts to aid in thinking through the role of a POSC in the care they receive.

Health Care Team: Scenario Two



Jane is a 30-year-old woman. She entered the emergency department via ambulance after a single car rollover accident. She is found to be five months pregnant with her first child and reports no prior prenatal care for this pregnancy. Police require a toxicology screen that indicates the presence of methamphetamine and alcohol. Jane reports not having a stable home or support system.

Questions to Consider

[You Are the Emergency Room Health Care Provider]

- **What are the most immediate needs for Jane?**

Immediate supports for Jane include connection to a prenatal care provider, an offer for substance use treatment, an offer for Home Visiting and an offer to meet with a clinical social worker. Determine if a POSC is currently in place. If so, the POSC should be reviewed with Jane to determine if any changes are needed. If no, Jane should be engaged in the co-development of a POSC.

- **Does this situation require a notification or referral to CPS-Centralized Intake? If yes, which one?**

This situation does not require a notification or referral to CPS-Centralized Intake. The infant has not been born and Jane has no other children.

- **What is the role of the health care team in relation to the POSC? Are you co-developing the POSC with Jane, or referring to a different provider to co-develop the POSC?**

A POSC should be offered and coordinated during pregnancy by the health care team.

- **Is a service referral necessary? If yes, who are you referring to?**

Referrals that are applicable, necessary and agreed upon (with the patient's consent) may include, but are not limited to, treatment providers, Home Visiting, additional health care providers, WIC, social work, etc.

Questions to Consider - *Continued*

[You Are the Emergency Room Health Care Provider]

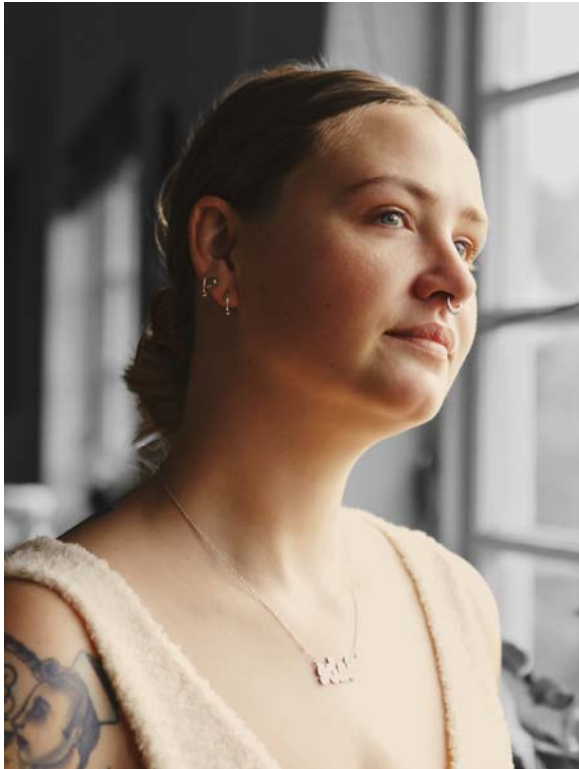
- **What does care coordination look like for this family? Who might the parent want to share the POSC with? Who might you (with consent) want to share the POSC with?**

Care coordination (with the patient's consent) may include sharing the POSC with other supports and providers that include, but are not limited to, treatment providers, Home Visiting, additional health care providers, WIC, social work, behavioral health providers, etc.

- **Who will provide ongoing support, monitoring and updating of the POSC as it pertains to the health and safety needs of Jane, her infant and other household or family members?**

According to the policies and procedures of the health care team, the POSC may be updated and monitored by one or as many team members as needed.

Home Visitor: Scenario Two



Chantele is a 24-year-old woman who was referred to Home Visiting by her obstetrician as she verbalized a desire for more support. She is currently 26 weeks pregnant with her first child. She does not have a stable home or a support system. While completing a screening tool for substance use, she disclosed that she is currently struggling with dependency on pain medications. Through motivational interviewing techniques, Chantele was able to verbalize a desire to seek out MAT, but does not fully understand its benefits nor does she have a vehicle for transportation.

Questions to Consider

- **What are the most immediate needs for Chantele?**

Immediate supports for Jane include connection to a substance use treatment provider, transportation resources and co-development of a POSC.

