COMMONWEALTH of VIRGINIA

Department of Health

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November 9, 2026

MEMORANDUM

TO: The Honorable L. Louise Lucas
President Pro-Tempore, Senate of Virginia

The Honorable Don Scott
Speaker, House of Representatives

FROM: Dr. Cameron Webb
State Health Commissioner, Virginia Department of Health

SUBJECT: 2025 Report on the Plan for Services for Substance-Exposed Infants

This report is submitted in compliance with the Code of Virginia - § 32.1-73.12, which states:

> *The Department shall serve as the lead agency with responsibility for the development, coordination, and implementation of a plan for services for substance-exposed infants in the Commonwealth...The Department shall report annually on December 1 to the General Assembly regarding implementation of the plan.*

Should you have any questions or need additional information, please feel free to contact me at (804) 864-7002.

CW/KB
Enclosure

Pc: The Honorable Marvin B. Figueroa, Secretary of Health and Human Resources

PLAN FOR SERVICES FOR SUBSTANCE EXPOSED INFANTS

REPORT TO THE GENERAL ASSEMBLY

2025

VIRGINIA DEPARTMENT OF HEALTH

PREFACE

In 2017, the Governor and General Assembly directed the Secretary of Health and Human Resources to convene a workgroup to study barriers to the identification and treatment of substance-exposed infants (SEI) in the Commonwealth. Aligned with the workgroup's recommendations, in 2018, the General Assembly amended the Code of Virginia § 32.1-73.12 to identify the Virginia Department of Health (VDH) as the lead agency to develop, coordinate, and implement a plan for services for SEI in collaboration with key stakeholders. The Code requires that VDH submit a report to the General Assembly by December 1 of each year regarding implementation of the plan.

STUDY CONTRIBUTORS

Virginia Department of Health

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EXECUTIVE SUMMARY

In 2017, the Governor and General Assembly directed the Secretary of Health and Human Resources (SHHR) to convene a workgroup to study barriers to the identification and treatment of substance-exposed infants (SEIs) in the Commonwealth of Virginia. In 2018, following the workgroup's recommendations, the General Assembly enacted Chapter 695 of the 2018 Acts of Assembly which amended the Code of Virginia § 32.1-73.12 to identify the VDH as the lead agency to develop, coordinate, and implement a plan for services for substance-exposed infants. VDH is required to submit a report to the General Assembly regarding implementation of the plan by December 1 of each year.

The Code also requires VDH to work cooperatively with designated stakeholders to carry out its duties. VDH therefore convened a workgroup to develop and implement a plan for SEIs. The workgroup created a plan entitled the "Pathways to Coordinated Care (PCC) Strategic Plan" (PCC Strategic Plan). The PCC Strategic Plan is now the official plan for services for SEIs in the Commonwealth. The workgroup met from 2018 to 2021 and was on hiatus from 2022 to 2023 due to the COVID-19 pandemic and staff capacity. VDH has hired a coordinator, conducted informational interviews with people involved in developing the initial plan, and reconvened partners across the Commonwealth in October 2024. This report covers the 2025 reporting period. Summary points are listed below.

2025 REPORT SUMMARY

1. Over the past year, VDH continued strengthening collaboration with sister state agencies, community partners, and stakeholders to address perinatal substance use. Staff engaged in numerous discussions to build relationships and gather essential insights to inform the SEI workgroup and guide the implementation of the PCC Strategic Plan.

2. VDH analyzed 2024 survey responses that were received following the statewide webinar held in October of that year. Staff identified key themes within each section to help frame the initial discussions of the workgroups.

3. VDH facilitated workgroup meetings, which met virtually for three sessions to review, refine, and update the PCC Strategic Plan. A final meeting was held for workgroups to come together and review the new goals, strategies, and outline for the updated plan.

4. With support from the workgroups, VDH began pursuing additional funding to advance statewide efforts on addressing perinatal substance use.

5. The updated PCC Strategic Plan included in this report as Appendix C. It includes goals and their associated strategies that fall under five main areas: screening, coordination, education, communication.

INTRODUCTION

REPORT MANDATE

Code of Virginia § 32.1-73.12, as enacted by Chapter 695 of the 2018 Acts of the Assembly, directs the VDH to serve as the lead agency for the development, coordination, and implementation of a plan for services for substance-exposed infants (SEIs) in the Commonwealth. The statute mandates that the plan supports a trauma-informed approach for identifying and treating SEIs and their caregivers, and that VDH work cooperatively with designated stakeholder organizations to develop and implement the plan. Participation in this work is open to other nonmandated stakeholders as may be appropriate. VDH is also required to report annual updates to the General Assembly on the implementation of the plan for services for SEIs (Appendix A).

ACTIVITIES

Over the course of 2025, VDH engaged in activities to inform implementation of the PCC Strategic Plan, including increasing staff capacity for this work, continuing to develop relationships with key implementation partners throughout the state, and gathering information on substance use among the pregnant and postpartum population.

Additionally, VDH staff facilitated five workgroups aligned with the PCC Strategic Plan's focus areas: Coordination, Screening, Education, Communication, and Data. Each group met for three sessions to review and revise their assigned section. A final meeting brought all workgroups together to review one another's updates to language and content.

Additional information on these activities is included in the "2025 Updates on Implementation" section of this report.

REPORT OUTLINE

This report will discuss background information that details how the Commonwealth's PCC Strategic Plan came to fruition in its current version. It will also highlight previous workgroup activities, provide a status update on the plan, and give next steps to move the plan forward.

HISTORY OF THE PCC STRATEGIC PLAN AND WORKGROUP

The Virginia opioid addiction crisis is a public health emergency. In 2017, the Governor and General Assembly directed the Secretary of Health and Human Resources to convene a workgroup to study barriers to the identification and treatment of substance-exposed infants (SEIs) in the Commonwealth. In December 2017, the workgroup made recommendations in a report submitted to the General Assembly. The recommendations included:

- Identifying a state agency to develop and implement a comprehensive plan to address substance-exposed infants;
- Identifying a state agency with a recovery/treatment model to lead coordination of the development of a standardized Plan of Safe Care process;
- Developing a coordinated system of information sharing between agencies; and
- Formalizing processes and systems of care across agencies and organizations, including memorandum of understandings (MOUs), screenings used, protocols, forms, and referral processes.

Following the workgroup's recommendations, the Virginia General Assembly amended the Code of Virginia § 32.1-73.12 in 2018 to identify the VDH as the lead agency to develop, coordinate, and implement a plan for services for SEIs. The statute specified that the plan must:

1. Support a trauma-informed approach to the identification and treatment of substance-exposed infants and their caregivers and include options for improving screening and identification of substance-using pregnant women; and
2. Include the use of multidisciplinary approaches in intervention and service delivery during the prenatal period and following the birth of the substance-exposed child, and in referrals among providers serving substance-exposed infants, their families and caregivers.

The General Assembly directed VDH to work cooperatively with the following stakeholders to develop and implement the plan:

- Virginia Department of Social Services (DSS);
- Virginia Department of Behavioral Health and Developmental Services (DBHDS);
- Community Services Boards (CSBs) and Behavioral Health Authorities;
- Local Departments of Health;
- Virginia Chapter of the American Academy of Pediatrics (AAP);
- American College of Obstetricians and Gynecologists (ACOG), Virginia Section;
- Other stakeholders as may be appropriate.

In FY2018, VDH conducted an environmental scan to capture efforts and resources currently available to pregnant and post-partum women and SEI across the Commonwealth. VDH did so because, at the time, various state and local agencies, health systems, and community partners were involved in efforts to provide services and resources for SEI and their families. VDH identified a lack of coordination and knowledge of these efforts and resources among partners

and health systems. Many partner organizations struggle to fully know what is available within their respective communities, may not be using the most updated resources, or may be located in a region that experiences challenges providing adequate supports for families.

In FY2019, VDH analyzed the results of the scan, and in FY2020, VDH convened four different "pillar" workgroups to develop a statewide strategic plan for families and infants impacted by substance exposure and maternal substance use. The resulting Pathways to Coordinated Care (PCC) Strategic Plan is included in Appendix C. In FY2021, the Commissioner of Health and SHHR reviewed and approved the PCC Strategic Plan and it is now the official Plan for Services for SEIs. Virginia's Maternal Mortality Review Team (MMRT) has also reported that maternal deaths related to mental health and accidental overdose are contributors to the Commonwealth's mortality rates and that they are considered preventable deaths. Both plans include objectives related to maternal mental health needs, a key preventative measure for reducing exposure to substances among infants.

The COVID-19 pandemic delayed implementation of the PCC Strategic Plan and interrupted workgroup meetings, as VDH and stakeholder resources were limited and redirected to support pandemic response activities. In FY2023, VDH staff reviewed the PCC Plan, identifying the need to update it due to the impact of the pandemic on the health care workforce, availability of resources involved in caring for the perinatal population with substance use disorders and affected infants, and to confirm whether partners previously assigned to specific deliverables still have capacity to carry out the designated responsibilities.

Additional details on the workgroup's activities and accomplishments are outlined in previously published reports to the General Assembly and can be accessed on the Virginia Legislative Information System.

