**REPORT OF THE SECRETARY OF HEALTH AND HUMAN RESOURCES**

# Report of Barriers to the Identification and Treatment of Substance-Exposed Infants (HB2162, Chapter 197, 2017 Acts of Assembly)

**TO THE GOVERNOR AND THE GENERAL ASSEMBLY OF VIRGINIA**

# HOUSE DOCUMENT NO. 19

**COMMONWEALTH OF VIRGINIA**
**RICHMOND**
**2017**

# COMMONWEALTH of VIRGINIA

## Office of the Governor

William A. Hazel, Jr., MD
Secretary of Health and Human Resources

December 1, 2017

Members, Virginia General Assembly
900 E. Main Street
Richmond, Virginia 23219

RE: Report on Barriers to Treatment and Identification of Substance-Exposed Infants in the Commonwealth, HB2162 (Delegate Pillion)

Dear Legislators:

I am pleased to submit the Department of Social Services' report on substance-exposed infants prepared pursuant to House Bill 2162 (2017). If you have questions or need additional information concerning the report, please contact me at bill.hazel@governor.virginia.gov.

Sincerely,

William A. Hazel, Jr., M.D.

Attachment



Patrick Henry Building • 1111 East Broad Street • Richmond, Virginia 23219 • (804) 786-7765 • Fax (804) 786-3389 • TTY (800) 828-1120
www.governor.virginia.gov

# Report of Barriers to the Identification and Treatment of Substance-Exposed Infants

## *A Report Summarizing the Study Required by House Bill 2162 (2017)*

# Preface

The General Assembly of Virginia passed House Bill 2162 on February 2, 2017, which directed the Secretary of Health and Human Resources to convene a work group to study barriers to the identification and treatment of substance-exposed infants (SEIs) in the Commonwealth. The work group was directed to include representatives of the Departments of Behavioral Health and Developmental Services, Health, Social Services and any other stakeholders the Secretary deemed appropriate. The work group's charge included the following duties:

- Review current policies and practices governing the identification and treatment of SEIs in the Commonwealth, including barriers related to identification and reporting of such infants, data collection, interagency coordination and collaboration, service planning, service availability, and funding; and,

- Develop legislative, budgetary, and policy recommendations for the elimination of barriers to treatment of SEIs in the Commonwealth.

The Secretary must report his findings to the Governor and the General Assembly by December 1, 2017.

The Virginia Department of Social Services (VDSS) Division of Family Services staff developed this technical report with the assistance of an independent contractor, *toXcel*[1], with expertise in health and planning. Study findings are the result of four work group meetings, five regional town halls, and 134 responses to a survey on SEI policies and practices circulated to a variety of stakeholders and experts across the Commonwealth. In addition to staff from VDSS, Department of Behavioral Health and Developmental Services and the Department of Health, work group membership included representatives of the organizations listed below:

[1] http://toxcel.com/

American Civil Liberties Union of Virginia
Anthem
B2L Consulting, Inc.
Bon Secours
Children's Health Insurance Program of Virginia & Parents as Teachers State Office
Children's National Health System
Court Improvement Program of the Supreme Court of Virginia
Department of Medical Assistance Services
Early Impact Virginia
Family and Children's Trust Fund of Virginia
Fauquier Health's Family Centered NAS Care
Frederick/Winchester Juvenile & Domestic Relations Court
Greater Richmond Stop Child Abuse Now
Infant Toddler Connection
INOVA Hospital
Magellan Healthcare of Virginia
March of Dimes
Mary Washington Hospital
Rappahannock Area Community Services Board
Richmond City Health District
State Early Childhood
Valley Health
Virginia Commonwealth University
Virginia Hospital and Health Care Association
Virginia Poverty Law Center
Virginia Premier
Voices for Virginia's Children
WilliamsMullen (representing the American Congress of Obstetricians and Gynecologists)
Winchester Medical Center

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# List of Acronyms

| | |
|---|---|
| AAP | American Academy of Pediatrics |
| ACOG | American Congress of Obstetricians and Gynecologists |
| ACT | Assertive Community Treatment |
| ACLU | American Civil Liberties Union |
| ACNM | American College of Nurse-Midwives |
| ARTS | Addiction and Recovery Treatment Services |
| ASAM | American Society of Addiction Medicine |
| AWHONN | Association of Women's Health, Obstetric and Neonatal Nurses |
| CAPTA | Child Abuse Prevention and Treatment Act |
| CHIP | Children's Health Insurance Program |
| CPS | Child Protective Services |
| CSB | Community Services Board |
| DBHDS | Department of Behavioral Health and Developmental Services |
| DFS | Division of Family Services |
| DJJ | Department of Juvenile Justice |
| DMAS | Department of Medical Assistance Services |
| DOJ | Department of Justice |
| EIV | Early Impact Virginia |
| EMS | Emergency Medical Services |
| FACT | Family and Children's Trust Fund of Virginia |
| FAMIS | Family Access to Medical Security |
| GAP | Governor's Access Plan |
| HB2162 | House Bill 2162 |
| HIPAA | Health Insurance Portability and Accountability Act |
| ICD | International Classification of Diseases |
| ITC | Infant Toddler Connection |
| LARC | Long Acting Reversible Contraception |
| LDSS | Local Department of Social Services |
| MAT | Medically Assisted Treatment |
| MDT | Multidisciplinary Team |
| MIECHV | Maternal, Infant, and Early Childhood Home Visiting |
| MOU | Memorandum of Understanding |
| NANNP | National Association of Neonatal Nurse Practitioners |
| NAS | Neonatal Abstinence Syndrome |
| NCSACW | National Center on Substance Abuse and Child Welfare |
| NICU | Neonatal Intensive Care Unit |
| OB/GYN | Obstetrician/Gynecologist |
| OSHHR | Office of Secretary for Health and Human Resources |
| OTP | Opioid Treatment Program |
| ROI | Release of Information |
| SCAN | Stop Child Abuse Now |
| SEFP | South Eastern Family Project |
| SEI | Substance-Exposed Infants |
| START | Sobriety Treatment and Recovery Team |

| | |
|---|---|
| SUD | Substance Use Disorder |
| VDH | Virginia Department of Health |
| VDSS | Virginia Department of Social Services |
| VHHCA | Virginia Hospital and Health Care Association |
| VLDS | Virginia Longitudinal Data System |
| VNPC | Virginia Neonatal Perinatal Collaborative |
| WMC | Winchester Medical Center |

# Executive Summary

Despite current laws and efforts of state agencies and service organizations, the number of substance-exposed infant (SEI) cases reported to local departments of social services (LDSS) has more than doubled since 2009. This indicates a need for improving current strategies and developing new policies, practices, and programs to prevent and treat SEIs. As of July 2017, there are four SEI-related mandates in the Code of Virginia: Screening all pregnant women for substances, mandated reporter requirements, hospital referrals to the local Community Services Board (CSB) upon discharge, and developing a Plan of Safe Care when an SEI is identified.

In response to the growing crisis, the Virginia General Assembly passed House Bill 2162, sponsored by Delegate Todd Pillion during the 2017 session, which mandated the formation of a work group to identify barriers to the identification and treatment of SEIs and make recommendations to mitigate those barriers. The Virginia Department of Social Services Division of Family Services (VDSS) was assigned leadership of the work group charged with: (1) reviewing existing Virginia policies and practices and models from other states, and (2) developing legislative, budgetary, and policy recommendations for the elimination of barriers to treatment of SEIs in the Commonwealth.

VDSS leadership linked this study to work currently underway through the *Three Branch Initiative* (sponsored by the National Governor's Association, National Conference of State Legislators, and Casey Family Programs) focused on finding solutions to prevent child fatalities for children under the age of four. This study also complements the substantial work undertaken by the *Governor's Task Force on Prescription Drug and Heroin Abuse* established by Governor McAuliffe on September 26, 2014 through Executive Order 29.

Recommendations resulted from a multi-method approach to studying the issue over a four-month period to maximize inclusion and coverage of varying viewpoints. Between April and July 2017, there were four work group meetings, five regional town halls, and 134 responses to an online survey[2]. An analysis of all documented comments revealed the consistent identification of the following barriers:

- Collaboration across disciplines and sectors occurs in some localities and regional areas, yet it is far from comprehensive in scope and coverage;
- Absence of a clear understanding of the breadth and totality of resources in the community and what other federal, state or local agencies do;
- Lack of consensus about Plans of Safe Care and other SEI-related mandates, particularly how they apply to specific agencies' responsibilities;
- Limited data collection, and challenges with sharing what data is collected;
- Insufficient services for pregnant and postpartum women, particularly for long-term substance abuse interventions that encompasses the needs of the whole family;
- Insufficient efforts to integrate the father and broader caregiver support system into prevention efforts; and,
- Lack of opportunities for multidisciplinary prenatal intervention.

[2] Meeting summary notes, attendance rosters, and survey data can be obtained through request to the VDSS Division of Family Services.

The same analysis revealed the consistent identification of the following nine categories of recommendations:

- Multi-sector state, regional, and local partners can benefit from working together on this issue (e.g. forming multidisciplinary teams);
- Explore universal screening options (currently required under § 54.1-2403.1) and testing as methods to identify more substance-using pregnant women;
- Support a multidisciplinary approach during the prenatal period as the most effective intervention plan;
- Improve the existing referral system between the hospitals and local CSBs as required by § 32.1-127(6);
- Identify data points to be collected (to include, but not limited to) annual reporting requirements mandated by the Child Abuse and Prevention Treatment Act (CAPTA), and a reliable data system to understand both the scope of the problem and the short- and long-term outcomes of interventions;
- Increase collaboration between LDSS, hospitals, adoption agencies, and other partners at the time of hospital discharge of the mother and/or infant so that all partners and support networks can be present to coordinate an approach. Integrate the Plan of Safe Care into the discharge plan and include family members and other caregivers in plan objectives;
- Support a trauma-informed approach to identification and treatment of SEIs and their full family and caregiver constellation;
- Improve availability of home visiting programs to support pregnant women with a SUD and/or a SEI to ensure adherence to, and continuity of, the Plan of Safe Care; and,
- Improve workforce development options for LDSS, CSBs, and other private and community partners related to SEIs. Many professionals do not understand the complexity of the SEI issue.