- **Does this situation require a notification or referral to CPS-Centralized Intake? If yes, which one?**

Not at this time. At the birth event, if the infant screens positive for opioids and Chantele is receiving MAT, a notification is needed. If the infant screens positive and the exposure is not attributed to medical treatment, a referral to CPS-Centralized Intake is required.



- **What is the role of a home visitor in relation to the POSC? Are you co-developing the POSC with Chantele, or referring to a different provider to co-develop the POSC?**

As the home visitor, you should co-develop the POSC with Chantele. You should also ensure that the POSC has all the referrals with the contact information in one place. You want to encourage Chantele to call any of the identified referral agencies. If she is not comfortable doing so, support her in making the calls and provide warm handoffs when possible. You will continue to support her and follow-up on the POSC at every visit.

- **Is a service referral necessary? If yes, who are you referring to?**

Referrals should be made to housing and transportation resources and a MAT provider. Medicaid can cover transportation to medical appointments, including MAT, so ensure Chantele has that information.

- **What does care coordination look like for this family? Who might the parent want to share the POSC with? Who might you (with consent) want to share the POSC with?**

Encourage Chantele to share her POSC with her PCP, prenatal care provider and substance use treatment provider, as applicable. If CPS becomes involved after the birth of the baby, Chantele should also be encouraged to share her POSC with the CPS case manager. With Chantele's consent, the POSC may be shared with any of these agencies.

Child Welfare Case Manager: Scenario Two

Heather is a 33-year-old woman who has a history of opioid use. Her parental rights to three children have previously been terminated due to her opioid use and subsequent failure to complete court-ordered services. To date, her opioid use has been in remission for two years and she receives methadone treatment to manage her dependency. She delivered a baby girl 18 months ago who was born exposed to methadone. CPS was involved due to the child being born exposed to methadone and due to her prior history with child welfare. The investigation was not confirmed and the child remains in her care.

Heather recently delivered a baby boy full-term who was also exposed to methadone. The infant is currently being monitored for symptoms of Neonatal Opiate Withdrawal Syndrome due to the prenatal exposure to methadone, but is otherwise healthy. Heather received consistent prenatal care throughout her pregnancy and reports she has a POSC in place. She reported to hospital staff that she is prepared for the new baby and has everything she needs to care for him.

Questions to Consider

- **What are the most immediate needs for Heather? Her newborn? Other household members?**

Heather's immediate needs include ensuring she has support mechanisms in place to assist her with her recovery. It would be pertinent to ensure Heather does have what is needed for both children in her care. The newborn should be monitored for symptoms of Neonatal Opiate Withdrawal Syndrome. The needs of other household members and out-of-home support individuals should be considered after these individuals are identified. Additionally, Heather may benefit from safe sleep education.

- **Does this situation require a notification or referral to CPS-Centralized Intake? If yes, which one?**

Due to the prior termination of parental rights, the birth of another child will trigger a referral for another CPS investigation. CPS will be responsible for POSC related tasks as part of that investigation.

- **What is the role of a child welfare case manager in relation to the POSC? Are you co-developing the POSC with Heather, or referring to a different provider to co-develop the POSC?**

The child welfare case manager will be responsible for ensuring a POSC is in place during their investigation. If one is not in place, the case manager will engage with the family to co-develop a plan and refer to appropriate services as needed.

- **Is a service referral necessary? If yes, who are you referring to?**

Service referrals should be made based on the needs identified by the parent and their family within the POSC. This may include referrals such as [Help Me Grow](https://www.hillcountrytx.gov/help-me-grow/) (URL: [bit.ly/40Kbmyb](https://www.hillcountrytx.gov/help-me-grow/)), Home Visiting, prevention services, Early On, etc.

- **What does care coordination look like for this family? Who might the parent want to share the POSC with? Who might you (with consent) want to share the POSC with?**

New and existing service providers should assist Heather and any other appropriate care providers in updating the POSC as needed.

Substance Use Treatment Team: Scenario Two

Karen is a 33-year-old mother of four children ages 9, 7, 5 and 3, who is 20 weeks pregnant with her fifth child. Her work referred her to your treatment program following a random drug screen at work (positive for THC). She denies any drug use; stating that she vaped marijuana for her morning sickness because it was all natural. She denies any child welfare involvement in the past and denies any support needs at this time.