2025 UPDATES ON IMPLEMENTATION

Over the past year, VDH staff continued working with partners, building new relationships, and facilitated workgroup meetings to update each section of the plan. Details of this work are as follows:

VDH continued strengthening relationships with partners across Virginia to address perinatal substance use

The SEI Plan Coordinator and the Maternal and Infant Health Programs Coordinator continued conducting informational interviews with stakeholders across the state and in bordering states to strengthen connections and gain more insight on the impact of perinatal substance use in communities. Many partners highlighted child custody and family reunification processes as topics important to pregnant and parenting families dealing with substance use issues. In the fall of 2024, the Virginia Department of Criminal Justice Services (DCJS) established a workgroup to study and recommend ways to prioritize treatment for incarcerated pregnant women needing substance abuse treatment. Through participation in this group and informational interviews with partners, VDH staff recognized the need to strengthen connections

with the legal and judicial systems to more effectively address perinatal substance use and associated issues families experience. To broaden impact, VDH engaged partners from the justice system, carceral settings, and organizations supporting incarcerated women, meeting with groups such as the Virginia Sheriffs Association, Virginia Association of Regional Jails, Virginia Indigent Defense Commission, Assisting Families of Inmates, and the Virginia Prison Birth Project. Building these connections is vital to fostering cross-disciplinary learning and reducing stigma and barriers for pregnant and parenting women with substance use disorder (SUD). VDH aims to continue expanding these partnerships to enhance cross-sector coordination and education.

VDH reviewed survey feedback following the PCC Strategic Plan webinar

Following the kick-off webinar VDH held in October 2024 to reengage stakeholders, attendees were provided with an online survey that would allow them to provide feedback on the plan. Respondents were invited to comment on any section of the plan: Screening, Coordination, Education, Communication, and Data. While the Data section was included in the original PCC Strategic Plan diagram, it did not contain specific goals or objectives. VDH clarified that this section required development, whereas the remaining ones needed revisions to better reflect the state's current priorities and operational capacity. In total, VDH received 93 survey responses.

VDH analyzed feedback from the survey, identifying themes to present at the first round of workgroup meetings. For the Screening pillar, three key themes emerged. The first involved confusion about who is responsible for developing Plans of Safe Care (POSC) and when they should be implemented, whether before, during, or after pregnancy. Many respondents recommended establishing a clear standard that designates which provider is to complete a POSC and when it should be written. The second theme emphasized the need to more widely implement best practices for both substance use screening and drug testing. Although there are various methods and policies currently in use, respondents stressed the importance of greater consistency across the state. There are a variety of ways to initiate a conversation about a pregnant patient's substance use but a potential lack of awareness of screening tools that can be used with the perinatal population, and a need for training on how to best use the existing tools. Challenges also remain in selecting testing methods, such as urine and follicle testing, and the need for testing to be balanced with concerns about patient rights and ensuring informed consent. The third theme focused on the language used throughout the PCC Strategic Plan. Respondents recommended incorporating anti-stigmatizing and inclusive language that reflects safety and support for pregnant and parenting women.

For the section focused on Coordination, three key themes emerged. First, respondents emphasized the need for more resources to support warm handoffs among providers. While there was strong support for screening for substance use, many noted that treatment and referral options remain limited, especially in rural areas. Even with Medicaid coverage, there is concern that access can be restricted to self-pay programs or out-of-state providers. This contributes to providers feeling unsure about screening if they have nowhere to refer a patient for further care. The second theme called for clearer goals and outcomes for infants, especially if they will have very specific needs. Although the plan outlines care during pregnancy and postpartum, it lacks detailed goals related to infant health and child development, particularly for children exposed to substances who may require specialized supports. Respondents stressed the importance of

educating families on early intervention programs and increasing referrals and care coordination. The third theme revolved around strengthening the perinatal support workforce. Increasing access to doulas, community health workers (CHWs), home visitors, and peer recovery specialists was a frequent recommendation. Respondents cited a need for better reimbursement rates, limited insurance coverage of peer services, and insufficient training as key barriers.

In the Education pillar, respondents commented on the need for provider training on substance use and stigma during pregnancy. Trauma-informed, nonjudgmental care was lifted up as essential to help women feel safe disclosing substance use and accessing support. The second theme for this section emphasized the need for improved public awareness of possible health impacts of using substances, regardless of what a substance's legal status may be. This includes both prescription and over-the-counter drugs, as well as cannabis-related products. The third theme focused on the need for transparency around how social services may interact with pregnant families dealing with substance use. Fear of losing custody of children and involvement with law enforcement was frequently mentioned as a reason individuals avoid seeking care, leading to delays in treatment and poorer health outcomes. Survey respondents also called for clear, accessible information about what to expect from healthcare providers and supporting state agencies when a child is born with prenatal exposure to substances.

The first theme in feedback from the section on Communication centered on inconsistent dissemination of information. Although resources are available to support pregnant and parenting women with substance use disorder and their infants, for both providers and the public, respondents noted that the information is often fragmented and does not reliably reach its intended audiences. They recommended developing a clear strategy to ensure materials are accessible and appropriate for a range of audiences. Survey feedback also concerned feasibility of the proposed toll-free hotline. While a hotline could potentially offer increased referrals to resources, respondents questioned the creation and staffing of such a service given the lack of budgetary support or current infrastructure to operate it.

The Data pillar remains in development, as the first iteration of the plan did not include any goals. Survey respondents were still invited to provide comments, and they emphasized the importance of establishing clear measures of success through a standardized evaluation framework for the plan. A defined baseline was suggested to support any ongoing assessments, highlight the impact of changes, and guide future improvements. Respondents also suggested more accurate and transparent data collection due to existing systems often facing issues such as underreporting, limited access, and missing indicators. Respondents also strongly urged incorporating families with lived experience in the development of the plan and any associated work in order to better reflect those most affected, and to acknowledge the importance of their voice at the table.

VDH facilitated workgroup sessions aligned with each focus area of the PCC Strategic Plan

The online survey also offered attendees the option to volunteer to join workgroups, and a total of 68 people signed up to participate. Each workgroup met three times via Zoom for either 60 or 90-minute sessions, and all workgroups came together for a final fourth meeting to review one another's proposed updates.

The first meeting included a discussion of workgroup expectations, emphasizing VDH's role as facilitator rather than owner of the plan. Members reviewed key themes identified in the feedback survey and identified areas for improvement in the section of the plan their workgroup focused on. The next two meetings focused on defining specific goals and strategies, as well as structure of the plan, in order to improve readability and utility. The SEI Plan Coordinator reviewed other states' strategic plans related to pregnancy and substance use in order to understand what others have successfully implemented, incorporating some of their strategies to reformat the PCC Strategic Plan and include actionable steps. These steps were then refined by workgroups to reflect feasibility given limited funding as well as other work happening in the state related to perinatal substance use. The goal was to enhance existing efforts while integrating new approaches and ideas where appropriate.

Narrative sections were added to the plan to provide more context for each section, including for the three underlying themes: Plans of Safe Care, Disparities, and Social Determinants. These were visually presented as steps in the diagram for the original iteration of the plan. To further define them and how they related to the plan, each workgroup created word clouds to capture key ideas and values for each one. The updated PCC Plan includes an explanation for how they support the goals included in the plan and how they each represent values that the workgroups wanted woven throughout.

Additionally, an appendix was added to include a blank template of a Plan of Safe Care document from the Virginia DSS, along with verbal screening and toxicology testing guidelines from Carilion Clinic Department of Obstetrics and Gynecology in Roanoke, Virginia. These can serve as useful models for other agencies and health systems to put into practice. They also provide a starting point as the group plans to continue collecting resources related to perinatal substance use that can be widely shared from a centralized place.

The final meeting convened all workgroups to review an outline of the full plan, share the updated three underlying themes, and provide an opportunity for discussion. Following this meeting, a final online survey was sent to workgroup participants to allow for any lingering feedback to be submitted, and to offer any comments on possible future directions that could be recorded for future meetings. The survey remained open for one week. After it closed, VDH staff reviewed the responses and incorporated any necessary revisions, noting any comments regarding implementation. The finalized PCC Strategic Pan was then submitted for approval to VDH agency leadership. Approval is pending at the time of submission of this report.

VDH began pursuing funding to support PCC Strategic Plan initiatives

During workgroup meetings, pursuing funding to implement parts of the strategic plan was discussed. In order to capitalize on open application windows, VDH staff submitted two grant proposals to the Virginia Opioid Abatement Authority (OAA) for funding consideration. The first proposal requested support for a statewide conference on perinatal substance use to promote cross-sector collaboration and provide training for professionals on addiction, substance use, and pregnancy. The second proposal sought funding to adapt the Academy of Perinatal Harm Reduction's Pregnancy and Substance Use Harm Reduction Toolkit into a Virginia-

specific resource. The toolkit provides guidance on clinical care, legal systems, social services involvement, harm reduction, and stigma. It also offers practical tools to support providers and families in navigating the complex intersection of substance use and pregnancy. To ensure the adaptation reflects Virginia's laws, culture, and patterns of drug use, the project would have included an advisory board of individuals with lived experience. Although neither proposal was funded this cycle, VDH plans to reapply in the future and to support the workgroups' efforts to secure more financial support for this work.