# Background

The literature indicates that substance-exposed infants (SEI) are at risk for low birth weight, neurological and congenital problems, developmental delays, neglect and/or abuse, and mental health and substance abuse problems of their own as they get older. It is critical to intervene as early as possible in a substance-using woman's pregnancy to ensure the best possible outcome for her and her infant. Substance-using women that are pregnant and/or actively parenting minor children may need a variety of services including treatment for their substance use (and often for other co-occurring mental health disorders or trauma); education on health, parenting, nutrition, budgeting, and how to prepare and care for a SEI; and, assistance with housing, transportation, and childcare. Providing services and treatment to this vulnerable population requires the coordination and collaboration of multiple partners including state and local departments of social services (LDSS), Virginia Department of Behavioral Health and Developmental Services (DBHDS), state and local health departments (VDH), hospitals, medical providers, insurance providers, Community Services Boards (CSBs), home visiting programs, treatment facilities, and other supporting early intervention service providers.

Despite the efforts of state agencies and service organizations, the number of SEI cases reported to LDSS has more than doubled in the seven-year period between 2009 and 2016. In 2016, LDSS responded to 1,334 SEI reports compared to 742 cases in 2009 – a near 80 percent increase[3]. Reversing this trend requires improved coordination and collaboration among federal, state and local agencies; better data collection, storage, and sharing of data; increased focus on prevention; and, new or enhanced methods to identify and treat at-risk women and SEIs. For certain recommendations, progress will not come about without additional funding. Currently, funding levels and services to address SEIs and connected issues such as mental health, substance use, trauma, and care coordination vary dramatically across the Commonwealth. Rural and smaller localities are not funded at the same level as urban areas and have fewer services due to sparse population density. Yet, many rural areas may see higher rates of SEI. In response to the growing crisis, the Virginia General Assembly passed House Bill 2162[4] (as part of a "package" of bills during the 2017 session) which mandated a study to identify barriers to the identification and treatment of SEIs and make recommendations for eliminating those barriers.

*SEI Workgroup*

In compliance with the legislation, a work group convened and facilitated by *toXcel* identified barriers and recommendations presented in this report. VDSS elected to take a comprehensive approach to the study by convening a workgroup of experts, conducting regional town hall meetings, and administering a standardized survey instrument.

The roster of the 56 work group members is included in Appendix B. Members were recruited from a combination of organizations, stakeholder groups, and sectors to ensure depth of knowledge and varying perspectives on SEI issues. The work group met four times between April and July 2017. The model used to conduct the work group sessions was organized around

[3] Virginia Child Welfare Outcome Report (VCWOR) October 2016, Version 4.43, Substance Abuse Newborn Annual Base Report.
[4] The full text of HB2162 is included as Appendix A.

five commonly accepted intervention points for maternal and child health. Table 1 summarizes the group's meeting schedule and objectives.

**Table 1. SEI Work Group Meeting Schedule and Objectives**

| Meeting | Date | Objective |
|---|---|---|
| 1 | April 14, 2017 | Discuss the work group's scope, SEI definitions, and stakeholder perspectives |
| 2 | May 18, 2017 | Discuss existing policies, programs, practices, and barriers, and recommendations in relation to Intervention Point 1 (pre-pregnancy) and Intervention Point 2 (prenatal screening) |
| 3 | June 13, 2017 | Discuss existing policies, programs, and practices, barriers, and recommendations in relation to Intervention Point 3 (testing at birth) and Intervention Points 4 & 5 (postnatal services for infants, children, parents) |
| 4 | July 21, 2017 | Review barriers and recommendations obtained from all sources, identify themes, and prioritize recommendations |

*Town Hall Meetings*

To capture regional perspectives across the Commonwealth, five town hall meetings were conducted in June and July. Flyers promoting the town halls were distributed to contact lists maintained by VDSS staff with encouragement for recipients to share information and encourage attendance from their stakeholder groups. Each town hall, which lasted three hours, began with a panel of SEI experts from the respective region to set the stage and provide context. Panels included representatives from LDSS, medical centers, CSBs, law enforcement, and service organizations. Panelists provided an overview of their organization's work to identify and treat SEIs and families, how they collaborate with other agencies, and recent successes related to this work. The moderator then posed the following questions to the panel to delve further into the topic:

- What limitations and barriers does your organization face when trying to address the needs of SEIs and families?
- From a state-level policy perspective, how can we better support organizations like yours to improve SEI outcomes in Virginia?
- What opportunities do you see to reframe how we identify and treat these infants and their families?
- How can identification of SEI focus on treatment as opposed to surveillance (e.g. CPS response)? That is, what would primary and secondary interventions (prevention and family engagement) look like as opposed to the tertiary response of CPS assessment and/or investigation?
- What other opportunities do you see to work collectively with organizations in your community and region to better address the needs of this vulnerable population?

The second segment of the town hall was devoted to audience dialogue about their experiences with SEIs, successful programs and practices in the region, the barriers they face, and their

recommendations for improving identification and treatment of SEIs. Follow-up questions were used to ensure rich audience discussion.

- Can you tell us about your organization's work?
- What policies and practices have the most impact on SEI affected infants and their families?
- What limitations and barriers are faced when trying to address the needs of SEIs and families?
- How can a balance be achieved between safety of the infant and creating a systemic response that will encourage mothers to get treatment?
- What other opportunities do you see for organizations in your community and region to work collectively to better address the needs of this vulnerable population?
- From a state policy perspective, how can we better support stakeholders to improve SEI outcomes in Virginia?

In total, 244 participants registered to participate in the town hall meetings representing VDSS, LDSS, health departments, CSBs, hospitals, medical centers, educational institutions, home visiting programs, law enforcement, and early intervention service agencies. Table 2 depicts the town hall meeting schedule and number of registrants for each.

**Table 2. Town Hall Schedule and Number of Registrants**

| Town Hall | Date | Location | # Registrants |
|---|---|---|---|
| Eastern Region | June 15, 2017 | Portsmouth | 40 |
| Richmond Area | June 22, 2017 | Henrico | 53 |
| Northern Virginia | June 26, 2017 | Winchester | 55 |
| Piedmont Region | July 17, 2017 | Bedford | 56 |
| Western Region | July 18, 2017 | Abingdon | 40 |

To provide an additional mechanism for obtaining input, an online survey modeled after a similar Substance Abuse and Mental Health Services Administration (SAMHSA) instrument, regarding SEI policies and practices, was circulated to a variety of stakeholders and experts across the Commonwealth. The web-based survey was created using Qualtrics[5] and included 24 questions consisting of fixed response and open-ended questions. A link to the survey was provided to town hall attendees, work group members, and distributed by email to VDSS contact lists. Questions were structured to provide opportunities to provide ratings and subjective feedback in the following categories:

- Approach to the identification of infants, mothers, and families who need services;
- Interagency coordination and collaboration;
- Service gaps and daily practice;
- Reimbursement and access;
- Training and staff development; and,
- Quality and outcome monitoring.

[5] www.qualtrics.com

Participation in the survey was voluntary, responses anonymous, and there was no compensation provided. The survey was open from June 26 to July 19, 2017 and collected 134 responses.[6] In preparation for the final work group meeting on July 21, 2017, documented barriers and recommendations from the work group sessions, town hall meetings, and survey responses were compiled into a single document. The summary was distributed to the work group in advance of the meeting to facilitate discussion of themes and prioritization of recommendations. Work group members unable to attend the final meeting were provided an opportunity to submit written feedback.

[6] For a copy of the survey, please contact the Virginia Department of Social Services, Division of Family Services.

## Existing Law, Policies, Programs, and Practices

Information about existing SEI policies, programs, and practices derived from work group members, town hall meeting attendees, and through a review of literature that included the *Code of Virginia*, reports, guidelines, manuals, news articles, presentations, and websites.[7] The discovery process identified several successful local and national strategies for possible replication and expansion statewide.

*Current Code of Virginia Mandates*[8]

**§ 32.1-127 Regulations (Health)**
B. 6. Shall also require that each licensed hospital develop and implement a protocol requiring written discharge plans for identified, substance-abusing, postpartum women and their infants. The protocol shall require that the discharge plan be discussed with the patient and that appropriate referrals for the mother and the infant be made and documented. Appropriate referrals may include, but need not be limited to, treatment services, comprehensive early intervention services for infants and toddlers with disabilities and their families pursuant to Part H of the Individuals with Disabilities Education Act, 20 U.S.C. § 1471 et seq., and family-oriented prevention services. The discharge planning process shall involve, to the extent possible, the father of the infant and any members of the patient's extended family who may participate in the follow-up care for the mother and the infant. Immediately upon identification, pursuant to § 54.1-2403.1, of any substance-abusing, postpartum woman, the hospital shall notify, subject to federal law restrictions, the community services board of the jurisdiction in which the woman resides to appoint a discharge plan manager. The community services board shall implement and manage the discharge plan.

**§ 54.1-2403.1. Protocol for certain medical history screening required (Professions and Occupations)**
As a routine component of every pregnant woman's prenatal care, every practitioner licensed pursuant to this subtitle that renders prenatal care, regardless of the site of such practice, shall establish and implement a medical history protocol for screening pregnant women for substance abuse to determine the need for a specific substance abuse evaluation. The medical history protocol shall include, but need not be limited to, a description of the screening device and shall address abuse of both legal and illegal substances. The medical history screening may be followed, as necessary and appropriate, with a thorough substance abuse evaluation.
The results of such medical history screening and of any specific substance abuse evaluation which may be conducted shall be confidential and, if the woman is enrolled in a treatment program operated by any facility receiving federal funds, shall only be released as provided in federal law and regulations. However, if the woman is not enrolled in a treatment program or is not enrolled in a program operated by a facility receiving federal funds, the results may only be released to the following persons:

[7] The policies, programs, and practices summarized in this section are not all-inclusive, but represent significant examples of strategies available to overcome barriers with identifying and treating SEIs. List of items reviewed is available upon request from the VDSS Division of Family Services.
[8] Note: Code citations are presented in full to avoid misinterpretation through summarization.

The subject of the medical history screening or her legally authorized representative.
Any person designated in a written release signed by the subject of the medical history screening or her legally authorized representative.

Health care providers for the purposes of consultation or providing care and treatment to the person who was the subject of the medical history screening.

The results of the medical history screening required by this section or any specific substance abuse evaluation which may be conducted as part of the prenatal care shall not be admissible in any criminal proceeding.

Practitioners shall advise their patients of the results of the medical history screening and specific substance abuse evaluation, and shall provide such information to third-party payers as may be required for reimbursement of the costs of medical care. However, such information shall not be admissible in any criminal proceedings. Practitioners shall advise all pregnant women whose medical history screenings and specific substance abuse evaluations are positive for substance abuse of appropriate treatment and shall inform such women of the potential for poor birth outcomes from substance abuse.