Questions to Provider

- **What are the most immediate needs for Karen or her family?**

Determine whether a POSC is in place. If not, assist with co-development. Consider providing education regarding marijuana use, misuse, dependency and possible effects of exposure on the fetus. Referral to her prenatal care provider to discuss alternatives to marijuana for morning sickness. Offer safe sleep education and resources and assess any barriers to implementing safe sleep practices. Connect Karen to preventative resources as needed.

- **Does this situation require a notification or referral to CPS-Centralized Intake? If yes, which one?**

Not at this time as there have been no expressed or suspected concerns for child abuse and/or neglect regarding her other four children.

- **What is the role of the treatment provider in relation to the POSC? Are you co-developing the POSC with Karen, or referring to a different provider to co-develop the POSC?**

Karen's substance use treatment provider can provide her with a POSC handout and co-develop a POSC with her if one does not already exist. If a POSC has already been developed, the treatment provider should review it with Karen to see if any updates are necessary.



- **Is a service referral necessary? If yes, who are you referring to?**

Karen should be engaged regarding which substance use treatment option may be best for her. These may include inpatient or outpatient treatment, or one-on-one counseling. If she has not yet initiated prenatal care, Karen also needs a referral for prenatal care.

- **What does care coordination look like for this family? Who might the parent want to share the POSC with? Who might you (with consent) want to share the POSC with?**

The POSC should be shared with any health care provider who is working with Karen, including her prenatal care provider. The POSC should also be shared with all other care providers involved with the family, including a treatment provider if treatment is sought, with Karen's consent.

- **Who will provide ongoing support, monitoring and updating of the POSC as it pertains to the health and safety needs of Karen, her children and other household or family members?**

New and existing service providers should assist Karen and any other applicable care provider in updating the POSC as needed.

Parents Sharing POSC with Their Support System

It can be challenging for families to share their personal challenges with health care providers, social workers, home visitors and other care providers. Understanding and being sensitive to this discomfort is essential to providing necessary information and support to families. Professionals working with pregnant and parenting individuals should strive to create an environment that empowers individuals to share information and advocate for their own needs.

Talking Points for Discussing a POSC

“Hi [Name], I wanted to introduce you to a tool we have been using to help identify and organize supports, be able to quickly reference information and demonstrate all they have been doing to keep themselves, their children and their family healthy and safe. It is called the Plan of Safe Care. The plan was originally created for pregnant and postpartum parents who have a history of substance use and their infants. You do not have to use it but I thought it might be helpful to you. If it’s okay with you, I will show you the tools and resources so you can decide if it’s something you want to use.”

Additional information to provide families regarding a POSC include:

- Many people can help parents and families complete the POSC. Encourage individuals to share it with other providers but note they do not have to share it with anyone they do not want to or trust.

Example Language:

“There are sections here, like the medical and psychiatric history sections, where it might be helpful to have someone help you fill it out. It can be really helpful to both you and the people you are working with to show them this—that way they can see what you have already done and it can help both of you identify services or resources you still need. There may be people you don’t want to show it to and that is ok.”

- Some things will not apply to the pregnant individual or family. Remind them that they can skip questions that don't apply or cross them out.

Example Language:

"This is **your** Plan of Safe Care. You don't have to answer any questions on these forms that you don't want to or that don't apply to you. It is ok to cross them out or put n/a for not applicable."

- This is a living document and was created for families and providers to update as services progress and needs are met or new needs arise. Having an updated plan can be very helpful at the time of delivery and when meeting with new service providers, going to court, meeting with child welfare case managers, etc.

Example Language:

"You will want to keep this updated, so it may be most helpful to take it to doctors' appointments, meetings with your social worker, case manager, etc."

For Pregnant Individuals:

"It is really important you update your plan before you deliver your baby, and that you remember to take your plan with you to the hospital. This way, you can show the nurses and doctors anything you think will help them take care of you - like your medication list, the doctors you get care from, etc."

For Individuals on Medication-Assisted Treatment:

"For individuals on MAT, we highly recommend you take your plan to the hospital with you and have your MAT provider and prescription information with you. Because your baby may have withdrawal symptoms from the MAT, it can be helpful to show this to your doctors and the staff at the hospital so they know all that you have done to prepare for your baby and who to contact at your MAT clinic if they need to verify your prescription."

For Families Working with Child Welfare or Going to Court:

"This is a really great tool to help you showcase all that you have done and accomplished to help keep yourself and your baby healthy and safe. Families have really found this tool helpful when they are meeting with their case manager, lawyer and when going to court. Be sure to update it before you go to court or see your case manager."