NEXT STEPS

Through the end of 2025 and moving into 2026, VDH staff plan to:

- Utilize multiple platforms to disseminate the approved plan and updated goals once finalized by agency leadership. Outreach efforts may include hosting a statewide webinar, presenting at local health district meetings with the Title V Maternal and Child Health (MCH) block grant team, and leveraging additional communication channels to ensure broad awareness and engagement.
- Collaborate with partners to identify and pursue funding opportunities to support the implementation of newly identified goals and strategies within the PCC Strategic Plan.
- Engage with localities across the state by participating in regional meetings and hosting listening sessions to gather input on how communities can engage with the PCC Strategic Plan. These meetings will provide an opportunity to discuss challenges, share successes, and strengthen local-state collaboration.
- Strengthen relationships with stakeholders supporting the PCC Strategic Plan, SEIs, and pregnant and parenting women with SUD. Expand outreach to new organizations and individuals who can contribute valuable insights, including persons with lived experience, diverse clinicians and providers, and community-based agencies serving families affected by substance use. The focus will remain on advancing the implementation and tracking progress of action steps across all sections of the plan.
- Utilize the data section of the PCC Strategic Plan as a tool to convene partners across the state, routinely review perinatal substance use data, and support data-informed updates to the plan.
- Convene partners regularly to review plan goals and strategies. These meetings will serve as a forum for stakeholders to review implementation progress, identify opportunities for new goals, and contribute to ongoing partner updates. Meetings would also facilitate monitoring data, timely response to emerging issues, recognition of successful local initiatives, and guidance development for VDH and other partners on matters related to maternal health and substance use.

APPENDIX A – CODE OF VIRGINIA § 32.1-73.12

Article 17.
Substance-Exposed Infants.

§ 32.1-73.12. Department to be lead agency for services for substance-exposed infants. The Department shall serve as the lead agency with responsibility for the development, coordination, and implementation of a plan for services for substance-exposed infants in the Commonwealth. Such plan shall support a trauma-informed approach to identification and treatment of substance-exposed infants and their caregivers and shall include options for improving screening and identification of substance-using pregnant women; use of multidisciplinary approaches to intervention and service delivery during the prenatal period and following the birth of the substance-exposed child; and referral among providers serving substance-exposed infants and their families and caregivers. In carrying out its duties, the Department shall work cooperatively with the Department of Social Services, the Department of Behavioral Health and Developmental Services, community services boards and behavioral health authorities, local departments of health, the Virginia Chapter of the American Academy of Pediatrics, the American Congress of Obstetricians and Gynecologists, Virginia Section, and such other stakeholders as may be appropriate. The Department shall report annually on December 1 to the General Assembly regarding implementation of the plan.

APPENDIX B – ACRONYMS AND ABBREVIATIONS

This is a listing of the acronyms and abbreviations appearing throughout the report and its appendices.

CHW – Community Health Worker

DCJS – Department of Criminal Justice Services

MCH – Maternal and Child Health

MMRT – Maternal Mortality Review Team

MOU – Memorandum of understanding

OAA – Virginia Opioid Abatement Authority

PCC Strategic Plan – Pathways to Coordinated Care Strategic Plan

POSC – Plans of Safe Care

SHHR – Secretary of Health and Human Services

SEI – Substance-Exposed Infant

SUD – Substance Use Disorder

VDH – Virginia Department of Health

APPENDIX C – UPDATED PATHWAYS TO COORDINATED CARE STRATEGIC PLAN

VDH VIRGINIA DEPARTMENT OF HEALTH

PATHWAYS TO COORDINATED CARE STRATEGIC PLAN

STATE PLAN FOR SUBSTANCE-EXPOSED INFANTS (SEI)

Virginia's strategic plan for pregnant and parenting women with substance use disorder and substance-exposed infants. This document was created through the collective efforts of partners across the Commonwealth.

2025

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INTRODUCTION

Substance Use Disorders (SUDs) continue to have a profound impact on individuals, families, and communities across Virginia, supporting the need for a statewide plan focusing on substance use in pregnancy and substance-exposed infants (SEI). The Pathways to Coordinated Care (PCC) Strategic Plan focuses on improving early identification and screening of pregnant and parenting women with SUD, as well as substance-exposed infants. It also seeks to expand multidisciplinary care, strengthen referral networks, and increase education and awareness around harm reduction principles and evidence-based care. Updating the plan relied on thoughtful group discussion and an understanding that collective impact will be necessary to achieve any defined goals. Partners from various agencies came together to align efforts, share resources, and pinpoint gaps in care. Through this coordinated effort, this plan is designed to improve maternal and infant health outcomes across the state.

In 2023, the Virginia Department of Health (VDH) recorded 2,463 drug overdose deaths, 21,811 overdose-related emergency department visits, and 381 cases of Neonatal Abstinence Syndrome in infants under one year of age (Virginia Department of Health, 2024). From 2018 to 2022, accidental overdoses were recorded as the leading cause of pregnancy-associated deaths, accounting for 40 percent of fatalities. Recent Virginia Pregnancy Risk Assessment Monitoring System (PRAMS) data show that 11.8 percent of respondents used cannabis before or during pregnancy (PRAMS, 2025). Additionally, 19.4 percent smoked cigarettes in the three months prior to pregnancy, with 8.8 percent continuing during the last trimester. Alcohol use in the final three months of pregnancy was also reported by 8.2 percent of respondents. Furthermore, the Virginia Neonatal Perinatal Collaborative (VNPC) reports a rise in severe maternal morbidity among deliveries involving opioid use disorder from 2021 to 2023 (Overeem, 2025). These figures reflect the serious impacts of substance use on families in the Commonwealth, particularly among pregnant women and their infants.

Infants exposed to substances during a pregnancy have elevated risks of adverse health outcomes including developmental delays, neonatal withdrawal symptoms, preterm birth, poor fetal growth, and birth defects. Mothers with substance use disorders are also more vulnerable to complications such as preeclampsia, hypertension, hemorrhage, postpartum depression, and an increased risk of death (Louw, 2018). Co-occurring mental health conditions are common in this population and can further complicate the treatment and care needed during a pregnancy and following delivery (Li et al., 2024). Over the past seven years, approximately 83 percent of pregnancy-associated deaths in Virginia were deemed preventable (Virginia Maternal Mortality Review Team (MMRT), 2024). Although there is exemplary work happening through local, regional, and state initiatives to improve service delivery and treatment, significant areas for improvement remain. Timely access to early intervention, early and consistent prenatal care, and medications for opioid use disorder (MOUD) treatment are essential, yet many families still face barriers that delay or prevent care (Sutter et al., 2017).

In this plan, you will find a shared vision and a set of goals aimed at strengthening care for pregnant and parenting women with substance use disorder, substance-exposed infants, and their families. It also highlights the underlying values that guide this work, while featuring spotlights on current initiatives that showcase the important efforts already happening across Virginia. Together, these components provide a foundation for continual progress and collective action to improve maternal and infant health outcomes. The sections that follow take a closer look at the priority areas of the PCC Strategic Plan and their associated goals and strategies. First, a list of key terms and partners in development of the plan is included.

KEY TERMS

Below is a list of terms and associated abbreviations contained in this document.

CAPTA	Child Abuse Prevention and Treatment Act
CPS	Child Protective Services
CSB	Community Service Board
DBHDS	Department of Behavioral Health and Developmental Services
DMAS	Department of Medical Assistance Services
DSS	Department of Social Services
MMRT	Maternal Mortality Review Team
MOUD	Medications for Opioid Use Disorder
NAS	Neonatal Abstinence Syndrome
OAA	Opioid Abatement Authority
PCC	Pathways to Coordinated Care
POSC	Plan of Safe Care
PRAMS	Pregnancy Risk Assessment Monitoring System
SEI	Substance-Exposed Infant
SUD	Substance Use Disorder
VDH	Virginia Department of Health
VEDSS	Virginia Electronic Disease Surveillance System
VNPC	Virginia Neonatal Perinatal Collaborative

CONTRIBUTING PARTNERS: PAST AND PRESENT

Organizations	Areas of Expertise/roles
Department of Behavioral Health and Developmental Services (DBHDS)	Behavioral Health
Virginia Department of Social Services (VDSS)	Maternal and Child Health Epidemiologists
Virginia Department of Health (VDH)	Peer Recovery
Department of Medical Assistance Services (DMAS)	Home Visiting
Office of the Children's Ombudsman	Child Fatality Specialists
Virginia Hospital and Healthcare Association (VHHA)	Infant & Toddler Connection (Early Intervention)
Virginia Neonatal Perinatal Collaborative (VNPC)	Case Management
Local Health Districts (LHD)	Obstetrics and Gynecology Clinicians
Community Service Boards (CSB)	Doulas
Community-Based Organizations	Opioid Abatement Specialists Perinatal Substance Use Nurse Navigators Outpatient Clinical Supervisors

BACKGROUND AND LEGISLATION OVERVIEW

In 2017, the Governor and General Assembly directed the Secretary of Health and Human Resources (SHHR) to convene a workgroup to study barriers to the identification and treatment of SEI in the Commonwealth (Chapter 197 of the 2017 Virginia Acts of Assembly). Aligned with the workgroup's recommendations, in 2018, the General Assembly amended the Code of Virginia § 32.1-73.12 to identify the VDH as the lead agency to develop, coordinate, and implement a plan for services for SEI in collaboration with key stakeholders. The Code requires that VDH submit annual reports to the General Assembly; these reports are where the public can find annual activities related to the SEI Plan and a full history of how work has progressed over the years. Reports can be accessed on the Virginia Legislative Information System (LIS): https://rga.lis.virginia.gov/search/?query=substance-exposed+infants

The first iteration of the SEI Plan was entitled "Pathways to Coordinated Care (PCC) Strategic Plan." The workgroup responsible for crafting and designating it the PCC Plan met from 2018 to 2021. Implementation of the plan was on hiatus from 2022 to 2023 due to the COVID-19 pandemic; during this time, many workgroup members redirected their focus to pandemic response. In 2024, VDH was able to hire an SEI Plan Coordinator to support the logistics of updating and implementing the plan and reconvening partners. Updates to the PCC Plan address impacts of the pandemic on the healthcare workforce, availability of substance use prevention or treatment resources, and low utilization of a Plan of Safe Care (POSC) as a tool.

