SAMHSA MDT Framework for Substance Exposed Infants (SEI)

for XXX Multi-Disciplinary Team (MDT), Your City

SAMPLE Follow-up Implementation Assessment Report

(Data Source: Survey of MDT members)

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SEI Framework Description:

The SEI Framework is divided into guides for each of the **five primary systems** that might participate in an MDT for Substance Exposed Infants: the mother's medical care providers, the infant's medical providers, substance use treatment and medication-assisted treatment providers, child welfare, and the dependency court. MDT members from those systems are asked to indicate whether certain policies or practices were in place within the systems to which each of them belong. The statements are grouped into **four-time frames**: pre-pregnancy, pregnancy, labor and delivery, and postpartum and beyond. The guide also contained a **cross-system** guide for all participants with policy or practice statements organized by **seven content areas**: Perspectives, Approach, Coordination, Reimbursement and Access, Service Gaps and Daily Practice, Training and Staff Development, and Quality and Outcome Monitoring. All MDT members were asked to indicate which of those policies and practices were in place for the MDT as a whole.

Methodology:

The XXX Clinic asked the Human Services Implementation Lab at Portland State University (the PSU I-Lab) to survey their XXX Multi-Disciplinary Team (MDT) for Substance Exposed Infants on the nature of their work. The goal was to establish a baseline understanding of the practices and policies used across systems in working with pregnant women with opioid use disorder. The I-Lab based this survey on the National Center for Substance Abuse and Child Welfare (NCSACW)'s five-point **Substance Exposed Infants (SEI) Framework** for MDTs and distributed it by web survey to MDT members in the Fall of 2021 and 2022. The web survey was conducted using Qualtrics web survey software. Analysis was conducted using SPSS 28.0. Based on the survey responses, items were scored as follows: **0 = Supports are not in place or status is unknown**; **1= Supports are somewhat in place;** and **2= Supports are 100% in place**. Fidelity scores from 2020 and 2021 are included in this Year 2 report. Responses to additional MDT feedback questions start on page 23.

Suggested Citation:

Cellarius, K. (2021) SAMPLE Follow-up Implementation Assessment Report for the SAMHSA MDT Framework for Substance Exposed Infants (SEI). Portland, OR: Portland State University.

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Findings:

The policies and practices for pregnant and post-partum women and their substance exposed infants are well thought out within the XXX MDT and across the MDT partner agencies. However, enhancements can still be made. These findings are designed to be a guide for the MDT members as they continue to provide enhanced care to the families that they serve. The charts and tables starting on the next page provide more detail on the findings listed below.