Talking Points for Families Who Want or Ought to Share Their POSC with Providers

- **If you are currently using substances and are willing to share that information:**

“You may or may not know but I have a history of substance use, and I am actively working towards my recovery. I have decided to build a Plan of Safe Care to help me organize and keep track of everything I am doing as part of my recovery. This tool can also help those I am working with know more about my history, my strengths and goals, and what services I have completed and those I still need help with. As part of our visit today, I would like to share my plan with you and have you help me complete some questions. I would also like to put your business card in my binder so I can always know how to reach your office.”

- **If you have an open child welfare case and are willing to share that information:**

“My family has a lot going on right now. I am working with CPS to ensure my children and family are safe and healthy. As part of this work, I am using a tool called the Plan of Safe Care to help me organize and keep track of everything I am doing. This tool can also help those I am working with know more about my history, my strengths and goals, and what services I have completed and those I still need help with. As part of our visit today, I would like to share my plan with you and have you help me complete some questions. I would also like to put your business card in my binder so I can always know how to reach your office.”

- **Consent/Permission to Share Information: If you think your CPS case manager or another care provider would want to contact this provider, you may ask if they have a form for you to sign to give them permission to do this.**

“I think my [CPS case manager, lawyer, recovery coach, insert name of provider] will want to talk with you about my care here. Do you have a specific form I need to sign to give you permission to talk with them? I would also like a copy of that form to keep in my POSC.”

- **What if they ask me more about the POSC and what its purpose is?**

“A POSC is a tool designed to help me demonstrate my progress and easily communicate what I have done and what I need from the individual I am working with. My POSC will focus on my baby’s health, development and safety, as well as my family’s physical and emotional health, substance use treatment, parenting ability and readiness to care for my baby. My portfolio can also be seen as a “recovery resume” and will help me communicate all the work and preparations I have made for myself and my baby.”

Figure 3a: What's Different - Health Care Team Prenatal (OB/GYN, Midwife, PCP, etc.)

What Stays the Same?	What Changes?	What Happens with Partner Agencies?
<p>If substance use/misuse is identified and there are other minor children in the home, and there are concerns of abuse or neglect regarding those children, make a referral for suspected child abuse and/or neglect to CPS-Centralized Intake.</p>	<p>POSC parent handout/ brochure will be provided to patient.</p> <p>Member of the health care team conducts universal screening, using validated screening tool, for substance use.</p> <p>If screen is positive, a member of the health care team may co-develop the POSC, or refer the family to a treatment provider, Home Visiting or Help Me Grow (URL: bit.ly/40Kbmyb).</p>	<p>Coordinate care via referrals to any necessary and agreed upon providers (treatment provider, CPS-Centralized Intake, Home Visiting, etc.).</p>

Figure 3b: What's Different - Delivery Admission

What Stays the Same?	What Changes?	What Happens with Partner Agencies?
<p>Infant screening positive for withdrawal or testing positive for substances not attributed to medical treatment results in a referral of suspected abuse to CPS-Centralized Intake.</p> <p>CPS-Centralized Intake determines if the referral should be assigned for investigation.</p> <p>Health care team coordinates infant and patient discharge with child welfare case manager, if applicable.</p>	<p>Infant screening positive for withdrawal or testing positive for substances attributed to medical treatment, and there are no other concerns for child abuse and/or neglect, requires a referral to Help Me Grow (URL: bit.ly/40Kbmyb) and a notification to the CPS-Centralized Intake hotline.</p> <p>Health care team provides observations, information to CPS-Centralized Intake.</p> <p>POSC parent handout/brochure will be provided to patient.</p> <p>Health care team provides information to parent regarding POSC process. Health care team will coordinate care via referrals to any necessary and agreed upon providers (Home Visiting, treatment providers, etc.).</p> <p>Delivering hospital may assist in initial co-development of POSC, and provides a copy to the parent, or refer the family to another provider, such as treatment or Home Visiting, to assist with the co-development of the POSC.</p> <p>Obtain consent to coordinate care and share POSC with other providers.</p>	<p>CPS-Centralized Intake evaluates notifications and referrals to determine appropriate screening decision. If CPS-Centralized Intake determines the notification is appropriate, they will inquire of the health care provider about a POSC and the date of the referral to Help Me Grow (URL: bit.ly/40Kbmyb).</p> <p>If CPS-Centralized Intake determines the referral will not be screened in for investigation, they will assess the need for a referral to front-end prevention services where available.</p> <p>If CPS-Centralized Intake screens the referral in for investigation, CPS will investigate to assess impact of substance use on child safety and establish POSC (if not already in place).</p>