Virginia's MMRT has continued to find that maternal deaths related to mental health and accidental overdose are contributors to the Commonwealth's maternal mortality rates. In addition, these deaths are considered preventable. This highlights the importance of using the tools at our disposal more effectively and working together to identify where Virginia can make progress in serving pregnant and parenting families with SUDs in an evidence-based and compassionate manner.

UPDATING THE PLAN

The first iteration of the PCC Strategic Plan outlined objectives and activities for four of the five pillars: Screening, Coordination, Education, and Communication. Activities were organized into short-, medium-, and long-term goals, with specific agencies or VDH staff assigned to complete the tasks within set timeframes. The plan also identified groups expected to be served and defined desired outcomes after completing the goals. Developed before the COVID-19 pandemic and approved by the prior administration, implementation was significantly affected by limited funding, shifting partner priorities, and reduced staff capacity during and following the pandemic. The most recent General Assembly report includes a copy of the original plan, which can be found here: 2025 SEI Plan General Assembly Report: *Plan for Services for Substance-Exposed Infants*. As VDH rebuilt its staffing and reengaged partners, it became clear that the plan needed to be updated to better reflect the current landscape of care in Virginia and priorities of partners involved in working with pregnant and parenting families with substance use related issues. The revised plan needed to be flexible and adaptive so it can evolve as needs change, while also serving a broad range of audiences who seek to understand and support coordinated efforts for supporting women and their families impacted by substance use.

In October 2024, VDH hosted a webinar about the PCC Strategic Plan. The webinar reengaged stakeholders from various sectors across the state and renewed attention on the needs of pregnant and parenting women with SUD and their infants. The presentation included a historical timeline of the plan, a brief overview of national and state data on substance use among women of reproductive age, and an overview of the original plan. Webinar registrants received a survey link following the online event. This survey allowed for feedback from both those in attendance, as well as those unable to participate in the live webinar, and provided an opportunity for people to sign up for a work group. These groups would meet for a pre-determined number of meetings and be focused on updating individual sections of the plan, originally referred to as pillars, which are now called priority areas.

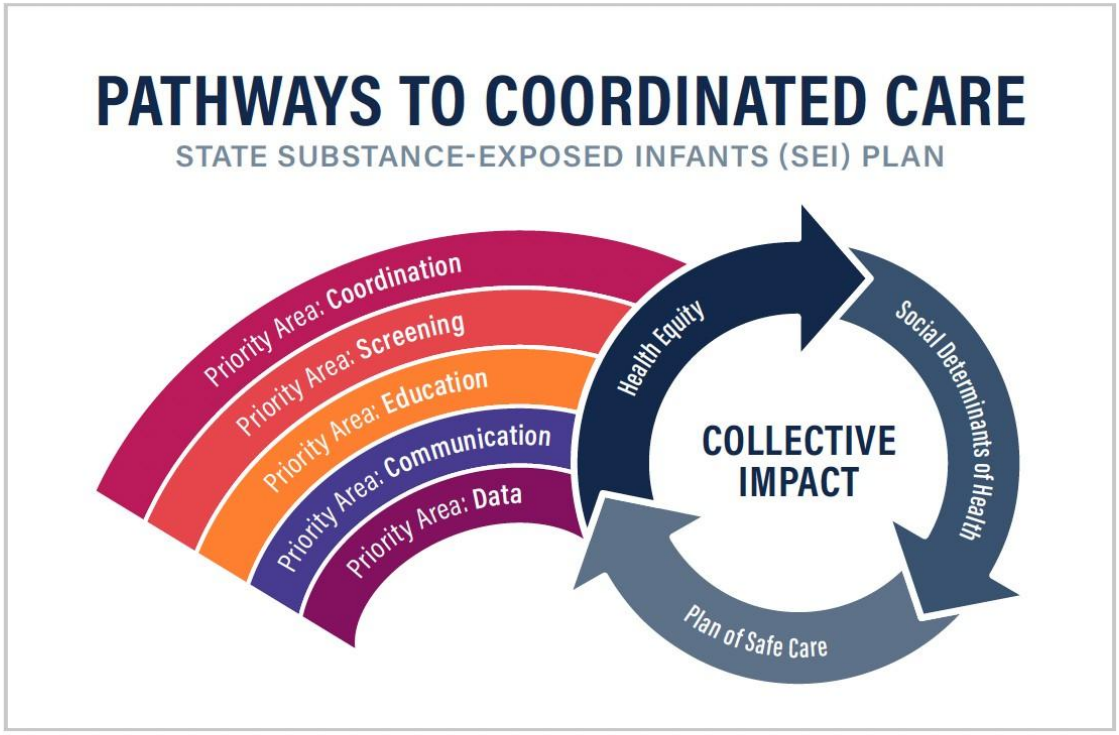
The updated PCC Strategic Plan now includes five priority areas; Coordination, Screening, Education, Communication, and Data. While Data was included as a priority area in the first draft, it now features defined objectives and goals that strengthen its role in the plan. Each group meeting was facilitated by the SEI Plan Coordinator and the Maternal and Infant Health Programs Coordinator at VDH. Every group came together for three virtual meetings. Their task was to review and update the goals and strategies associated with their priority area as well as review the underlying themes that guide the plan. As the former iteration of the plan did not provide definitive context for these themes, expanding upon them as a group was an important step

in reinforcing a common vision and strengthening the foundation of the work. In addition to updating the plan, a decision was made by workgroups to highlight examples of work already happening across the state to celebrate ongoing efforts. The inclusion of these highlights helps to demonstrate the momentum and variety of ways this work takes shape.

A fourth meeting brought workgroup members from across all priority areas together to see one another's updates and provide a more complete picture of how each area's goals contribute to the work as a whole. Attendees were also provided with an outline of what this final document would include. Following the meeting, a survey was sent to workgroup participants to gather feedback on all goals and strategies, as well as document any issues that workgroup members would like to see addressed in the future. The PCC Strategic Plan is guided by a collective impact approach that brings together agencies, institutions, and community organizations to align efforts for system-level change, with recognition that no single entity can do everything. Cross-sector collaborations are essential to accomplish key aspects of the work that address gaps, strengthen existing efforts, and improve maternal and infant health outcomes across Virginia.

PLAN DIAGRAM

Below is the updated visual for the state PCC Strategic Plan. It highlights the five priority areas: Coordination, Screening, Education, Communication, and Data. These areas are the focal points the plan is organized around. Each priority area connects to the underlying themes shown in the circular arrows: Plan of Safe Care, Social Determinants of Health, and Health Equity. The continuous connection between these themes reflects how they are represented throughout the goals and strategies of the plan. The words collective impact is found at the center of this circle in order to recognize the necessity of partners coming together to make positive changes that have utility for our state.



THEMES

UNDERLYING THEMES

To develop the PCC Strategic Plan, VDH engaged 60 voluntary participants from diverse stakeholder groups with expertise in maternal and infant health, substance use, treatment, and recovery. Ensuring that the collective expertise of these individuals informed the plan was a central priority. Workgroup members contributed language and ideas that helped shape the plan's underlying themes, which serve as the foundation for its goals and strategies. A word cloud exercise was conducted across all workgroups, prompting participants to reflect on what the themes evoked, what they valued, what they would change, and how each theme connected to the plan's five priority areas. Insights from this exercise helped VDH define and contextualize each theme. The following three themes serve as the driving force behind efforts to strengthen support systems for pregnant and parenting women with substance use disorder and substance-exposed infants in Virginia.

Plan of Safe Care (POSC)

A plan of safe care is a document jointly developed by a pregnant or parenting woman and her provider(s) to identify needed services, detail plans for caregiving, and organize support. In Virginia, there are a few applicable federal and state laws that require the development of a POSC for a substance-exposed infant. Section 106(b)(2)(B)(iii) of the Child Abuse Prevention and Treatment Act (CAPTA) requires states to ensure that a POSC is developed for infants affected by substance use, addressing the needs of both the infant and the parent. The Comprehensive Addiction and Recovery Act (CARA) went into effect July of 2016, which included the Title V Section 503 "Infant Plan of Safe Care." The law amended CAPTA to require states to monitor how local entities provide referrals and services to substance-exposed infants and their families. In response, Virginia's General Assembly revised § 63.2-1505, 63.2-1506, and 63.2-1509 of the Code of Virginia in 2017 to align with these federal requirements. Section § 63.2-1506 of the Code of Virginia specifically mentions POSCs, requiring development regardless of whether child protective services find abuse or neglect after a family assessment. Similarly, § 54.1-2403.1 of the Code of Virginia requires licensed practitioners to screen all pregnant patients for substance use, provide counseling, and assess the need for treatment. These policies emphasize early identification and intervention, marking key opportunities for providers to initiate a POSC.