**§ 63.2-1505. Investigations by local departments (Welfare-Social Services)**
A. An investigation requires the collection of information necessary to determine:

1. The immediate safety needs of the child;

2. The protective and rehabilitative services needs of the child and family that will deter abuse or neglect;

3. Risk of future harm to the child;

4. Alternative plans for the child's safety if protective and rehabilitative services are indicated and the family is unable or unwilling to participate in services;

5. Whether abuse or neglect has occurred;

6. If abuse or neglect has occurred, who abused or neglected the child; and

7. A finding of either founded or unfounded based on the facts collected during the investigation.

B. If the local department responds to the report or complaint by conducting an investigation, the local department shall:

1. Make immediate investigation and, if the report or complaint was based upon one of the factors specified in subsection B of § 63.2-1509, the local department may file a petition pursuant to § 16.1-241.3;

2. Complete a report and enter it into the statewide automation system maintained by the Department;
3. Consult with the family to arrange for necessary protective and rehabilitative services to be provided to the child and his family;

4. Petition the court for services deemed necessary including, but not limited to, removal of the child or his siblings from their home;

5. Determine within 45 days if a report of abuse or neglect is founded or unfounded and transmit a report to such effect to the Department and to the person who is the subject of the investigation. However, upon written justification by the local department, the time for such determination may be extended not to exceed a total of 60 days or, in the event that the investigation is being conducted in cooperation with a law-enforcement agency and both parties agree that circumstances so warrant, as stated in the written justification, the time for such determination may be extended not to exceed 90 days. If through the exercise of reasonable diligence the local department is unable to find the child who is the subject of the report, the time the child cannot be found shall not be computed as part of the total time period allowed for the investigation and determination and documentation of such reasonable diligence shall be placed in the record. In cases involving the death of a child or alleged sexual abuse of a child who is the subject of the report, the time during which records necessary for the investigation of the complaint but not created by the local department, including autopsy or medical or forensic records or reports, are not available to the local department due to circumstances beyond the local department's control shall not be computed as part of the total time period allowed for the investigation and determination, and documentation of the circumstances that resulted in the delay shall be placed in the record.

In cases in which the subject of the investigation is a full-time, part-time, permanent, or temporary employee of a school division who is suspected of abusing or neglecting a child in the course of his educational employment, the time period for determining whether a report is founded or unfounded and transmitting a report to that effect to the Department and the person who is the subject of the investigation shall be mandatory, and every local department shall make the required determination and report within the specified time period without delay;

6. If a report of abuse or neglect is unfounded, transmit a report to such effect to the complainant and parent or guardian and the person responsible for the care of the child in those cases where such person was suspected of abuse or neglect; and

7. If a report of child abuse and neglect is founded, and the subject of the report is a full-time, part-time, permanent, or temporary employee of a school division located within the Commonwealth, notify the relevant school board of the founded complaint.
Any information exchanged for the purposes of this subsection shall not be considered a violation of § 63.2-102, 63.2-104, or 63.2-105.

C. Each local board may obtain and consider, in accordance with regulations adopted by the Board, statewide criminal history record information from the Central Criminal Records

Exchange and results of a search of the child abuse and neglect central registry of any individual who is the subject of a child abuse or neglect investigation conducted under this section when there is evidence of child abuse or neglect and the local board is evaluating the safety of the home and whether removal will protect a child from harm. The local board also may obtain such a criminal records or registry search on all adult household members residing in the home where the individual who is the subject of the investigation resides and the child resides or visits. If a child abuse or neglect petition is filed in connection with such removal, a court may admit such information as evidence. Where the individual who is the subject of such information contests its accuracy through testimony under oath in hearing before the court, no court shall receive or consider the contested criminal history record information without certified copies of conviction. Further dissemination of the information provided to the local board is prohibited, except as authorized by law.

D. A person who has not previously participated in the investigation of complaints of child abuse or neglect in accordance with this chapter shall not participate in the investigation of any case involving a complaint of alleged sexual abuse of a child unless he (i) has completed a Board-approved training program for the investigation of complaints involving alleged sexual abuse of a child or (ii) is under the direct supervision of a person who has completed a Board-approved training program for the investigation of complaints involving alleged sexual abuse of a child. No individual may make a determination of whether a case involving a complaint of alleged sexual abuse of a child is founded or unfounded unless he has completed a Board-approved training program for the investigation of complaints involving alleged sexual abuse of a child.

**§ 63.2-1506. Family assessments by local departments (Welfare-Social Services)**
A. A family assessment requires the collection of information necessary to determine:

1. The immediate safety needs of the child;

2. The protective and rehabilitative services needs of the child and family that will deter abuse or neglect;

3. Risk of future harm to the child; and

4. Whether the mother of a child who was exposed in utero to a controlled substance sought substance abuse counseling or treatment prior to the child's birth; and

*5.* Alternative plans for the child's safety if protective and rehabilitative services are indicated and the family is unable or unwilling to participate in services.

B. When a local department has been designated as a child-protective services differential response system participant by the Department pursuant to § 63.2-1504 and responds to the report or complaint by conducting a family assessment, the local department shall:

1. Conduct an immediate family assessment and, if the report or complaint was based upon one of the factors specified in subsection B of § 63.2-1509, the local department may file a petition pursuant to § 16.1-241.3;

2. Immediately contact the subject of the report and the family of the child alleged to have been abused or neglected and give each a written and an oral explanation of the family assessment procedure. The family assessment shall be in writing and shall be completed in accordance with Board regulation;

3. Complete the family assessment within 45 days and transmit a report to such effect to the Department and to the person who is the subject of the family assessment. However, upon written justification by the local department, the family assessment may be extended, not to exceed a total of 60 days;

4. Consult with the family to arrange for necessary protective and rehabilitative services to be provided to the child and his family. Families have the option of declining the services offered as a result of the family assessment. If the family declines the services, the case shall be closed unless the local department determines that sufficient cause exists to redetermine the case as one that needs to be investigated. In no instance shall a case be redetermined as an investigation solely because the family declines services;

5. Petition the court for services deemed necessary;

6. Make no disposition of founded or unfounded for reports in which a family assessment is completed. Reports in which a family assessment is completed shall not be entered into the central registry contained in § 63.2-1515; and

7. Commence an immediate investigation; if at any time during the completion of the family assessment, the local department determines that an investigation is required.

C. When a local department has been designated as a child-protective services differential response agency by the Department, the local department may investigate any report of child abuse or neglect, but the following valid reports of child abuse or neglect shall be investigated: (i) sexual abuse, (ii) child fatality, (iii) abuse or neglect resulting in serious injury as defined in § 18.2-371.1, (iv) child has been taken into the custody of the local department, or (v) cases involving a caretaker at a state-licensed child day center, religiously exempt child day center, licensed, registered or approved family day home, private or public school, hospital or any institution. If a report or complaint is based upon one of the factors specified in subsection B of § 63.2-1509, the local department shall (a) conduct a family assessment, unless an investigation is required pursuant to this subsection or other provision of law or is necessary to protect the safety of the child, and (b) develop a Plan of Safe Care in accordance with federal law, regardless of whether the local department makes a finding of abuse or neglect.

**§ 63.2-1509. Requirement that certain injuries to children be reported by physicians, nurses, teachers, etc.; penalty for failure to report (Welfare-Social Services)**

A. The following persons who, in their professional or official capacity, have reason to suspect that a child is an abused or neglected child, shall report the matter immediately to the local department of the county or city wherein the child resides or wherein the abuse or neglect is believed to have occurred or to the Department's toll-free child abuse and neglect hotline:

1. Any person licensed to practice medicine or any of the healing arts;

2. Any hospital resident or intern, and any person employed in the nursing profession;

3. Any person employed as a social worker or family-services specialist;

4. Any probation officer;

5. Any teacher or other person employed in a public or private school, kindergarten or nursery school;

6. Any person providing full-time or part-time child care for pay on a regularly planned basis;

7. Any mental health professional;

8. Any law-enforcement officer or animal control officer;

9. Any mediator eligible to receive court referrals pursuant to § 8.01-576.8;

10. Any professional staff person, not previously enumerated, employed by a private or state-operated hospital, institution or facility to which children have been committed or where children have been placed for care and treatment;

11. Any person 18 years of age or older associated with or employed by any public or private organization responsible for the care, custody or control of children;

12. Any person who is designated a court-appointed special advocate pursuant to Article 5 (§ 9.1-151 et seq.) of Chapter 1 of Title 9.1;

13. Any person 18 years of age or older who has received training approved by the Department of Social Services for the purposes of recognizing and reporting child abuse and neglect;

14. Any person employed by a local department as defined in § 63.2-100 who determines eligibility for public assistance;

15. Any emergency medical services provider certified by the Board of Health pursuant to § 32.1-111.5, unless such provider immediately reports the matter directly to the attending physician at the hospital to which the child is transported, who shall make such report forthwith;

16. Any athletic coach, director or other person 18 years of age or older employed by or volunteering with a private sports organization or team;

17. Administrators or employees 18 years of age or older of public or private day camps, youth centers and youth recreation programs; and
18. Any person employed by a public or private institution of higher education other than an attorney who is employed by a public or private institution of higher education as it relates to information gained in the course of providing legal representation to a client.

This subsection shall not apply to any regular minister, priest, rabbi, imam, or duly accredited practitioner of any religious organization or denomination usually referred to as a church as it relates to (i) information required by the doctrine of the religious organization or denomination to be kept in a confidential manner or (ii) information that would be subject to § 8.01-400 or 19.2-271.3 if offered as evidence in court.

If neither the locality in which the child resides nor where the abuse or neglect is believed to have occurred is known, then such report shall be made to the local department of the county or city where the abuse or neglect was discovered or to the Department's toll-free child abuse and neglect hotline.

If an employee of the local department is suspected of abusing or neglecting a child, the report shall be made to the court of the county or city where the abuse or neglect was discovered. Upon receipt of such a report by the court, the judge shall assign the report to a local department that is not the employer of the suspected employee for investigation or family assessment. The judge may consult with the Department in selecting a local department to respond to the report or the complaint.