Figure 3c: What's Different - Child Welfare

What Stays the Same?	What Changes?	What Happens with Partner Agencies?
<p>Health care provider makes a referral to CPS-Centralized Intake regarding an infant born exposed to substances not attributed to medical treatment.</p> <p>CPS-Centralized Intake determines whether the referral will be screened out or screened in for investigation by CPS.</p> <p>If the referral is screened in for investigation, the referral is assigned to a CPS case manager for further assessment.</p>	<p>Health care providers will continue to make referrals to CPS-Centralized Intake regarding an infant born exposed to substances not attributed to medical treatment, and will begin making notifications to CPS-Centralized Intake regarding infants born exposed to substances attributed to medical treatment.</p> <p>When a notification is applicable, health care providers will attempt to co-develop, with the family, a POSC, or make a referral to Help Me Grow (URL: bit.ly/40Kbmyb) and then complete the notification to the CPS-Centralized Intake hotline.</p> <p>CPS-Centralized Intake will determine whether a notification or referral is appropriate.</p> <p>If a referral is screened in for investigation, CPS must ensure a POSC is in place or assist the family in co-developing a plan.</p> <p>If the case remains open, child welfare case managers will coordinate care with the family and other providers and help adjust the POSC as needed throughout the duration of the case.</p> <p>Upon case closure, the family, in collaboration with their providers, is ultimately responsible for the monitoring of their POSC.</p>	<p>Treatment provider or home visitor, as applicable, maintains POSC with family.</p> <p>Treatment provider or home visitor, as applicable, provides care coordination for the parent and child and maintains contact with the ongoing child welfare case manager, if the family receives ongoing child welfare services.</p>

Figure 3d: What's Different - Home Visiting


What Stays the Same?	What Changes?	What Happens with Partner Agencies?
<p>Individual is referred to and enrolled in Home Visiting services.</p> <p>Individual is identified as pregnant or in their first year postpartum.</p> <p>Pregnant or postpartum individual responds affirmatively to screen or self-discloses substance use during visit.</p> <p>If there are other minor children in the home, and concerns of abuse or neglect regarding those children, home visitor makes a referral to CPS-Centralized Intake.</p>	<p>The home visitor determines whether the parent was already offered a POSC prenatally or postpartum.</p> <p>If a POSC has not yet been developed, the home visitor will:</p> <ul style="list-style-type: none"> • Provide the POSC parent handout/ brochure to family. • If the parent is in agreement, the home visitor will complete the POSC with the family utilizing the template or personalized tool. <p>The home visitor will refer the pregnant or postpartum individual to identified community resources, including substance use treatment.</p> <p>The home visitor will provide the pregnant or postpartum individual with their POSC tool and provide information on how to utilize it for care coordination.</p>	<p>If consents are signed by parent, home visitor can provide other care providers (prenatal care provider, substance use treatment provider, child welfare case manager, etc.) with a copy of the POSC to support better care coordination.</p>

Figure 3e: What's Different - Treatment Providers

What Stays the Same?	What Changes?	What Happens with Partner Agencies?
<p>Individual is seen for substance use/misuse.</p> <p>If there are other minor children in the home, and there are concerns of abuse or neglect regarding those children, substance use treatment provider makes a referral to CPS-Centralized Intake.</p>	<p>Treatment provider asks all individuals if they are pregnant or would like to have a child in the next year.</p> <p>POSC parent handout/ brochure will be provided to parent.</p> <p>Pregnant individual with substance use/misuse referred by health care provider for prenatal POSC.</p> <p>Treatment provider co-develops POSC with parent and provides copy.</p> <p>Obtains consent to coordinate care with other providers.</p>	<p>Health care provider provides prenatal/ postpartum care to new parent and makes referral to pediatrician for infant as needed.</p> <p>If consents are signed by parent, care coordinated between other involved providers (health care provider, child welfare case manager, Home Visiting, etc.).</p>

Figure 4: Handout - POSC


PLAN OF SAFE CARE




What Is a Plan of Safe Care?

- ♥ A personalized guide to ensure the necessary resources are provided to help families thrive.
- ♥ A “recovery resume” or diary that helps communicate your strengths, needs, and accomplishments to your providers.
- ♥ A tool to help with care coordination.