Despite having policies in places that would support the development of POSCs for exposed newborns, POSCs are underutilized. This is due to a variety of reasons. In Virginia, there is no system or mechanism in place for ensuring that a provider initiates the creation of a POSC with a family or for monitoring the implementation of that plan. There is ongoing uncertainty around who should initiate the POSC and when that should occur. Even if a plan is created, fragmented care systems (e.g., as women receiving care from multiple providers during pregnancy and the postpartum period) often result in barriers to implementation and monitoring of the plan.

The PCC workgroups recognize these plans as valuable tools that can link clinical care providers with social and community support, as well as provide a plan for what happens if a parent does use substances. Providers need more access to necessary tools, training, and harm reduction knowledge to effectively initiate POSCs and ensure its utility. Each plan may include medical, behavioral, and social services tailored to the family's needs, requiring multidisciplinary engagement and collaboration among providers, agencies, and patients. Multidisciplinary collaboration is essential to expanding proactive perinatal substance use interventions in the state and is a core element of the PCC Strategic Plan.

Social Determinants of Health

Social Determinants of Health (SDOH) were identified by workgroups as foundational to understanding the broader conditions that shape how a person experiences their environment and their ability to thrive. Limited access to stable housing, income, health insurance, and support services can negatively impact maternal health outcomes. It also makes it difficult to access care and parent effectively, especially in under-resourced communities. Addressing these social and economic factors is essential to improving maternal and infant health outcomes across the Commonwealth. This theme reflects the value of creating supportive environments and communities that promote health, stability, and opportunity for all families.

Health Equity

Health equity emerged as a core value across all workgroups, reflecting a shared commitment to reducing disparities in perinatal care. In this context, equity means ensuring access to evidence-based, trauma-informed, and culturally responsive services for all, with a focus on those at greatest risk. It also involves addressing systemic barriers such as stigma, gaps in provider training for caring for pregnant and parenting women with SUD, and policies that may discourage women from seeking care. Rather than serving as a standalone goal, equity functions as a guiding lens for every strategy in the PCC Strategic Plan.

PATHWAYS TO COORDINATED CARE:
VIRGINIA'S STATE PLAN FOR SUBSTANCE-EXPOSED INFANTS

This strategic plan outlines Virginia's approach to supporting pregnant and parenting families impacted by substance use. It is organized into five priority areas: Coordination, Screening, Education, Communication, and Data. These priorities represent the key issues that guide planning efforts. Each area includes goals that outline desired outcomes, along with strategies that detail the actions needed to achieve them. The following section includes how these elements are addressed within each priority area of the Virginia state plan for SEI.

PRIORITY AREA: COORDINATION

Care coordination is essential to improving health outcomes for pregnant and parenting families, perhaps even more so when a family is dealing with substance use issues. This population often interacts with multiple systems including healthcare, behavioral health, social services, and more. They may face delays or barriers in accessing specialized care and treatment, along with insufficient follow-ups. These gaps can lead to missed opportunities for SEI and consistent prenatal care and increase the risk of adverse outcomes for both mother and child. The 2023 Virginia Maternal Mortality Review Team Annual Report included recommendations for providers to make appropriate referrals for birthing persons with a history of chronic conditions, mental illness, and chronic substance use (Virginia MMRT, 2024). The report can be found here: Virginia Maternal Mortality Review Team Annual Report. The report called for improved coordination of care within and between health systems. These findings underscore the urgent need for systemic improvements that prioritize workforce development, integrated service delivery, and streamlined referral processes. Strengthening care coordination not only addresses these structural deficiencies, but also creates a more compassionate and effective framework for engaging families early and consistently during pregnancy and the postpartum period.

GOAL 1: Improve the development of a coordinated approach in local perinatal, behavioral, and social service networks to enhance warm handoffs, referral pathways, and ongoing care for families impacted by maternal substance use and substance-exposed infants.

Strategy 1: Increase the number of local coalitions or collaborative groups within Community Service Board service areas focused on pregnant and parenting women with substance use disorder that will:

- Engage relevant partners, promote shared learning, and monitor improvements in referral pathways and care coordination aligned with local needs.
- Include a plan of safe care as a designated area of focus.
- Establish a shared agreement among participating members to define expectations, strengthen collaboration, and support coordinated efforts.

Strategy 2: To support Strategy 1, the Virginia Department of Health will map current efforts and pinpoint where local coalitions or collaborative groups are needed to support pregnant and parenting women with substance use disorder.

GOAL 2: Expand specialized training to better equip people serving in peer support roles (Peer Recovery Specialists, Community Health Workers, Doulas, Home Visitors) that support pregnant and postpartum women with substance use disorder.

Strategy 1: Collaborate with a variety of partners to identify training opportunities for people serving in perinatal peer support roles serving this population. The Virginia Department of Health will model sharing existing training and resources by listing them in an accessible manner on the agency's website.

Strategy 2: Explore opportunities to collaborate with care providers, hospital systems, and other relevant groups to increase awareness of the value perinatal peer support can bring to care teams supporting pregnant and postpartum women with substance use disorder. Identify potential pathways for integrating trained peers into existing service models and gather input from local partners on barriers and opportunities to expand the use of perinatal peer support across settings.

Strategy 3: Explore a perinatal peer endorsement or certification pathway, modeled after programs like Postpartum Support Virginia's Perinatal Mental Health Certification (PMH-C), to establish a recognized standard for providers supporting pregnant and postpartum women with substance use disorder. Work with stakeholders to position the endorsement as an incentive for both providers and families.

GOAL 3: Promote early identification, intervention, and coordinated support for the health and developmental needs of substance-exposed infants.

Strategy 1: Take collective action to assess states support (programmatic and financial) of early intervention services for substance-exposed infants. This includes coordination from hospital to community-based care and support, as well as availability of resources for assessment as the infant grows and any appropriate treatments.

Strategy 2: The Virginia Department of Health will research other states' legislation on social holds for infants at hospitals to allow additional time for Child Protective Services to develop a plan of safe care and explore kinship care as an alternative to foster care while parents seek treatment.

PRIORITY AREA: SCREENING

Screening for substance use during the perinatal period is a process that involves verbally assessing women for potential substance use risks through standardized questions and tools, such as the 4Ps (Pregnancy, Past, Partner, and Parental Use) questionnaire, for example. This differs from testing, which involves biological samples such as urine or blood analysis. Screening for substance use during the perinatal period is essential to ensuring timely, appropriate care for families; it helps facilitate the early identification of women who may benefit from treatment and support. When done well, it can also help foster trust and open communication between patients and providers. This trust and early engagement are critical points for initiating POSCs, which are meant to help coordinate services for both the mother and infant but also to address the health and safety needs of the family. Without routine screening, many women may go unidentified until a crisis arises, leading to missed opportunities for early intervention. Ensuring screening tools are accessible and that providers are trained to use them effectively supports consistent practice across settings and promotes better health outcomes. You can find Carilion Clinic's Obstetrics & Gynecology Clinical Guidelines for Maternal Substance Use in Appendix C for an example of how one system in Virginia sets policy for screening the pregnant and parenting women they serve.

GOAL 1: Ensure that recommended verbal screening tools for women of childbearing age, including those who are pregnant and postpartum, are evidence-based and accessible online for healthcare providers to reference.

Strategy 1: Recommend providers and agencies implement guidelines that follow their professional organization's requirements, such as the American College of Obstetricians and Gynecologists, American Society of Addiction Medicine, and Substance Abuse and Mental Health Services Administration.

Strategy 2: The Virginia Department of Health will improve accessibility of evidence-based screening tools by adding them to the webpage associated with the state Substance-Exposed Infants plan. This accessibility aims to increase provider utilization of the tools, address best practices for continuing Medications for Opioid Use Disorder treatment, enhance patient outcomes and improve connections to needed services.

Strategy 3: Recommend that healthcare facilities have policies where they establish clear definitions distinguishing *screening* (verbal tools assessing risk) from *testing* (biologic toxicology) with patients. These policies should outline the appropriate use of each method, emphasizing clinical relevance, minimizing unnecessary testing, and ensuring that all patients provide informed consent.

GOAL 2: Assess policies and practices for billing related to screening for substance use and identify if there is an opportunity to adjust billing practices to help incentivize more providers to initiate a Plan of Safe Care.

Strategy 1: Work with Managed Care Organizations serving their Medicaid members to assess if they offer any education regarding billing for screening and treatment for substance use disorder. Include information on how a plan of safe care can be a part of this service for pregnant and postpartum women.

Strategy 2: Explore Medicaid reimbursement policy options with the Department of Medical Assistance Services that would allow non-clinical perinatal health workers (e.g., peer recovery specialists, doulas, home visitors) to bill for creating and implementing a plan of safe care.

PRIORITY AREA: EDUCATION

Expanding education on the intersections of pregnancy and substance use is essential to improving outcomes for women, infants, and families. Central to this effort is equipping both clinical and non-clinical providers to deliver appropriate, informed care grounded in evidence-based practices. Accessible training opportunities strengthens their ability to deliver care that meets the needs of pregnant and postpartum women with SUD. Involving families and community services in these efforts helps reinforce recovery support systems and encourages healthy parenting (Morgan et al., 2024). Collectively, these strategies can contribute to building the capacity of providers and communities to provide more informed support to perinatal populations affected by substance use.