If the information is received by a teacher, staff member, resident, intern or nurse in the course of professional services in a hospital, school or similar institution, such person may, in place of said report, immediately notify the person in charge of the institution or department, or his designee, who shall make such report forthwith. If the initial report of suspected abuse or neglect is made to the person in charge of the institution or department, or his designee, pursuant to this subsection, such person shall notify the teacher, staff member, resident, intern or nurse who made the initial report when the report of suspected child abuse or neglect is made to the local department or to the Department's toll-free child abuse and neglect hotline, and of the name of the individual receiving the report, and shall forward any communication resulting from the report, including any information about any actions taken regarding the report, to the person who made the initial report.

The initial report may be an oral report but such report shall be reduced to writing by the child abuse coordinator of the local department on a form prescribed by the Board. Any person required to make the report pursuant to this subsection shall disclose all information that is the basis for his suspicion of abuse or neglect of the child and, upon request, shall make available to the child protective services coordinator and the local department, which is the agency of jurisdiction, any information, records, or reports that document the basis for the report. All persons required by this subsection to report suspected abuse or neglect who maintain a record of a child who is the subject of such a report shall cooperate with the investigating agency and shall make related information, records and reports available to the investigating agency unless such disclosure violates the federal Family Educational Rights and

Privacy Act (20 U.S.C. § 1232g). Provision of such information, records, and reports by a health care provider shall not be prohibited by § 8.01-399. Criminal investigative reports received from law-enforcement agencies shall not be further disseminated by the investigating agency nor shall they be law-enforcement agencies subject to public disclosure.

B. For purposes of subsection A, "reason to suspect that a child is abused or neglected" shall include (i) a finding made by a health care provider within six weeks of the birth of a child that the child was born affected by substance abuse or experiencing withdrawal symptoms resulting from in utero drug exposure;(ii) a diagnosis made by a health care provider within four years following a child's birth that the child has an illness, disease or condition which, to a reasonable degree of medical certainty, is attributable to maternal abuse of a controlled substance during pregnancy; or (iii) a diagnosis made by a health care provider within four years of a child's birth that the child has a fetal alcohol spectrum disorder attributable to in utero exposure to alcohol. When "reason to suspect" is based upon this subsection, such fact shall be included in the report along with the facts relied upon by the person making the report.

C. Any person who makes a report or provides records or information pursuant to subsection A or who testifies in any judicial proceeding arising from such report, records, or information shall be immune from any civil or criminal liability or administrative penalty or sanction on account of such report, records, information, or testimony, unless such person acted in bad faith or with malicious purpose.

D. Any person required to file a report pursuant to this section who fails to do so as soon as possible, but not longer than 24 hours after having reason to suspect a reportable offense of child abuse or neglect, shall be fined not more than $500 for the first failure and for any subsequent failures not less than $1,000. In cases evidencing acts of rape, sodomy, or object sexual penetration as defined in Article 7 (§ 18.2-61 et seq.) of Chapter 4 of Title 18.2, a person who knowingly and intentionally fails to make the report required pursuant to this section shall be guilty of a Class 1 misdemeanor.

E. No person shall be required to make a report pursuant to this section if the person has actual knowledge that the same matter has already been reported to the local department or the Department's toll-free child abuse and neglect hotline.

*Virginia Policies, Programs, and Practices*

**Central Virginia Family Resiliency Project** is a comprehensive, coordinated, and multidisciplinary approach to supporting pregnant women with substance use disorders (SUD) and their children in Central Virginia sponsored by the Virginia Commonwealth University Health System (VCUHS), Family Lifeline, Stop Child Abuse Now (SCAN), and Richmond Behavioral Health Authority (RBHA). This project, expected to be implemented February 1, 2018, is based on a regional approach to develop appropriate clinical standards of care for pregnant women with SUD and their children. Additionally, the project will provide community and networking training events and a multidisciplinary clinic that provides co-located substance abuse treatment, psychiatric care, obstetric care, reproductive life planning, pediatric care, parenting education, care coordination and home visiting services. Goals are to reduce the

number and severity of obstetric complications, reduce rates of maternal substance abuse, deliver healthy infants, provide effective and desired reproductive life planning services, support early maternal-child attachment, reduce rates of child abuse and maltreatment, and ensure proper developmental follow-up of infants exposed to drugs *in utero*.

**DMAS Addiction and Recovery Treatment Services (ARTS)** is a new Virginia Medicaid benefit that went into effect on April 1, 2017 for members already eligible for Medicaid and FAMIS. It provides a variety of traditional and community-based benefits for pregnant women with a SUD. Eligible SUD services may include inpatient detox, outpatient therapy, medication assisted treatment, residential treatment center, crisis intervention, and case management/care coordination. Services are based on American Society of Addiction Medicine (ASM) criteria and the primary service limit is for residential treatment which includes a 90-day maximum length of stay. Because DMAS received a demonstration waiver, ARTS must comply with Federal requirements.

**Early Impact Virginia (EIV)**, formerly the Virginia Home Visiting Consortium, facilitates the coordination and delivery of home visiting services provided by public and private agencies. EIV includes seven member organizations (including CHIP of Virginia and Healthy Families Virginia) and nine early childhood partners (including DBHDS, VDH, DMAS, and VDSS). Families may receive home visiting services funded through Maternal, Infant and Early Childhood Home Visiting (MIECHV) grants awarded to local programs or nurse home visits through the state and federally-funded Healthy Start program.

**Fauquier Hospital Community Coalition of Family-Centered NAS Care** is an interagency collaboration that includes neonatal medical staff (e.g., NICU RN, MD, SW, and Pharmacist), the local CSB, OB/GYNs (including the Addiction Specialist), a Community Mental Health Leader (from the Mental Health Association of Fauquier County), LDSS, family practice doctors/pediatricians, and hospital administrators. The coalition was organized by the hospital's neonatologist with goals to decrease length of stay of SEIs by 10 percent and decrease the amount of separation experienced between mother and infant. Data thus far demonstrates a direct correlation with a decreased length of stay for mothers "rooming in" (staying with infant) more than 10 hours per day. There are two leadership teams within the neonatal team serving a central role for the coalition. One leadership team is charged with managing the patient and family from birth to post-discharge services and one assists the mother with education and resources when she first learns she is pregnant. Both leadership teams are exploring a central case management system to coordinate services for the mother and infant, however, funding is needed for implementation.

**Governor's Access Plan (GAP)** is a Medicaid plan that provides limited medical and behavioral health care coverage for low-income individuals with Serious Mental Illness (SMI). For qualified participants, it includes mental health services and SUD treatment, medical doctor visits, medications, access to a 24-hour crisis line, recovery navigation services, and case management. GAP is a limited benefit that covers primary care, specialty care, mental health services, and addiction treatment. Effective October 1, 2017, the GAP program will cover the comprehensive continuum of Medicaid Addiction and Recovery Treatment Services (ARTS) services including residential treatment, partial hospitalization, intensive outpatient, case management, and

medically assisted treatment (MAT) for individuals with opioid use disorder for qualified participants.

**Handle with C.A.R.E. (C**oordinating **A**ccess, **R**esponding **E**ffectively to Maternal Substance Use) is an initiative developed to identify a coordinated, state-level response to maternal substance use. In 2015, Virginia received technical assistance from the National Center on Substance Abuse and Child Welfare (NCSACW) to address SEIs. An interagency work group was formed, which included DBHDS, VDH, VDSS, DMAS, Early Impact Virginia, VHHA, CSBs, LDSSs, Opioid Treatment Programs (OTPs), and medical providers. The charge for this group is to develop a comprehensive work plan to improve state-level assistance to substance-using pregnant and parenting women and their families through:

- Implementation of SEI legislation, policies, and practices;
- Identification of standards of care for serving women; and
- Identification of standards of care for serving SEIs.

At the forefront of Virginia's efforts to promote a common understanding of critical issues with SEIs, Handle with C.A.R.E. is currently developing guidance for CSBs to facilitate prenatal and hospital postpartum substance use referrals, OTP guidance, and coordination for developing Plans of Safe Care.

**Plan of Safe Care** is required for all SEIs by the Child Abuse Prevention and Treatment Act (CAPTA) to address the needs of infants and their mothers. Plans must address use of both legal and illegal drugs including the use of MAT, and is initiated as soon as the child is identified as substance exposed, whether this is prior to, during, or after delivery. A Plan of Safe Care is unique to an individual SEI's needs and developed with the mother, her health care provider, other service providers, and her personal support system. The Code of Virginia § 63.2-1506 mandates development of a Plan of Safe Care when a provider reports identification of an SEI.

**Project LINK** is a regional program consisting of nine sites funded by DBHDS. Each site is affiliated with at least one CSB and provides services to pregnant and parenting women and their families that live within the community served by the CSB. The program provides a coordinated interagency system for screening, referrals, and services. LINK provides support to help find services, transportation, and childcare. A LINK specialist is assigned to participating families to provide case management duties, conduct home visits and provide referrals and education on health and parenting.

**South-Eastern Virginia Family Project (SEFP)[9]** is a comprehensive residential treatment program in Newport News for substance-using pregnant women and is approved for Medicaid reimbursement. An intensive day treatment program is also available for pregnant women and their children who are in need of less restrictive services. Treatment services are provided in a residential environment where women and their newborns can remain together throughout their treatment stay. Mothers receive clinical treatment for their addiction and any mental health needs, and learn parenting skills.

[9] South-Eastern Virginia Family Project (accessed August 24, 2017). "How can we help." Retrieved from http://www.sefp.org/.

**Substance Abuse Services Council**[10] is established by the Code of Virginia [§ 2.2-2696] to advise the Governor, the General Assembly and the Board of DBHDS in matters pertaining to substance abuse. Its members are representatives of state and provider agencies, senators, delegates, and advocacy organizations appointed by the Governor. The Code requires DBHDS to provide staff and funding to support the operation of the Council.

**VaAware** was established in August 2017 as a clearinghouse of information as part of an effort to combat addiction and the opioid crisis. This collaboration is between VDH, DBHDS, DCJS, and the Department of Health Professions. Treatment information for families, access to local resources organized by county/city, information for practitioners and law enforcement, and research and data on addiction topics is located at the website (vaaware.com). Local area task forces connected to this effort include Bounce Back from Addiction (Henrico County), One Care of Southwest VA, Road to Recovery (Northern Shenandoah Valley), and Sink or Swim (Northern Neck area).

**Virginia Premier Health Plan -- Healthy Heartbeats** is an example of a prenatal care program provided through a managed-care organization using a team approach including a medical outreach representative, registered nurse case manager, health educator, obstetrician/OBGYN, WIC, and the local health department. The program includes screening and referral for high-risk pregnancies, transportation to and from doctor visits, referral to community resource agencies and classes, help with breastfeeding and other postpartum needs, and free prenatal and parenting classes.