The goal of a Plan of Safe Care is to strengthen the family, help pregnant individuals have a healthy pregnancy, and keep child(ren) safely at home.






Who Can Benefit from a Plan of Safe Care?

The Plan of Safe Care tool was designed to address the health, development, safety, and well-being needs of infants born exposed to substances and their caregivers and family members.

Who Should Be Involved in Helping Me to Create and Update My Plan of Safe Care?


A Plan of Safe Care should include input from all care providers involved in your care and the care of your child(ren). **This could be:**

- ♥ Pregnancy Care Provider.
- ♥ Primary Care Provider.
- ♥ Substance Use Treatment Provider or Recovery Coach.
- ♥ Home Visitor.
- ♥ Child Welfare Staff.
- ♥ Mental Health Provider.



When Do I Make a Plan of Safe Care?

A Plan of Safe Care can be developed anytime. Ideally, it is developed during pregnancy. If a Plan of Safe Care has not been started during pregnancy, it can be developed after delivery but before leaving the hospital. The earlier you start a Plan of Safe Care, the more time you have to prepare for your baby with support.




Will a Referral Be Made to Children's Protective Services (CPS)?

Substance use alone does not mean that a referral will be made to Child Welfare (sometimes referred to as CPS). Creating a Plan of Safe Care provides you the ability to advocate for yourself while taking the steps to build a safe and healthy environment for your child(ren).

You Are NOT Alone.

Many people struggle during pregnancy and after birth. Help and resources are available and many are low-cost or free. The Plan of Safe Care can help you advocate for yourself and your child(ren). Talk to your care provider today to build your Plan of Safe Care. Sharing your Plan of Safe Care with all of your care providers will help them help you!

If you want help now, please scan the QR Code below to access Michigan-specific Substance Use and Recovery Resources (URL: <https://bit.ly/3IPDKrV>).



Download

Figure 5: Handout - Community-Driven POSC

COMMUNITY-DRIVEN PLAN OF SAFE CARE



What is a Plan of Safe Care?

A Plan of Safe Care (POSC) is a personalized tool to support pregnant and parenting individuals impacted by substance use, their infants, and any other household members. The goal of a Plan of Safe Care is to strengthen the family, support a healthy pregnancy and keep child(ren) safely at home.

Background

Federal Law

In the 2018 revision to [The Child Abuse Prevention and Treatment Act](https://bit.ly/4nu30Uc) (URL: <https://bit.ly/4nu30Uc>), federal legislation required that every infant affected by substance use and their caregiver would have a Plan of Safe Care in place that also addresses the needs of any household members. Each state is able to develop what their POSC looks like.

Michigan POSC Protocol

Michigan's recent efforts to ensure that families are best supported through a POSC include:

- Beginning the POSC prenatally.
- Initiating the POSC through care providers such as home visitors, substance use treatment providers, and pregnancy health care providers.
- Using a common template.



Why is a POSC Important for Families?

- 52.6% of Michigan children under age 1 that are removed from their home have parental substance use as a condition of removal.
- 32% of pregnancy-associated deaths in Michigan are related to substance use.
- In states that are piloting a prenatal approach to POSC, there has been a reduction in child removal due to substances.
- A POSC provides comprehensive and coordinated support for the parent, infant and other family members.

What Does This Mean for My Work?

As a community-based provider, you can implement Michigan's Plan of Safe Care Protocol to support families impacted by substance use to:

- Understand the importance of having a personalized POSC.
- Initiate, modify, or complete their personalized POSC.
- Coordinate their care with other providers.
- Use their personalized POSC as an advocacy tool.



Four Ways to Prepare to Implement a Plan of Safe Care

- Ensure you are screening every pregnant and postpartum person with a validated screening tool such as those found in this [SAMHSA resource](https://bit.ly/4nrQnZS) (URL: bit.ly/4nrQnZS).
- Complete the MI POSC Learning Modules.
- Review Michigan's POSC Protocol which includes a link to the suggested template for use.
- Check out these free [resources](https://bit.ly/3GhfVbu) (URL: bit.ly/3GhfVbu) from the National Center on Substance Abuse and Child Welfare. They cover substance use, working with families, Plans of Safe Care and more.




For more information on implementing MI POSC Protocol in your Home Visiting Program, contact MDHHS-PlanofSafeCare@michigan.gov.