GOAL 1: Promote statewide provider awareness with identifying and treating substance use disorder in pregnant and postpartum women and infants prenatally exposed to substances including infants with Neonatal Abstinence Syndrome.

Strategy 1: The Virginia Neonatal Perinatal Collaborative (VNPC) will implement the Evidence-Based in Dyad Care Substance Use Disorder (EBDC-SUD) project — a statewide quality improvement initiative focused on delivering respectful, compassionate care and improving health outcomes for pregnant and parenting individuals, their babies, and families impacted by substance use disorder.

GOAL 2: Enhance statewide access to comprehensive online resources, including training, fact sheets, and support materials for pregnant and parenting women, their families, and providers.

Strategy 1: The Virginia Department of Health will collaborate with partners in identifying educational materials and trainings that already exist and establish a webpage that will include these resources. This will ensure they are available in one place, easier to locate, and be shared widely. The webpage will also include information for families on perinatal peer support options.

GOAL 3: Prioritize safe sleep education for families affected by substance use disorder with infants and toddlers aged 0 to 2, through coordinated efforts among state agencies, healthcare providers, and community partners.

Strategy 1: In order to address the number of infant deaths involving substance-exposed infants and safe sleeping environments, state agencies and organizations will collaborate to identify opportunities to improve and increase education around safe sleep for custodial parents and other adults living in the home or caring for the child. This can involve, but is not limited to, practices in local health districts, social services offices, Community Service Boards, and home visiting programs.

GOAL 4: Promote broad understanding of Child Abuse Prevention and Treatment Act (CAPTA) reporting requirements and the value of a Plan of Safe Care (POSC).

Strategy 1: Broader education on CAPTA and POSCs will be necessary across agencies and organizations that work with and serve birthing women and their families impacted by a substance use disorder. It will be important that the individuals that work with this population understand the fundamentals and the practice of developing a plan so that they can continue to promote transparency and education on CAPTA and POSCs.

Strategy 2: Facilitate understanding and trust for individuals introduced to CAPTA and POSCs through provision of resources and follow-up.

Strategy 3: The Virginia Department of Health will research legislation, implementation efforts, and compliance data from other states related to CAPTA reporting and a POSC initiation.

GOAL 5: Promote community awareness and education of substance use disorder and the effects on pregnant and parenting women and their children via collaborative education with the Department of Education's Family Life and Health and Physical Education programs.

Strategy 1: The Virginia Department of Health will review the substance use education curriculum currently implemented in middle and high schools across Virginia under Executive Order 28 to include identifying gaps and opportunities for improvement to ensure students are receiving evidence-based education on substance use, its risks, and available resources for prevention.

PRIORITY AREA: COMMUNICATION

Effective communication is key to fostering collaboration across clinical and non-clinical settings. When patients feel safe to express their needs, they are more likely to engage in their care. This empowers families to understand their options and make informed decisions. Furthermore, regular dialogue among healthcare providers, treatment prescribers, and community partners helps align efforts, promote best practices, and engage stakeholders across the state. Ongoing communication through shared tools, input from collective impact partners, and coordinated outreach ensures the strategic plan remains responsive to evolving needs.

GOAL 1: Develop or obtain a comprehensive toolkit for healthcare providers, service agencies, community partners, and individuals who are pregnant or parenting and affected by substance use. The toolkit should include information on drugs and alcohol in the perinatal period and state specific laws and policies.

Strategy 1: The Virginia Department of Health will assist in pursuing funding to adapt the Perinatal Harm Reduction Toolkit from the Academy of Perinatal Harm Reduction to Virginia-specific policies, resources, and provider needs. Incorporating input from people with lived experience to ensure relevance and impact. The toolkit will offer strategies to reduce the risks of substance use during pregnancy while prioritizing the dignity and well-being of the mother, infant, and family. Examples of potential funding sources include the Opioid Abatement Authority (OAA), grants, and partnerships with other agencies and local health departments (LHDs).

Strategy 2: Promote statewide awareness and use of the Perinatal Harm Reduction Toolkit.

- Make toolkit freely available for download on state agency websites and any other organization serving pregnant and postpartum population.
- Distribute printed copies at key events and through local health districts.
- Host a free educational webinar to introduce the toolkit, demonstrate practical applications, and increase awareness among providers and community members of harm reduction principles.

GOAL 2: Establish a structured approach for communication, coordination, and evaluation of the strategic plan.

Strategy 1: Develop and implement a timeline for hosting annual or biannual meetings with key partners to review progress on the plan's goals, assess implementation efforts, and identify opportunities for continued collaboration and improvement.

Strategy 2: Establish and maintain a statewide listserv to regularly distribute brief updates on Substance-Exposed Infants Plan efforts, related state initiatives, and regional activities to enhance communication among partners across Virginia about pregnancy and substance use.

Strategy 3: Pursue funding to support and organize a statewide conference on perinatal substance use that raises awareness, provides evidence-based education and training, and brings together professionals across sectors serving pregnant and parenting women with substance use disorder through the conference.

GOAL 3: Strengthen collaboration and communication between Obstetricians and Gynecologists (OB/GYNs), clinicians that are treating the pregnant and postpartum population, and clinicians that are prescribing Medications for Opioid Use Disorder (MOUD) as a part of treatment for substance use disorders.

Strategy 1: Support provider-to-provider education initiatives, ensuring access to training and resources in all regions.

Strategy 2: Explore opportunities to convene OB/GYNs, clinicians providing Medications for Opioid Use Disorders (MOUDs) for patients with opioid use disorder, and behavioral health clinicians in community settings to build relationships, share concerns, and identify ways to strengthen collaboration.

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PRIORITY AREA: DATA

The Data priority area was not fully developed in the initial development of the plan. This area now establishes a foundation for future plan updates by clarifying what data should be reviewed and reported annually. This information will help to evaluate plan initiatives, enhance the quality and consistency of data, and gather information on access to Medications for Opioid Use Disorder (MOUD) treatment and other recovery services in the state. Main efforts will include identifying key data elements for assessment, improving reporting practices where feasible, and focusing on specific data projects to improve support for ongoing strategies and plan evaluation.

GOAL 1: Identify key data to be annually reported in relation to the state Substance-Exposed Infants plan, supporting ongoing evaluation and planning efforts.

Strategy 1: Collaborate with the Virginia Department of Health Maternal and Child Health Epidemiology team and other agencies to identify key data sets to support evaluation and planning.

GOAL 2: Enhance state practices for the accurate and comprehensive collection of Neonatal Abstinence Syndrome (NAS) cases, and improve the quality, consistency, and reliability of the data collected.

Strategy 1: Enhance the quality of Neonatal Abstinence Syndrome (NAS) data by revising the confidential morbidity report used for collecting data on reportable conditions to align better with national standardized case definitions. The revised form will require the completion of all NAS supplemental fields, capturing detailed information such as maternal substance use history, detection of specific substances from the mother or newborn, and the infant's clinical outcome categorized as non-symptomatic, mild clinical signs, or severe clinical signs.

Strategy 2: Seek a funding opportunity to support the development of an educational curriculum for healthcare providers aimed at enhancing their understanding of public health reporting requirements for NAS in Virginia. The curriculum will cover legislative mandates for NAS reporting, best practices for reporting and follow up, and available community resources to support families affected by NAS.

GOAL 3: Assess the access to treatment and recovery services for pregnant individuals with substance use disorder.

Strategy 1: Survey provider perceptions towards providing Medications for Opioid Use Disorder (MOUD) treatment and working with the pregnant population with substance use disorders.

Strategy 2: Map out existing resources for Medications for Opioid Use Disorder (MOUD) treatment and recovery services across Virginia and identify areas of inadequate service, especially in rural and historically underserved regions.

SPOTLIGHT: ONGOING INITIATIVES IN VIRGINIA

Virginia continues to make strides in supporting pregnant and parenting women with substance use disorder and substance-exposed infants. While challenges remain, the state is fostering innovative programs and resources that are impactful and bring hope to communities. From initiatives funded by the Opioid Abatement Authority to federally supported services offering specialized care, Virginia is building a stronger capacity to support families impacted by substance use. We're proud to highlight some of these efforts below as examples of progress and dedication to this work.

PROJECT LINK (14 SITE LOCATIONS)

In Virginia, Project LINK operates within Community Services Boards (CSBs) and Behavioral Health Authorities (BHAs). As of FY24, there are 14 locations for the program, which is dedicated to improving access to care for pregnant, postpartum, parenting, and at-risk women with substance use or co-occurring disorders. The program seeks to reduce substance use, strengthen service coordination, and support the healthy development of children in affected families. Project LINK emphasizes advocacy, early identification and referral, interagency collaboration, and capacity building among service providers and community stakeholders. By offering evidence-based practice (EBP) trauma and parenting support services tailored to individual needs, the program addresses the complex intersection of substance use and motherhood, particularly for women experiencing significant social and economic challenges.

Eligibility includes:

- Pregnant women with current or past substance use
- Postpartum women with Substance Exposed Infants (SEI)
- Individuals identified through high-risk screenings
- Voluntary or provider-referred individuals
- Persons mandated to treatment by courts or social services

Service Locations:

The Virginia Department of Behavioral Health and Developmental Services has five primary service regions. Project LINK is not available in every region. Region 2 does not have a Project LINK program. However, Community Service Boards in the area have services to support women with substance use disorders and their families.