**Virginia Neonatal Perinatal Collaborative (VNPC)** is a group formed in 2017 that uses an evidence-based, data-driven collaborative process that involves care providers for women, infants, and families. Participating stakeholders include the Department of Health, DMAS, state chapters of national organizations (e.g. The American Congress of Obstetricians and Gynecologists [ACOG], Association of Women's Health, Obstetric and Neonatal Nurses [AWHONN], American College of Nurse-Midwives [ACNM], American Academy of Family Physicians [AAFP], American Academy of Pediatrics [AAP] and other organizations involved in the care of newborns (e.g., Anthem, Office of Secretary of Health and Human Resources [OSHHR], National Association of Neonatal Nurse Practitioners [NANNP]). VNPC goals[11] include:

- Provide assistance to hospitals and obstetric providers in performing quality improvement initiatives designed to improve pregnancy outcomes, including decreasing the preterm birth rate to Healthy People 2030 Goals and to decrease maternal mortality by 50 percent;
- Enhance the quality of state-wide perinatal data and provide hospital-specific data back to participating hospitals promptly so as to accomplish quality improvement goals;
- Provide assistance to hospitals and newborn care providers in performing quality improvement initiatives designed to improve neonatal outcomes, including decreasing morbidity and mortality as well as decreasing length of stay;

[10] Description from the DBHDS SASC webpage (http://www.dbhds.virginia.gov/about-dbhds/boards-and-councils/substance-abuse-services-council, accessed August 12, 2017).
[11] VNPC goals as listed on their website (http://www.vdh.virginia.gov/virginia-neonatal-perinatal-collaborative/, accessed August 12, 2017).

- Inform and involve the community, including health care providers, nurses, ancillary medical staff, payers, hospital administrators, and, patients in efforts to make Virginia the safest and best place to deliver babies; and
- Narrow the racial and ethnic disparities with the achievement of health equity in pregnancy and neonatal outcomes.

**Winchester Medical Center (WMC) Model** is a collaborative, initiated in 1999, in response to an upsurge in neonatal abstinence syndrome (NAS) in the area. The multidisciplinary community approach includes universal screening, a perinatal liaison, comprehensive medication management services, the Comfort Program, and a Parent Advisory Council. Urine drug screening is conducted for all pregnant women in OB/GYN offices to identify substance-using pregnant women and reduce subjectivity in determining who gets screened. As an additional measure, language directly addressing the screening is included on the consent form for women receiving mental health treatment. In addition to universal screening, a core toxicology test is performed on infants when appropriate (for example, when there is knowledge of prenatal substance use). A WMC perinatal liaison housed within two OB/GYN offices in the community focuses on prenatal care and connects pregnant women with SUD indicators to resources and services as soon as possible. Importantly, WMC has developed a comprehensive approach to medication management by contacting mothers directly to encourage them to engage in treatment. WMC also includes the Comfort Program, which facilitates bonding between mothers and infants and includes volunteers who provide comfort to the infant when the mother cannot and a Parent Advisory Council for parents in the NICU to look at the SEI issue from a multi-faceted perspective.

*Promising Policies, Programs, and Practices Implemented in Other States*

**Family-Based Recovery Program**[12] is a home visiting program available through referral from the Connecticut Department of Children and Families. Parents who have reported substance use within the last 30 days and who have children ages zero to 36 months living at home are eligible. The program integrates in-home, attachment-based parent-child therapy and treatment to reduce children's risk of abuse/neglect, poor developmental outcomes, and/or removal due to parental substance use. Treatment includes three in-home visits per week; two of the weekly visits focus on parental sobriety and psychological wellbeing and the third visit is with the parent and child to strengthen bonding and promote the child's healthy development. Case management services help parents identify basic needs and connect them with support services, such as housing assistance, access to transportation, and health insurance. Assessments, intervention, and advocacy are available for children, as well as psychiatric evaluation for parents and medication management as needed. Staff is accessible 24/7 via an on-call system to assist in developing safety plans when clients are in crisis or at high risk of relapse. No one is denied access to services due to inability to pay and the program uses a discounted, sliding fee schedule.

**SmartPhone Application.** Delaware is developing a SmartPhone application (app) designed to provide access for the mother and the medical provider while incorporating confidentiality. The app incorporates the Plan of Safe Care and provides real-time updates. It also notifies the central

[12] The Village for Families & Children (accessed August 24, 2017). Family-Based Recovery. Retrieved from http://thevillage.org/program/family-based-recovery/.

navigator (the mother's central point of contact/service coordinator) if the mother fails to make an appointment. This adaptation of a common mode of technology provides immediate and accurate information and allows for enhanced case management.

**KIDS NOW Early Childhood Initiative** is a state program operated by Kentucky's Cabinet for Health Services' Division of Substance Abuse with the goal of increasing the number of infants born free of the harmful effects of substances. The program has successfully strengthened outreach efforts to substance-using pregnant women by working with the 14 regional mental health boards, local health departments, private physician offices, and district and circuit court judges. Additionally, the Kentucky Medical Association is encouraging physicians to screen pregnant women to determine their risk for substance use during pregnancy and to refer them for substance use prevention or treatment services when needed.

**Sobriety Treatment and Recovery Team (START)**[13] Kentucky parents referred to Child Protective Services begin treatment after assessment within five days of the report. It is founded on the notion that parents are more likely to be agreeable to participate in treatment in order to keep their family intact. In addition to providing quick access to treatment, START uses MAT in conjunction with family mentors. Mentors are parents in sustained recovery for at least three years, and whose past experiences are related to child welfare, including the loss of child custody at some point. Mentors help patients navigate through the treatment and recovery process. They escort clients to treatment and attend community recovery support group meetings with them.

**Born Drug-Free Tennessee**[14] was implemented in 2015 by the East Tennessee NAS Task Force, which included representatives of East Tennessee Children's Hospital, Allies for Substance Abuse Prevention of Anderson County, Metro Drug Coalition, Rescue 180, HEAL of Sevier County, Ridgeview Behavioral Health Services, and Mary Beth West Communications. The initiative connects pregnant women with a SUD to a treatment provider and encourages entry into prenatal care as early as possible to improve the health outcomes of the mother and her infant. In addition, the program promotes access to voluntary Long-Acting Reversible Contraception (LARC) for substance-using women, which is available through the Tennessee Health Department. Funding for Born Drug-Free Tennessee is provided by Appalachia High Intensity Drug Trafficking Areas and the United Way of Greater Knoxville.

**Screening Tools.** In Washington State, the Department of Health collaborated with the Department of Social and Health Services to provide prenatal substance screening tools to providers to assist them in identifying women with substance use patterns and connect them with treatment. The tools include two guides: *Substance Abuse During Pregnancy: Guidelines for Screening* and *Guidelines for Testing* and *Reporting Drug Exposed Newborns in Washington State*.

[13] START originated in Ohio and municipalities in Indiana, Georgia, New York, and North Carolina have piloted their own versions of the program.
[14] Born Drug-Free Tennessee (accessed August 24, 2017). Retrieved from https://borndrugfreetn.com/.

## Barriers to the Identification and Treatment of Substance-Exposed Infants

Prior to the final work group meeting, an initial analysis was performed of all documented comments, responses and feedback collected between April and July. This revealed the consistent identification of the following barriers:

- Collaboration across disciplines and sectors occurs in some localities and regional areas, yet it is far from comprehensive in scope and coverage;
- Absence of a clear understanding of the breadth and totality of resources in the community and what other agencies do;
- Lack of consensus about Plans of Safe Care and other SEI-related mandates, particularly how they apply to specific agencies' responsibilities;
- Limited data collection, and challenges with sharing what data is collected;
- Insufficient services for pregnant women, particularly for long-term substance abuse intervention that encompasses the needs of the whole family;
- Insufficient efforts to integrate the father and broader caregiver support system into prevention efforts; and,
- Lack of opportunities for multidisciplinary prenatal intervention.

During the final work group meeting, members reviewed a comprehensive summary of barriers documented during their previous meetings, the five town hall meetings, and from open-ended survey responses. Members analyzed the summary document to identify barriers hindering the identification and treatment of SEIs. Next, the workgroup categorized the barriers according to the five content areas addressed in the study as follows:

*Identification and Reporting*

- **Stigma and lack of understanding of prenatal substance use.** A significant barrier is the stigma perceived on the part of service providers and fear felt by pregnant women. Many pregnant women may be reluctant to self-identify or seek services for fear of repercussions. Substance use during pregnancy is not necessarily a criminal offense in Virginia; however, stakeholders reported concerns that women reported to and arrested by the police would further contribute to the stigma and make women uncomfortable talking to their physician or seeking treatment.

  Stakeholders indicated that medical and service providers may carry societal assumptions about pregnant women and substance use, or may lack knowledge about how to identify infants that are at risk. For instance, an infant may be exposed to methadone. Because in most situations this drug is legal and an accepted treatment for substance dependence, a provider may not identify this infant as at risk for exposure. Prenatal providers also may not feel comfortable addressing substance use if their patient self-identifies and they do not understand the appropriate referrals needed in such cases.

- **Lack of a standard approach to screening and testing.** For the most part, identification of SEIs depends on the training and commitment of the provider. Pursuant to § 54.1-2403.1of the Code of Virginia, prenatal providers are required to screen expectant mothers. Without a standard screening procedure or tracking mechanism, it is difficult to

assess consistency among providers. Screenings can consist of simply asking the mother if she is using substances, or more indirectly stating, "you are not using any substances are you?" Other providers are trained to use evidence-based screening tools or other methods to obtain more accurate data from the screening. Stakeholders also reported that many healthcare providers opt not to screen their patients, due to the perceived lack of referral options for treatment. Screening without referral options creates greater liability for physicians and no additional support for the mother.

Currently, not all hospitals are screening infants for substance exposure at birth. Stakeholders report that screenings are performed inconsistently by hospitals postpartum and testing is generally completed only if there is suspicion of prenatal drug exposure. Further, stakeholders believe the current process is both stigmatizing and ineffective in identifying SEIs. A contributing factor for this barrier is the finding that stakeholders use the terms 'screening' and 'testing' interchangeably with a lack of clear definitions for either terms.

- **Current mandatory statutes.** Stakeholders perceive that current statutes may have an adverse effect on the referral process, although there was the acknowledgment that, as with any new legislation, formal guidance and cumulative practice will provide the "practice parameters," which cannot be legislated. Identified below are specific areas of the Code that stakeholders identified for review.