Download

Additional Resources

National Resources

- [CHARM Case Study](https://bit.ly/4etVPY7) (URL: bit.ly/4etVPY7): A case study of a successful collaborative serving pregnant women with opioid dependence, their babies and families.
- [Maternal and Child Health Bureau](https://bit.ly/3NFZsyz) (URL: bit.ly/3NFZsyz): Nationwide resource providing programs, research and local resources aiming to strengthen mothers, infants and their families.
- [National Center on Substance Abuse and Child Welfare \(NCSACW\)](https://bit.ly/3CFbFx0) (URL: bit.ly/3CFbFx0): Provides expertise and technical assistance to support states on developing POSC.
- [PI-17-02 | Guidance on Amendments Made to the Child Abuse Prevention and Treatment Act from the U.S. Department of Health and Human Services](https://bit.ly/3NI62Jm) (URL: bit.ly/3NI62Jm): Administration for Children and Families (ACF) to states on implementing provisions in CAPTA as amended by CARA, relating to infants affected by substance use.
- [Substance Abuse and Mental Health Services Administration](http://bit.ly/4ecOBYo) (URL: <http://bit.ly/4ecOBYo>): State-licensed treatment facility finder - SAMHSA's National Helpline: 1-800-662-HELP (4357).
- [The American College of Obstetrics and Gynecology](https://bit.ly/3pdY5xv) (URL: bit.ly/3pdY5xv): Informed Consent and Shared Decision-Making in Obstetrics and Gynecology.

State and Local Resources

- Contact information for publicly funded substance use and mental health services can be found at [Get Help Now - Behavioral Health](https://www.michigan.gov/get-help-now-behavioral-health) (URL: [bit.ly/43R23eD](https://www.michigan.gov/get-help-now-behavioral-health)).
- [Early On](https://www.michigan.gov/early-on) (URL: [bit.ly/3NkPL72](https://www.michigan.gov/early-on)) has a referral system set up specifically for MDHHS child welfare case managers.
- [Mandated Reporters](https://www.michigan.gov/mandated-reporters) (URL: [bit.ly/3T4fioU](https://www.michigan.gov/mandated-reporters)).
- [MDHHS Home Visiting Models](https://www.michigan.gov/mdhhs-home-visiting-models) (URL: [bit.ly/42R6Ta8](https://www.michigan.gov/mdhhs-home-visiting-models)): Michigan supports eight different Home Visiting models; please check this site to see what programs are available.
- [MI Bridges](https://www.michigan.gov/mi-bridges) (URL: [bit.ly/3dfqk8E](https://www.michigan.gov/mi-bridges)): MI Bridges can help access more than 30,000 state and local services across the state.
- Michigan Children's Protective Services Centralized Intake: 855-444-3911.
- [Michigan Guide to Creating a Collaborative Approach to Supporting Families with Babies with Neonatal Opioid Withdrawal Syndrome \(NOWS\)](https://www.michigan.gov/michigan-guide-to-creating-a-collaborative-approach-to-supporting-families-with-babies-with-neonatal-opioid-withdrawal-syndrome-nows) (URL: [bit.ly/42SfUA2](https://www.michigan.gov/michigan-guide-to-creating-a-collaborative-approach-to-supporting-families-with-babies-with-neonatal-opioid-withdrawal-syndrome-nows)).
- [Michigan 211](https://www.michigan.gov/michigan-211) (URL: [bit.ly/3qYJmXB](https://www.michigan.gov/michigan-211)): An easy way to connect with help of all kinds, right in the community.
- [Plan of Safe Care](https://www.michigan.gov/plan-of-safe-care) (URL: [bit.ly/40egkSD](https://www.michigan.gov/plan-of-safe-care)).
- Safe sleep programs in Michigan are longstanding and dedicated to providing Michiganders with accurate information about best practices and state-specific data. For more information please visit the [MDHHS Safe Sleep Resources by County](https://www.michigan.gov/mdhhs-safe-sleep-resources-by-county) (URL: [bit.ly/3vVnCeX](https://www.michigan.gov/mdhhs-safe-sleep-resources-by-county)) and download the [Baby, We've Got Your Back Brochure](https://www.michigan.gov/baby-weve-got-your-back-brochure) (URL: [bit.ly/3T8V78U](https://www.michigan.gov/baby-weve-got-your-back-brochure)) - This resource is also available in additional languages.



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