Region 1

- Alleghany-Highlands CSB
- Blue Ridge Behavioral Healthcare
- Horizon Behavioral Healthcare
- Rappahannock Area CSB
- Region Ten CSB

Region 3

- Cumberland Mountain CSB
- Dickenson County Behavioral Health
- Highlands CSB
- Mount Rogers CSB
- New River Valley CSB
- Planning District One

Region 4

- District 19 CSB

Region 5

- Hampton Newport News CSB
- Virginia Beach CSB

**Specific information can be found on the individual CSB and BHA webpages.*

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THE OPIOID ABATEMENT RESOURCE AND SUPPORT (OARS) PROGRAM

The Opioid Abatement Resource and Support (OARS) program in James City County, Virginia supports parents with substance use disorders, particularly opioid use disorder, in their recovery. It helps families build safe, stable, and nurturing environments for their children. The program works to prevent child removal, support reunification, and promote long-term family stability through trauma-informed care, parenting education, and coordinated services. OARS primarily serves families referred by Child Protective Services (CPS) or other agencies due to concerns related to substance use, neglect, or parenting challenges.

Offering focused support for pregnant and parenting women, the OARS program promotes early engagement with prenatal providers and delivers tailored case management for mothers with substance use disorder. A dedicated Opioid Abatement Coordinator from James City County Department of Social Services advocates for these women by helping them maintain contact with their infants, secure medical care, navigate insurance issues, and participate in safe care planning. The program also connects families to peer recovery support and coordinates services for substance-exposed infants, often prior to or alongside CPS involvement.

Grounded in the belief that supporting both recovery and parenting strengthens families, OARS helps parents build stability to meet child welfare goals. By partnering with CPS, peer recovery groups, treatment providers, and other agencies, the program delivers coordinated services that promote long-term wellbeing for parents and children.

THE GROVE ON PATTERSON

The Grove on Patterson is a 24/7 residential treatment program located in Roanoke, Virginia. The program was created specifically for pregnant and parenting women with substance use disorders. Supported by addiction specialists and OB/GYN providers, the program delivers comprehensive care throughout every stage of recovery. Upon arrival, participants enter a safe and nurturing community of peers who understand the unique challenges of motherhood and recovery. The Grove emphasizes personalized care through individualized treatment plans and stage-matched recovery services that address both substance use and emotional well-being. The program helps women strengthen connection to their children and develop the tools for long-term recovery and stability. Women across Virginia who are pregnant or up to one year postpartum are eligible to apply through an easy online application.

Services Include:

- Substance use treatment
- Medical and psychiatric care for pregnancy, birth, and beyond
- Caring staff, parenting classes, peer support, and more
- A house that feels like home

*For more information, visit thegroveonpatterson.org.

NEXT STEPS

The VDH appreciates the individuals, agencies, organizations, and community partners who have supported the development and evolution of this strategic plan over the years. As facilitators of this work, VDH is committed to maintain ongoing communication through a dedicated listserv to sustain momentum and strengthen collaboration across the state. Annually, VDH plans to bring together invested partners to review the plan, make updates where needed, and discuss emerging issues. These efforts will help ensure the SEI plan remains a living, evolving document that identifies and responds to the needs of pregnant and parenting women, SEI, and their families in Virginia. Metrics to track success will also be developed and shared with partners.

Moving forward, VDH aims to expand partnerships beyond traditional clinical and community care settings to include sectors that also intersect with this population. Families affected by substance use often interact with legal and judicial systems. Including partners from the justice system, carceral settings and organizations that support incarcerated women will help broaden the reach and impact of this work. It is also a hope to build stronger connections to various professional associations to further impact collaboration and foster shared learning across disciplines. This will help create more opportunities to bring people together in person for cross-sector collaboration. VDH is eager to learn how these perspectives can be integrated into the plan and expand the collective impact of this work for all families.

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APPENDIX A
GLOSSARY

TERM	DEFINITION
Substance-Exposed Infants (SEI) Plan	Original legislation (House Bill 1157/Senate Bill 389) required the development of a strategic plan informed by barriers in identifying and treating substance-exposed infants in the Commonwealth.
Pathways to Coordinated Care (PCC) Strategic Plan	The developed SEI Plan was named Pathways to Coordinated Care.
Plan of Safe Care (POSC)	A collaborative document developed by a health care provider and the mother to coordinate existing supports and connect families with new services. Its primary goal is to promote healthy pregnancies, strengthen the family unit, and ensure that infants and young children can remain safely at home after hospital discharge (IHR, 2022; VDSS, 2017).
Substance Use Disorder (SUD)	A chronic, relapsing brain disease that is characterized by compulsive seeking and use, despite harmful consequences. Drugs cause physical changes in the brain that alter its structure and how it works (VDH, 2025).
Substance-Exposed Infant (SEI)	In-utero exposure to one or a combination of substances (e.g., opioids, cocaine, heroin, alcohol, tobacco etc.). Which can lead to a risk of developing neonatal abstinence syndrome (NAS), fetal alcohol spectrum disorder (FASD), and other neurobehavioral and developmental complications after birth (Anbalagan et al., 2024).
Neonatal Abstinence Syndrome (NAS)	A condition in which newborns experience withdrawal symptoms after being exposed to certain substances, such as opioids or stimulants, before birth (CDC, 2024).
Fetal Alcohol Spectrum Disorder (FASD)	An umbrella term describing a range of effects that can occur in an individual exposed to alcohol in utero, which may result in physical, cognitive, behavioral, or learning disabilities with lifelong implications (FASD United, 2024).

TERM	DEFINITION
Medications for Opioid Use Disorder Treatment (MOUD)	The use of FDA approved medications (methadone, buprenorphine, naltrexone) as a stand-alone treatment for opioid addiction. MOUD helps manage cravings and withdrawal, supports long term recovery, and may be used for months or years depending on individual needs (SAMHSA, 2024).
Verbal Screening	A brief preliminary interview with an individual intended to determine if that individual may be at risk to have problems in a certain area such as substance abuse. Screening does not identify substance abuse or dependency, nor does it provide a substance use disorder diagnosis. Screening may be a combination of observation, open ended questions, and/or the use of a standardized set of questions.
Biological Testing	Laboratory testing of samples such as urine, blood, or hair to guide clinical management, performed only with informed consent and not recommended as a routine screening tool for identifying substance use in pregnancy.
Opioid Abatement Authority (OAA)	The Opioid Abatement Authority (OAA) was established by the Virginia General Assembly in 2021 as an independent entity to abate and remediate the opioid epidemic in the Commonwealth. It provides financial support from the Virginia Opioid Abatement Fund in the form of grants, donations, or other assistance for efforts to treat, prevent, and reduce opioid use disorder and the misuse of opioids.
Early Intervention	A term used to describe services and supports available to babies and young children with developmental delays and disabilities and their families (CDC, 2025).

APPENDIX B

PLAN OF SAFE CARE TEMPLATE

Below is a blank template of the POSC document that is used by the Virginia DSS and other agencies.



VIRGINIA DEPARTMENT OF
SOCIAL SERVICES

PLAN OF SAFE CARE FOR MOTHER, OTHERS AND SUBSTANCE-EXPOSED INFANTS

A Plan of Safe Care is a guide developed by service providers with their clients to ensure mothers and others have the necessary resources to safely care for the unique challenges of an infant who is exposed to substances during pregnancy. Each woman and infant's needs vary.

A Plan of Safe Care should include input from all service providers involved in the mother and infant's care to promote the best health outcomes. Service Providers can include: OB/GYNs, Doctors, Nurse Practitioners, Midwives, Opioid Treatment Programs, Community Service Boards, Child Welfare Providers, Home Visitors, and Part C Early Intervention.

HEALTH CARE		
	Plan (include WHO, WHEN, WHERE)	Comments
Prenatal Medical Care (Mother)		
Medical Care Post-Natal (Mother/others)		
Medical Care Coverage for Mother (e.g. FAMIS, Medicaid, private insurance, etc.)		
Delivery Plan (e.g. location, transportation, personal needs, medication at birth, etc.)		
Other		
SUBSTANCE USE AND MENTAL HEALTH		
	Plan (include WHO, WHEN, WHERE)	Comments
Mental Health Assessment		
Mental Health Treatment		
Substance Use Assessment		
Substance Use Treatment		
Medication Assisted Treatment		

Other		
DAILY LIVING		
	Plan (include WHO, WHEN, WHERE)	Comments
Financial Supports		
Safe Housing		
Food		
Transportation		
Other		
CHILD NEEDS		
	Plan (include WHO, WHEN, WHERE)	Comments
Safe Sleep Practices		
Post-discharge Supports		
Basic needs post-delivery (e.g. diapers, formula, clothing, crib, car seat, etc.)		
Breast Feeding (Y/N)		
Medical Care Coverage for Child (e.g. FAMIS, Medicaid, private insurance, etc.)		
Child Care		
Pediatric Care		
WIC		
Medical Home		
Other		
SUPPORTS		
	Plan (include WHO, WHEN, WHERE)	Comments
Family		
Formal Support Systems (e.g. DBDHS, CSB, CSA, CPS, DSS, VDH, etc.)		
Information Sharing (Release of Information)		
Home Visiting Program		
Early Intervention (Part C)		

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APPENDIX C

CARILION CLINIC: CLINICAL GUIDELINE FOR MATERNAL SUBSTANCE USE

Carilion Clinic Department of Obstetrics & Gynecology is located in Roanoke, Virginia and is the region's leading hospital system with a strong focus on serving pregnant and parenting individuals affected by substance use and infants born substance-exposed. Below are Carilion's guidelines for verbal screening and biologic toxicology testing for maternal substance use.