  Pursuant to § 32.1-127 of the Code of Virginia, hospitals are required to make a CSB referral if an infant is identified as substance-exposed. However, the execution of this mandate is inconsistent and the current law requiring medical providers to refer to the CSB is not enforceable. There is no mechanism to identify when a referral needs to be made and a lack of consequence for failing to make a referral. This is further complicated by the geographic location of CSBs and disparity in the available treatment options. For some families, the closest CSB requires significant travel and transportation is not always available. CSB referrals are also difficult when the child is delivered in a hospital that is not located in the locality where the mother lives. In these instances, the hospital may not have a relationship with the CSB that should receive the referral.

  Section § 63.2-1509 of the Code of Virginia, which mandates reporting requirements after SEI identification, was amended in 2017 to comply with the Federal Code in CAPTA. Consequently, there is not yet a common understanding about the Code's revised language, and which organization(s) should provide leadership in developing a Plan of Safe Care as required in § 63.2-1506.

  A common concern was also raised about the change to § 63.2-1509 (B)(i) including the phrase "affected by" which is open to interpretation and may lead to subjective referral decisions. Stakeholders expressed concern that this change may also result in the over-referral of infants who are experiencing withdrawal symptoms, widening the net to pull in families who do not need services, and excluding those who do.

Stakeholders also expressed ambivalence about Senate Bill 868 mandating a CPS response within 24 hours for every valid report or complaint regarding a child under the age of two because it may discourage service provider referrals who hold a perception of CPS as punitive rather than a support system to the family. It may also discourage women from disclosing prenatal substance use to their physician, which results in an immediate barrier between the mother and her doctor. On the other hand, SB1086 and HB1786 requiring a family assessment be completed for valid CPS complaints is a positive development because the focus is on support and prevention as opposed to investigation.

*Data*

- **Lack of centralized data system.** There is no centralized system to collect or report data and no clear consensus on the standardized data points to collect. Without a coordinated effort among organizations to use a centralized system for data collection and storage, the scale of the SEI crisis will never be known.

- **Limited data available.** There is little to no data that captures the scope of the SEI problem within the Commonwealth. VDH collects data about NAS births by county and makes this information available on their website.[15] In addition, VDSS reports SEI data under the requirements of CAPTA. Work group members indicated that several SEI data sets exist, but state agencies (e.g., VDSS, DBHDS, and VDH), insurance companies, hospitals, and other service organizations maintain them with no mechanism to share this data. The available data only includes what is relevant to the services provided by the respective maintaining organization, making it difficult to assess trends.

- **Lack of an identified lead state agency for interagency data sharing.** Given the absence of a centralized system, it follows that there is no structure for organizations to coordinate data sharing across providers (hospital to CSB, LDSS to CSB, insurer to CSB, etc.). This issue is compounded by the absence of an established lead agency to address SEIs. This lack of coordination creates gaps in the Commonwealth's ability to collect and analyze sound, reliable data and prevents an understanding of the true scope of the need and impact.

- **Inaccurate use of the International Classification of Diseases (ICD) diagnostic and procedure codes.** An Anthem study[16] found that hospitals' use of diagnostic codes related to SEIs can be inaccurate with little information provided about the infant's exposure and treatment while in the hospital. For example, codes used inappropriately do not differentiate between infants born with withdrawal symptoms from illegal substance and infants born with withdrawal symptoms from legally-prescribed substances. The imprecise use of ICD codes compounds issues with the referral process noted above.

[15] http://www.vdh.virginia.gov/data/opioid-overdose/

[16] *America's Opioid Epidemic and Its Effect on the Nation's Commercially-Insured Population* (Blue Cross Blue Shield, 2017).

*Interagency Coordination and Collaboration*

- **Lack of engagement and coordination among key stakeholders.** As one survey participant wrote, *"It is important that private obstetricians, behavioral health providers (inpatient and outpatient), and local hospitals develop a collaborative system for identifying pregnant and postpartum women impacted by substance use disorders/co-occurring disorders and provide comprehensive prevention, intervention, and or treatment services for identified families."*

  While LDSS and the CSBs are intricately involved in working with mothers and families on SEI issues across the Commonwealth, the challenges around SEIs are complex and involve numerous other partners. There is an overarching concern that key stakeholder agencies and organizations are not involved in collaboratively developing community responses to provide accessible services to mothers and children in need. These missing stakeholders differ from region to region, but can include Emergency Medical Services, Department of Juvenile Justice, law enforcement, early intervention providers, safety net providers, local health departments and community partners, such as local foundations and faith-based organizations.

  Town hall participants across the Commonwealth underscored the need to link and build relationships with hospitals and other private providers. Hospitals and private care providers are a critical part of addressing SEIs and yet there are vast differences in their level of engagement across the Commonwealth. Many hospitals and private providers do not refer women suspected of using substances to the CSB. When there is an alternate placement for the infant, hospitals do not adequately engage with LDSS, foster families, or adoption agencies during discharge planning after a delivery.

  Survey participants highlighted the need for increased involvement by the health department; given the focus on prevention and health education, and its role in providing WIC and other supportive resources with a focus on building relationships with other partners (e.g., Early Intervention, CSB, and LDSS) to jointly address SEIs.

- **Lack of mutual understanding of roles and responsibilities.** Coordination between key partners including hospitals, CSBs, LDSS, health department, and community organizations is inhibited by the lack of clear understanding of the roles that each of these organizations play in providing care to the mother and infant. Stakeholders reported a lack of formalized agreements such as a Memorandum of Understanding (MOU), standardized Plans of Safe Care, understanding of the reporting mandates, established processes and workflows, tools, and techniques that can be used to standardize the exchange of information and services. Given the various disciplines engaged in SEI-related issues within a community, a lack of standardized terminology was cited as particularly problematic in interagency coordination and collaboration.

  Stakeholders across the Commonwealth reported the persistence of silos in dampening collaboration efforts without enough team or wrap around opportunities to effectively plan for and coordinate needed client services. Even communities where strong relationships had developed, many times those relationships did not extend beyond the

person or department in an organization assigned to a project. This silo approach limits the flow of information, opportunities for comprehensive approaches, and is particularly problematic when staff leaves or transitions.

- **Lack of communication and coordination with foster and adoptive parents.** Foster parents, adoptive parents, and agencies that support adoptions play an important role in providing a safe temporary or permanent place for SEIs. Yet, foster parents and adoption support agencies who participated in Town Hall meetings reported receiving incomplete, and sometimes incorrect, information about the needs and concerns of the infants in their care. These stakeholders also reported that there was no place for foster parents to connect to for support and gather information on specialized care for SEIs.

- **Barriers related to state and regional lines.** Stakeholders were particularly concerned about children "falling through the cracks" due to lack of communication between states, or across municipalities, even when jurisdictional agreements exist. LDSS and CSB locality and regional catchment areas do not align perfectly. Additionally, there can be confusion about which partners to contact (e.g., the hospital is in one CSB district, but the mother lives in another CSB district). While a hospital may have an excellent relationship with the other local agencies in its immediate area, it may not have strong relationships in the entire catchment area that it serves. In these cases, a hospital is especially limited in providing referrals or making connections back in the patient's own community. This is particularly an issue in rural areas where there are fewer service providers and in the Southwest region where patients can cross borders of multiple states. This barrier is further complicated by families changing providers so they can circumvent identification by remaining unknown to LDSS or the CSB.

- **Communication challenges created by** the Health Insurance Portability and Accountability Act of 1996 (HIPAA)**.** Stakeholders report that in cases of hospital discharge or family planning, HIPAA regulations create barriers to partners sharing needed information. Although legislated to protect confidentiality, stakeholders maintain that due to HIPAA, hospitals and obstetricians alike are cautious when providing referrals to case management with other agencies or home visiting programs. Confidentiality regulations also impact follow-up services. As a result of the inability of organizations to share information with each other, a provider will not know if a mother missed an appointment and consequently cannot notify the referral source to follow-up with the patient.

- **Lack of an official lead agency.** Prevention services and resource coordination at both the prenatal and postpartum level is critical to addressing the SEI issue. Without an official lead agency guided by a recovery and treatment model, a gap exists that prohibits addressing SEIs during all intervention points. Currently VDSS is the *de facto* lead within the Commonwealth because of mandated reporting requirements. Many stakeholders see LDSS as the one place to refer and arrange for services because of the duty to respond. However, CPS is not involved with SEIs until postpartum and cannot provide critical support during the prenatal period. Further, the CPS process is a tertiary response and often perceived as punitive.

*Service Availability and Planning*

- **Lack of services focused on the mother and child.** The current system treats the infant and the mother separately, both institutionally and culturally. There are limited services available that focus on both (e.g., mother/child programs, treatment programs that allow mothers to bring infants). While pregnant women are a priority population for CSBs, there are limited services available to support the full range of needs that women (pregnant and postpartum) and their families may need. This is a critical issue because substance use often occurs with other mental health issues that may be related to trauma or a mental health disorder. Statewide, there is vast disparity in the funding for and availability of services across the spectrum (prevention, in-home, supportive wrap-around, and residential treatment) that are family-friendly and holistic in nature.

- **Limited availability of residential treatment centers and other treatment options**. The limited availability of treatment increases disparities between who truly have access to the best treatment options and others not as fortunate. The number of facilities that provide treatment for pregnant women is extremely limited and access decreases with lower population density. Further, the DMAS ARTS program does not cover residential treatment for women on FAMIS. For those eligible, the ARTS program offers a limited residential stay and also a reduced case management reimbursement, which may limit the number of participating providers. Project LINK provides intensive case management and home visiting for pregnant women is a good alternative model for treating the mother and infant together. Currently it is only available at nine of the 40 CSBs in Virginia and we believe that it may be close to a decade since the Virginia General Assembly allocated funds for perinatal addiction services.

- **Long waiting lists for women postpartum.** Even in areas where there is a full range of services available, there are long waiting lists. While pregnant women receive priority, they lose that priority once the infant is delivered. Stakeholders report that a woman seeking services postpartum may wait as long as four months or more for mental health services related to treatment. This problem is further complicated when the mother is separated from her child until she successfully completes treatment. Separation affects the mental health of the mother and interferes with the essential mother and child bonding experience.

- **Inability to continue medication-assisted treatment (MAT) services through the first year of postpartum for Medicaid-funded births**. The mother loses access to MAT services after birth because she is no longer eligible for this service postpartum through Medicaid. Loss of this treatment comes at a time when she may experience increased stress from caring for a newborn. In addition, stakeholders report lack of consistency and confusion over policies and protocols among MAT programs. One hospital social worker said, *"Medication-assisted programs all operate differently. Once the infant is delivered, it can be difficult to get answers from clinics regarding whether or not the mother is discharged from the clinic for non-compliance. Further, continuity of care can be a question after delivery and is an issue."*

- **Lack of education and LDSS partner engagement during hospital discharge planning**. The preferred outcome during discharge planning is to keep the mother and infant together and work with the infant's family to develop a care plan. When an alternate placement for the infant is needed, LDSS workers expressed frustration at the lack of coordination by the hospital prior to discharging the mother. In these situations, those stakeholders report the need for improved standard hospital discharge processes to include more education about SEIs and referral support for kinship, foster, and adoptive resources that may provide alternative care for the infant.

- **Failure to engage mothers may lead to recurring referrals for treatment.** In town hall meetings across the Commonwealth, LDSS staff reported working with women who have multiple substance-exposed children. This underscores the ineffectiveness of the current system in treating SEIs, the need for an enhanced focus on prevention, and education of medical and service providers on SEI-specific topics. Stakeholders emphasized the need for a spectrum of prevention efforts including drug prevention programs in elementary schools, and availability of LARC for women interested in avoiding unplanned pregnancies.

- **Barriers to accessing available services. E**ven when services are available in an area, they may still be inaccessible as the result of funding limitations, childcare options, or transportation. In general, there is no childcare for a mother's appointment and/or support group meeting. Housing is also a major issue for postpartum women. Not all women need residential treatment, but they do need a place to live in the community where they can focus their energies on living substance-free and caring for their infant. All barriers are further complicated by the lack of medical providers in very rural areas.

- **Lack of trained workforce to provide services.** The plurality and level of complexity of issues that influence substance use and abuse and accompanying familial issue (such as mental health, traumatic experiences, multi-generational addiction). For example, treating the substance use problem alone, without a focus on trauma, will not address the SEI issue long-term. Stakeholders advised that trauma-informed care needs to become a significant part of the substance use treatment process. Additionally, as highlighted earlier in this section, there is limited knowledge about SEIs and how to best support families and children affected by substance use to ensure the safety of the family unit and that basic needs are being met.

*Funding*

In many instances, addressing the barriers described above will require new or additional funding. The barriers summarized below are specific high-level areas where funding resources are lacking that arose in stakeholder dialogues.

Funding levels and services available to address SEIs and connected issues such as mental health, substance use, trauma, and care coordination vary dramatically across the Commonwealth. Rural and smaller localities are not funded at the same level as urban areas, yet many rural areas see much higher numbers of SEI cases despite fewer resources.

- **Lack of Medicaid coverage, particularly postpartum.** There are many people (mothers and children) with limited to no insurance coverage because of prohibitive eligibility criteria. Due to the recent changes and implementation of ARTS, more pregnant and postpartum women have access to insurance coverage for substance use treatment services. However, stakeholders repeatedly expressed concern about service barriers related to the 60-day postpartum care window closing for Medicaid women. Particularly when substance use is a presenting issue. As a result, women are vulnerable to relapse and lose any progress made through treatment to support the family. Additionally, substance use is not an eligibility criterion for GAP funding which would eliminate this program as a possible option for continued coverage.

- **Increased staffing at LDSS and CSBs.** Positions at LDSS and the CSBs are needed to sufficiently address the SEI issue, particularly positions dedicated as a liaison for SEIs, their families, and other providers of services. The current ratio of staff to SEI cases allows LDSS and CSBs to satisfy the minimum service requirements. Caseloads continue to increase not just from the rise of SEIs, but also due to the paradox of improved identification and referral systems. At current staffing levels, agencies cannot provide adequate follow-up and best practice service provision to get ahead of the issue.

- **Need for workforce development.** Workforce training and educational opportunities across all disciplines related to SEI are lacking and the complexity of the issues readily apparent. Specific needs include education for CSB staff related to MAT programs, education for the LDSS work force with a focus on identification of substance use, trauma focused interview techniques for children and parents, and methods to balance the safety and well-being of the child when a parent is using substances.

# Recommendations

The analysis used to identify commonly referenced barriers also yielded recommendations generated from work group discussions, town hall dialogue, and survey data. Common themes informing recommendations include the following:

- Multi-sector state, regional, and local partners can benefit from working together on this issue (e.g. forming multidisciplinary teams);
- Explore universal screening options (currently required under § 54.1-2403.1) and testing as methods to identify more pregnant women at risk of SUD;
- Support a multidisciplinary approach during the prenatal period as the most effective intervention plan;
- Improve the existing referral system between the hospitals and local CSBs as required by § 32.1-127(6);
- Identify data points to be collected (to include, but not limited to) annual reporting requirements mandated by CAPTA, and a reliable data system to understand both the scope of the problem and the short and long-term outcomes of interventions;
- Increase collaboration between LDSS, hospitals, adoption agencies, and other partners at the time of hospital discharge of the mother/and infant so that all partners and support network can be present to coordinate an approach. Integrate the Plan of Safe Care into the discharge plan and include family members and other caregivers in plan objectives;
- Support a trauma-informed approach to identification and treatment of SEIs and their full family and caregiver constellation;
- Improve availability of home visiting programs to support pregnant women with a SUD and/or a SEI to ensure adherence to, and continuity of, the Plan of Safe Care; and,
- Improve workforce development options for LDSS, CSB, and other private and community partners related to SEIs. Many professionals do not understand the complexity of the SEI issue.

During the final work group meeting, members used a summary of combined barriers and recommendations to identify themes surrounding issues related to identifying and treating SEIs. Based on these themes, members identified and prioritized recommendations with the highest promise to improve the identification and treatment of SEIs. To facilitate implementation, each recommendation was categorized as either short-, medium-, or long-term. Short-term was defined as “low-hanging fruit” with actions that can be implemented with minimal additional funding or resources (one year to 18 months). Medium-term recommendations were defined as those that need two to three years for implementation, require new or amended state legislation, realignment of existing funding, or a new funding stream altogether. Long-term recommendations were defined as needing more than three years to implement, although the time horizon to initiate movement on some action items would begin in the short term. Members also considered the severity of need when determining if a recommendation should be classified as short-, medium-, or long-term.

*Short-Term Recommendations*

***1. Legislative***

*1.1.* Maintain the scope and function of the Children's Cabinet, developed under the McAuliffe Administration, and recommend SEIs as a new priority area for their focus. This is necessary to maintain visibility of this complex issue and implement a robust cross-agency response.

*1.2.* Identify a state agency to develop and implement a comprehensive plan to address SEIs to include a centralized intake function. [Recommended Agency: VDH or DBHDS].

*1.3.* Require providers who prescribe medications in specific classes to develop a medication plan with a timeframe and strategy for tapering and discontinuing use, linked to a discussion of reliable contraceptive options (including LARC). The plan should consider the pros and cons of pharmacotherapy versus medically-supervised withdrawal.

***2. Budgetary***

*2.1.* Expand GAP funding for Medicaid beyond the current 60 days postpartum, preferably up to one year, while developing plans to undertake Medicaid reform to address the addiction crisis and offer stronger mental health treatment services for the uninsured. Expand GAP eligibility to include uninsured pregnant and postpartum women with a primary diagnosis of SUD. The goal will be to provide coverage to uninsured mothers to allow them to receive addiction treatment, primary care, and case management. Ensure ARTS coverage is specifically included in the plan.

*2.2.* Allocate funding for workforce training for all agencies that serve SEIs. In addition to the overarching focus on trauma-informed care, key topics should include clinical explanations of opioid use disorder and NAS, appropriate clinical training in evidence-based early childhood mental health treatment modalities for CSB mental health clinicians, and educating home visitors to partner with families experiencing substance dependency using trauma-informed practice.

*2.3.* Through a budget amendment, appropriate funding for Medicaid and FAMIS to add nurse and social worker home visiting services for pregnant women with SUD and SEIs as a covered service. This provides a professional responsible for connecting with the CSB in the development and follow-through of the Plan of Safe Care, addresses the mother-child dyad, and improves outcomes for mothers and infants, while reducing infant and child deaths due to maltreatment and abuse.

***3. Policy***

*3.1.* Collaborate through the use of interagency MOUs, educational events, and stakeholder meetings to provide clarity to health care providers about the reporting and referral processes mandated in § 63.2-1509. This effort should include guidance distinguishing infants affected by prenatal substance use as opposed to substance abuse. Consider including organizations such as the AAP, ACOG, Virginia Hospital

and Healthcare Association (VHHA), and other relevant organizations that support providers.

*3.2.* Start early to identify at-risk youth, women, and families. Launch a statewide, evidence-based awareness campaign to (1) mitigate the stigma associated with substance use and pregnancy; (2) emphasize that addiction is an illness; (3) provide scientifically-accurate information about common risks associated with substance use and abuse during pregnancy; and, (4) encourage disclosure of substance exposure before or during pregnancy in order to get care. The target audience should include expectant mothers and their families, school-aged teens, health care providers, mental health care providers, and other service providers. Leverage activities associated with the nascent Virginia Neonatal Perinatal Collaborative and VaAware clearinghouse to support the campaign.

*3.3.* Identify a state agency with a recovery/treatment model to lead coordination of the development of a standardized Plan of Safe Care process (including a required template) to be used across agencies and among recovery partners across the Commonwealth to guide referrals. Aim to develop these plans prenatally with as much objectivity as possible to avoid racial and socioeconomic status bias and include the family system in development. The agency should also coordinate and oversee training and implementation. [Recommended Agency: DBHDS].

*3.4.* Establish a primary point person, supported with newly allocated resources, where necessary, who follows the family affected by SEI to coordinate Plan of Safe Care services and communication. This point person could be a case manager, care coordinator, or navigator, home visiting nurse or social worker and should be integrated with the above Plan of Safe Care recommendations established (1)3.3.

*3.5.* Convene a time-limited multi-sector work group to clearly define and distinguish between screening and testing; identify clinically sound options for universal screening approaches for all women of childbearing age and criteria to trigger testing of SEIs; make recommendations for implementation of a statewide protocol; and, explore how Medicaid agencies and insurers can provide reimbursement for utilizing screening protocol(s) for early detection, and link screening to referral to treatment. With regard to testing, take under consideration the continuum of positive and negative aspects, including issues surrounding patient-informed consent and full understanding by all parties of the ramifications of a positive test result.