CARILION CLINIC
Department of Obstetrics & Gynecology

Clinical Guideline: Maternal Substance Use

Verbal Screening and Biologic Toxicology Testing

KEY TERMS: Maternal substance use, substance exposure, toxicology testing, urine drug testing

PURPOSE: Promote universal verbal screening for substance use exposure, review indications for biologic testing and link patients to care for substance use.

DEFINITIONS:

Substance exposure is defined as the use of (prescribed and non-prescribed) methadone, buprenorphine, opioids, cannabis, benzodiazepines, alcohol, other illegal/non-prescribed medications and/or misuse of prescription and over-the-counter medications.

Unhealthy substance use is defined as any use of alcohol and/or drugs that increases the risk of experiencing adverse health consequences, the severity of which generally increases with the amount and frequency of consumption. Unhealthy substance use includes risky use, problem use, and substance use disorders.

Substance use disorders (SUD) are defined by specific diagnostic criteria, and are classified in the Diagnostic and Statistical Manual, 5th Edition (DSM-5), based on the level of symptoms as mild, moderate, and severe. Individuals with substance use disorders are experiencing 2 or more symptoms (including problems related to use, difficulty in controlling use, and physical tolerance or withdrawal) in the past 12 months.

UNIVERSAL PERINATAL SCREENING:

Rationale: Substance use in reproductive-age people has increased significantly in the past decade. Substance use during pregnancy can cause serious consequences to the health of both the pregnant person and neonate. For the pregnant person, substance use may result in death from overdose, high blood pressure, heart attack or heart failure, stroke, seizures, or coma. For the fetus and neonate, maternal substance use can result in miscarriage, placental abruption, preterm birth, low birthweight, brain injury, birth defects, developmental delay, neonatal withdrawal syndrome, stillbirth, and neonatal death.

Because of the potential harms of substance use during pregnancy and the opportunity for intervention, universal screening for alcohol and other substances should be done for all persons during their antepartum, peripartum, and postpartum course. **The American College of Obstetricians and Gynecologists (ACOG) recommends universal screening for substance use regardless of age, sex, race, ethnicity, or socioeconomic status.** Screening

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based only on perceived risk factors may lead to missed opportunities and perpetuate racial and social discrimination.

When to Screen for Substance Use Exposure

Rationale: Screening is referred to as a universally administered verbal or written questionnaire tool designed to ascertain who is at high risk for having substance use exposure in pregnancy.

Inpatient:

- Arrival to the obstetrical unit

Outpatient:

- Initial prenatal visit
- Postpartum period after hospital discharge
- Identified clinical findings
- Provider concern

If the birthing person is involved in treatment, it is recommended to consult with providers who have an ongoing relationship with the birthing person to assess the level of engagement with recovery. (e.g., prenatal provider, SUD treatment provider, PCP)

How to Screen for Substance Use Exposure

- Frame the question and ask permission
  - Example script: *"Health professionals are encouraged to ask all women in pregnancy about substance use. We have resources at Carilion to help women enter treatment in pregnancy. Is it okay if I ask you about drug or alcohol use?"*
  - If the patient declines to answer, move on to the next set of clinical questions and document that screening questions were not answered. Consider re-addressing at a future encounter.
- Administer written or verbal screening tool that is validated in pregnancy for substance use in pregnancy. (i.e., 4 P's or 4 P's Plus)

BIOLOGIC TOXICOLOGY TESTING:

Rationale: Biologic toxicology testing should be used when clinical management is based on results of testing. Biologic toxicology testing is not recommended to be used for identification of persons at high risk for substance use in pregnancy. Biologic toxicology testing, which can be

performed on urine, blood, or hair, is discussed as a test and not as a screening technique.

- **If verbal disclosure is obtained and documented, biologic toxicology testing is not necessary.**
- Biologic toxicology testing is performed only with birthing persons verbal informed consent and documented in medical records.
    - Exception if person unable to provide consent (i.e., obtunded or unconscious)
- Obstetric provider should inform birthing persons about the following as part of obtaining consent:
    - Limitations of the testing (i.e., false positives)
    - Positive results will prompt confirmatory testing (see below)
    - Newborn toxicology testing may be recommended at the discretion of the newborn's clinician to assist in determining newborn medical management
- If the verbal screening does not clinically correlate with physical symptoms or neonatal presentation, indications for biologic toxicology testing may include:
    - Clinical signs/symptoms consistent with acute substance or alcohol intoxication or withdrawal, and not immediately attributable to another cause.
    - Historical indications for biologic toxicology testing may include:
        - If the birthing person desires to chest/breastfeed and the following conditions exist:
            - Report of substance use or positive urine toxicology screen during last trimester of pregnancy
            - Birthing person has an active substance use disorder and is not engaged in treatment
        - If the birthing person had no prenatal care and no history of substance use, urine toxicology testing is not required.
            - Conduct a verbal screening of the birthing person for substance use using a validated verbal screen.
        - If the birthing person desires toxicology testing.

Requests for Biologic Toxicology Testing from Non-Obstetrical Provider

If maternal biologic toxicology testing is requested by a non-obstetrical provider or social worker:

- Discussion of indication for maternal toxicology testing must take place between the requesting party and the obstetric provider.

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Department of Obstetrics & Gynecology

- Documentation of the indication for maternal toxicology testing and how the result will affect the care of the neonate and/or mother by the requesting party must be documented in the maternal chart.
- Verbal informed consent must be obtained and documented in the maternal chart by the requesting provider.
- Obstetric provider following the documented discussion may order the biologic toxicology testing.

MANAGEMENT OF A POSITIVE SCREENING OR BIOLOGIC TOXICOLOGY TEST RESULT:

Inpatient Positive Screen or Test Result

- Obstetric provider performs a brief intervention
  - *What is your understanding of how the substances that you are using may affect your pregnancy and baby?*
  - *Have you thought about decreasing or stopping your use of this substance?*
  - *Would you like more information about how we can support you or treatment programs?*
- Provide resource list of treatment programs
- Place referral to Social Work
  - Social Work to initiate a Plan of Safe Care and help coordinate treatment
- Collaborate with Lactation Services and Pediatrician regarding breastfeeding recommendation/guidelines
- Consider referrals to the following:
  - Inpatient Addiction Medicine Consultation if urgent treatment needed during admission
  - Emerald Program for pregnant or parenting persons with substance use exposure
  - Peer Support Specialists to help support once discharged

Outpatient Positive Screen or Test Result

- Obstetric provider performs a brief intervention
  - *What is your understanding of how the substances that you are using may affect your pregnancy and baby?*
  - *Have you thought about decreasing or stopping your use of this substance?*
  - *Would you like more information about how we can support you or treatment programs?*

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- Provide resource list of treatment programs
- Consider referrals to the following:
    - Emerald Program for pregnant or parenting persons with substance use exposure
    - Peer Support Specialist via Community Health and Outreach
    - Mental Health Care Coordination
        - Specify Emerald/Pregnancy program

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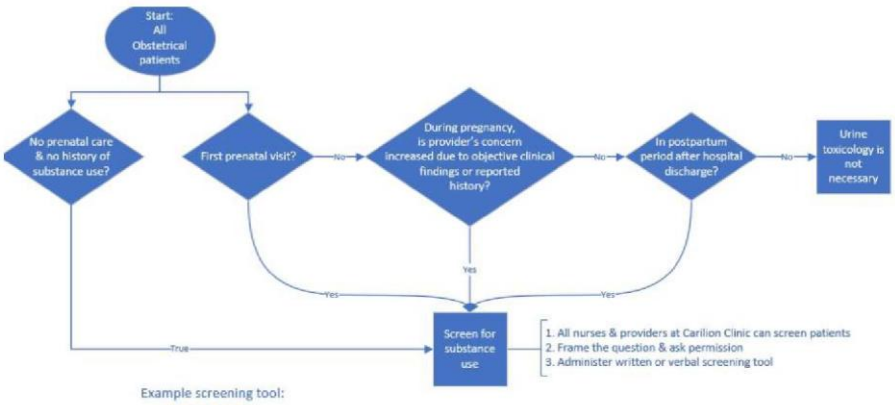
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Department of Obstetrics & Gynecology

SCREENING GUIDELINE PROCESS MAPS

All Obstetric Patients



Example screening tool:

THE 4 P'S

4 P's for Substance Abuse:

1. Have you ever used drugs or alcohol during **Pregnancy**?
2. Have you had a problem with drugs or alcohol in the **Past**?
3. Does your **Partner** have a problem with drugs or alcohol?
4. Do you consider one of your **Parents** to be an addict or alcoholic?

Scoring: Any "yes" should be used to trigger further discussion about drug or alcohol use. Any woman who answers "yes" to two or more questions should be referred for further assessment.

Source: Adapted from Ewing H Medical Director, Born Free Project, Contra Costa County, 111 Allen Street, Martinez, CA. Phone: 510-646-1165.

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