*3.6.* Educate obstetricians and medical providers about Plans of Safe Care, how this requirement (and opportunity) comes into play, and their legal responsibility to make a CSB referral if the mother discloses substance use. Ensure that obstetricians and medical providers consistently follow existing state law in § 32.1-127(6), which requires licensed hospitals to develop a discharge plan for substance abusing postpartum women and to notify the CSB of the jurisdiction in which the woman resides to implement the plan. Work with providers to shift the perspective from a lens of stigma to the approach of trauma-informed care. A climate of trust within the

patient-physician relationship promotes patient autonomy and enables effective intervention for women with SUD.

*3.7.* Require hospital discharge plans to include referrals to early intervention or home visiting programs, WIC, education and resources on SEI issues and best practices, primary care provider follow-up appointment dates and contact information, and other pertinent follow-up medical appointment dates.

*3.8.* Replicate the successful model of family partnership meetings employed by LDSS at critical decision points, particularly at discharge, to ensure that LDSS and the CSB work closely with the hospital to ensure positive outcomes.

*3.9.* Establish a regional multidisciplinary team (MDT) approach for SEI cases, similar to Child Fatality Review Teams, where all professionals meet on a regular basis in a forum to discuss general issues, examine trends to streamline processes in communities, and promote a coordinated and family-centered approach.

*3.10.* Utilize a trauma-informed care model in CSB and LDSS practices, SUD treatment, and MAT programs.

*3.11.* Require an SEI screening question in Well Baby checks.

*Medium-Term Recommendations*

***1. Legislative***

*1.2* Enact a statutory change to § 63.2.1506 that gives LDSS, with involvement of the family, the discretion to choose between a family assessment or mandate that the CSB develop a Plan of Safe Care. With open lines of communication between the CSB and LDSS, women who have an active Plan of Safe Care through the CSB can use the Plan in lieu of creating a separate, and perhaps redundant or even conflicting, LDSS family assessment.

*1.2* Require hospital release of information (ROI) forms to be detailed, comprehensive, and universal so consent can be accepted by all agencies and partners involved in the patient's care. Request a ROI at the time of referral for services or in the event of a positive screening result.

***2. Budgetary***

*2.1.* Create a universal repository for resources, a database of what is available for families and criteria for referral processes. Identify if updating an existing electronic system (such as 211 or the new website VaAware) can be used as a potential resource.

*2.2.* Expand coverage and funding of referral and support programs, like Project LINK, across the Commonwealth to all CSBs. This can be accomplished using a graduated or phase-in approach prioritizing underserved areas.

*2.3.* Provide additional funding to CSBs for SUD prevention and treatment programs in rural localities, focusing on programs that promote the bonding between mother and infant.

*2.4.* Develop pilot programs to expand successful multi-sector models to other areas of the state as described in the *Existing Policies, Programs, and Practices* section of this report.

***3. Policy***

*3.1* Develop guidelines for medical providers to strengthen clinical standards for identifying, referring, and treating SEIs that include instituting a universal screening conducted as part of comprehensive obstetric care. Universal screening should include using validated, evidence-based tools, and clinically-sound methods (such as verbal screening) to indicate whether testing of infants should be carried out under specified conditions for substance exposure per work group recommendations referenced under (1)3.5.

*3.2* Conduct an analysis of existing data sources, how they are used, the strengths and limitation of each, opportunities for coordination, and outcome measures most useful to local efforts. Identify a state agency to take the lead on data collection.

*3.3* Develop or expand a centralized data collection system (e.g., Virginia Longitudinal Data System - VLDS) that includes a mechanism to monitor outcomes for mothers and newborns post hospital discharge. Synchronize data requirements across payer/government organizations and develop a system for accountability among partners. Prioritize five or six key metrics that are uniformly defined and can be reliably collected. Form an agreement between stakeholders to collect and report data.

*3.4* Develop a coordinated system of information sharing between state and local agencies that addresses HIPAA requirements and provides simplified data access to community and private providers. Develop a standardized release form to support this system.

*3.5* Formalize processes and systems of care across agencies and organizations, including MOUs, screenings used, protocols, forms and referral processes. There needs to be intentional relationship development of all parties in the continuum of care from primary care to prenatal providers, SUD treatment providers, LDSS, home visiting programs, etc. These relationships need to be institutionally incentivized in order to be maintained and sustain the passing through of personal relationships.

*3.6* Develop, test, and implement an evaluation instrument that can be administered by a medical provider or treatment facility to assess unmet treatment needs of mothers struggling with SUDs and identify resources for addressing those needs.

*3.7* Develop guidelines for use of International Classification of Diseases (ICD) diagnostic and procedure codes related to the treatment of SEIs to correct inaccurate hospital coding, and provide information to include what the infant was exposed to and treatment the infant received while in the hospital setting.

*Long-Term Recommendations*

***1. Legislative***

*1.1.* Complete a feasible "Virginia option" to increase Medicaid coverage that will draw down enhanced federal matching dollars to focus on addressing the addiction crisis and strengthening mental health treatment for the uninsured.

*1.2* Consider options for improved oversight over buprenorphine prescriptions such as monitoring clinics through a central registration system, or including them in the current prescription monitoring system if determined to be a viable option.

***2. Budgetary***

*2.1.* Identify an insurance funding mechanism to place a trained and experienced counselor in substance use in offices of private care providers where practicable.

*2.2.* Develop an app for smart phones designed for access by the mother and provider while incorporating confidentiality based on the experience of the Delaware model. The app would be used primarily for the Plan of Safe Care and provide real time updates accessible by the family and service providers, and notify the central navigator if the mother did not make an appointment.

***3. Policy***

*3.1.* Consider development of a centralized system to coordinate screening, assessment and referral to services to ensure coordinated care and decrease the burden on health care providers.

*3.2.* Develop better measures to ensure long-term follow-up is coordinated, family-centered, and comprehensive. [Recommended Agency: Department of Health]

# Appendix A: Legislative Mandate

## 2017 SESSION

**ENGROSSED**

17100769D

**HOUSE BILL NO. 2162**

House Amendments in [ ] — January 30, 2017

*A BILL to require the Secretary of Health and Human Resources to convene a work group to study barriers to treatment of substance-exposed infants in the Commonwealth.*

Patron Prior to Engrossment—Delegate Pillion

Referred to Committee on Health, Welfare and Institutions

**Be it enacted by the General Assembly of Virginia:**

**1.** *§ 1. That the Secretary of Health and Human Resources shall convene a work group to study barriers to treatment of substance-exposed infants in the Commonwealth. Such work group shall include representatives of the Departments of Behavioral Health and Developmental Services and Health and Social Services and such other stakeholders as the Secretary of Health and Human Resources may deem appropriate and shall (i) review current policies and practices governing the identification and treatment of substance-exposed infants in the Commonwealth; (ii) identify barriers to treatment of substance-exposed infants in the Commonwealth, including barriers related to identification and reporting of such infants, data collection, interagency coordination and collaboration, service planning, service availability, and funding; and (iii) develop legislative, budgetary, and policy recommendations for the elimination of barriers to treatment of substance-exposed infants in the Commonwealth. The Secretary shall report his findings to the Governor and the General Assembly by December 1, 2017.*

**[ 2. That an emergency exists and this act is in force from its passage. ]**

ENGROSSED

HB2162E

# Appendix B: Work Group Membership

| Organization | Name |
|---|---|
| ACLU-VA | Gail Deady |
| Anthem | Dr. Susan Brown |
| B2L Consulting Inc. | Becky Bowers-Lanier |
| Bon Secours | Dr. Sofia Teferi |
| Children's National Health System | Dr. B. Snapp |
| Children's National Health System | Carter Batey |
| CHIP of Virginia & Parents As Teachers State Office | Lisa Specter-Dunaway |
| Court Improvement Program with the Supreme Court of Virginia | Lori Battin |
| Court Improvement Program with the Supreme Court of Virginia | Sandy Karison |
| DBHDS | Catherine Hancock |
| DBHDS, Office of Adult Community Behavioral Health Services | Gabriela Caldwell-Miller |
| DBHDS, Office of Substance Abuse Services | Martha Kurgans |
| DMAS | Brian Campbell |
| DMAS | Lacy Heiberger |
| DMAS | Dr. Kate Neuhausen |
| DMAS | Cheryl Roberts |
| DMAS | Dr. Mishka Terplan |
| DMAS ARTS | Ashley Harrell |
| FACT | Nicole Poulin |
| Fauquier Health's Family Centered NAS Care | Kelly Hill |
| Frederick County DSS | Tamara Green |
| Frederick/Winchester Juvenile & Domestic Relations Court | The Honorable Elizabeth Kellas |
| Greater Richmond SCAN | Jeanine Harper |
| Henrico DSS | Gretchen Brown |
| Infant Toddler Connection of Loudoun | Johanna Van Doren-Jackson |
| Infant and Toddler Connection of Shenandoah Valley | Sharlene Stowers |
| INOVA | Jennifer Sedlmeyer |
| Magellan Healthcare of Virginia | Jeannette Doree |
| Magellan Healthcare of Virginia | Allison Jackson |
| Magellan Healthcare of Virginia | Mira Signer |
| March of Dimes | Christy Keppel |
| Mary Washington Hospital | Dr. Joshua Attridge |
| Parent Representative | Faithea Flowers |
| PCAV, Early Impact Virginia | Laurel Aparicio |
| Rappahannock Area Community Services Board | Alison Standring |
| Richmond City Health District | Amy Vincent |
| State Early Childhood | Bonnie Grifa |

| | |
|---|---|
| Valley Health | Dr. Teresa Clawson |
| VCU Division of Pediatric Emergency Medicine | Dr. Robin Foster |
| VCU School of Public Health | Anna Scialli |
| VDH | Heather Board |
| VDH | Shannon Pursell |
| VDSS-DFS | Carl Ayers |
| VDSS-DFS | Anne Kisor |
| VDSS-DFS | Elizabeth Overall |
| VDSS-DFS | Christopher Spain |
| VDSS-DFS | Mary Walter |
| Virginia Hospital and Health Care Association | Wanda Clevenger |
| Virginia House of Delegates | The Honorable Chris Peace |
| Virginia House of Delegates | The Honorable Todd Pillion |
| Virginia Poverty Law Center | Valerie L'Herrou |
| Virginia Premier | Dara Rader |
| VOICES | Emily Griffey |
| WilliamsMullen (ACOG Lobbyist) | Nicole Pujar |
| Winchester City DSS | Amber Dopkowski |
| Winchester Medical Center | Maria DeLalla |