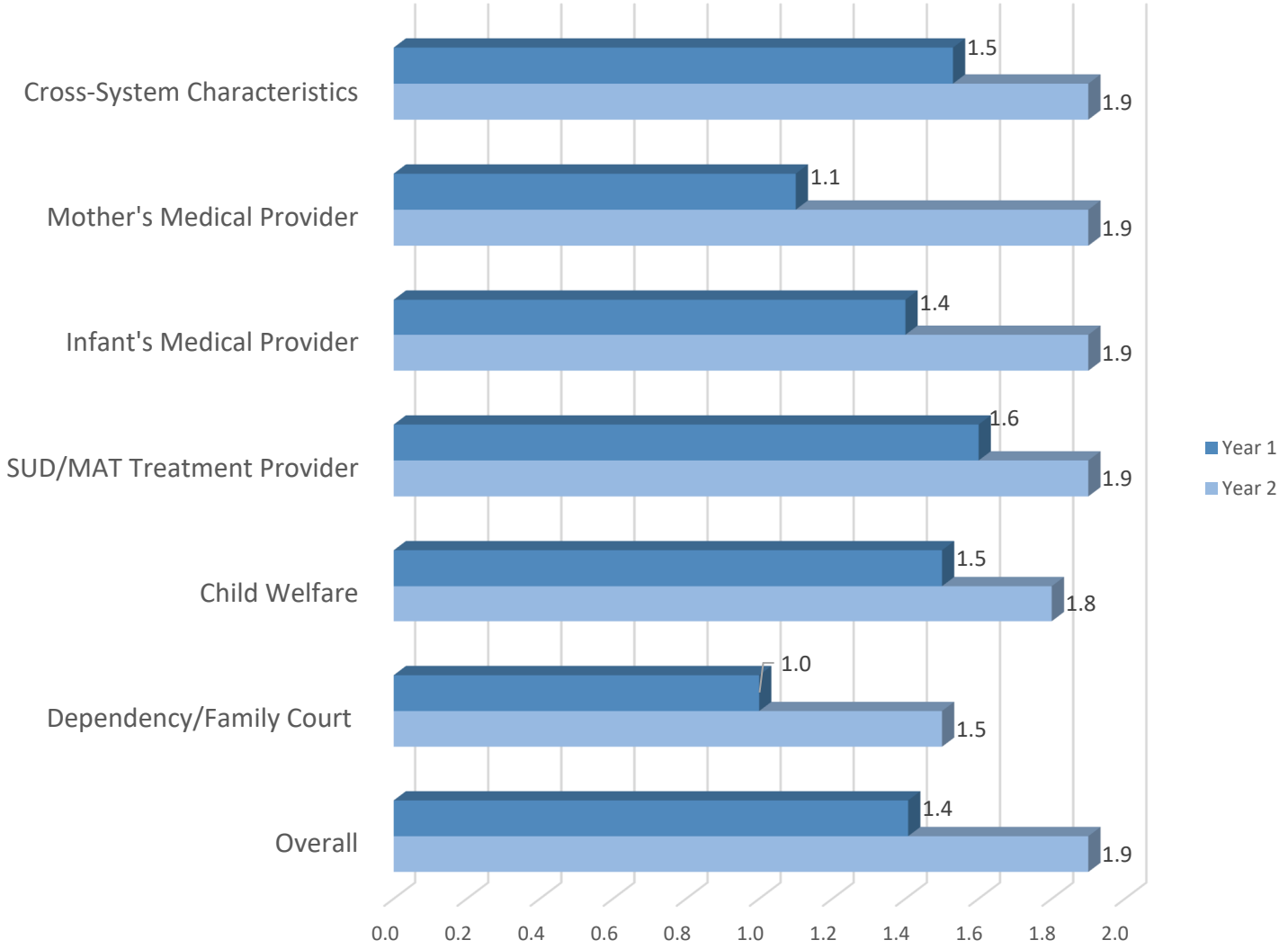
1. MDT Composition: In 2020, the 8-person MDT was composed of a single medical provider for both the mother and infant who was x-waivered to prescribe Medication for Opioid Use Disorder (MAT), three psycho-social SUD treatment providers, a child welfare representative and two support specialists. By 2021, the team had grown to 11 members (with two additional x-waivered medical providers and an additional child welfare representative). It had also split into two sections: (1) the original MDT which served only families involved with child welfare (post pregnancy only) and (2) the MDT Lite which served families not involved with child welfare (pre- and post-term). The XXX Clinic opened its doors and began providing medical care to pregnant and post-partum women and their substance exposed infants in 2019. Other MDT partners have been in existence for many years. The XXX MDT was designed to care for PPW not served by the county's family court.
2. Cross-system policies and practices: All cross-system areas became more solid in 2021 as reflected by an increase in overall mean score from 1.5 to 1.9 out of 2. Perspective and approach maintained a high level of alignment across systems with a mean score of 1.8 both years. Coordination and attention to service gaps also improved, increasing from 1.7 to 2.0 and from 1.6 to 1.9 respectively. The areas with the lowest levels of implementation in 2020: reimbursements for and access to services (mean=1.3), training & staff development (mean=1.3 each), and quality and outcome monitoring (mean=1.2) showed the greatest improvements with mean scores in 2021 of 2.0, 1.8 and 1.8 respectively.
3. Partner system policies and practices: The policies and practices of each partner agency role also into greater alignment with SAMHSA's recommendations resulting in a mean score or each system reaching at least 1.8 out of 2. The mother's medical treatment showed the greatest increase in fidelity, increasing from 1.1 in 2020 to 1.9 in 2021, due in part to the additional providers at XXX Clinic, fewer restrictions on groups during the 2nd year of COVID, and additional coordination with partners during the birth phase of patient care.
4. Supports across all phases of pregnancy are also increased in Year 2, especially during the Birth phase which increased from a score of 1.0 in 2020 to 1.8 in 2021 with additional policies and practices being in place especially in the areas of the mother's medical care and SUD treatment. Women already being served for a current or past pregnancy continued to receive full supports for a new pre-pregnancy phase (mean score=2.0 during both years), including opioid education and screenings, access to contraceptives and linkages to OUD treatment services.

Recommendations: Review the individual policies and practices listed on pages 8 and 9. In deciding which areas to work on, read the comments starting on page 10 for the areas receiving the lowest implementation scores. These policies and practices have the greatest room for improvement.

XXX MDT: SEI Framework Fidelity Scores

Mean Scores by Domain/ MDT Role

(Source: MDT members surveyed in 2020 (n=8) and 2021 (n=13))

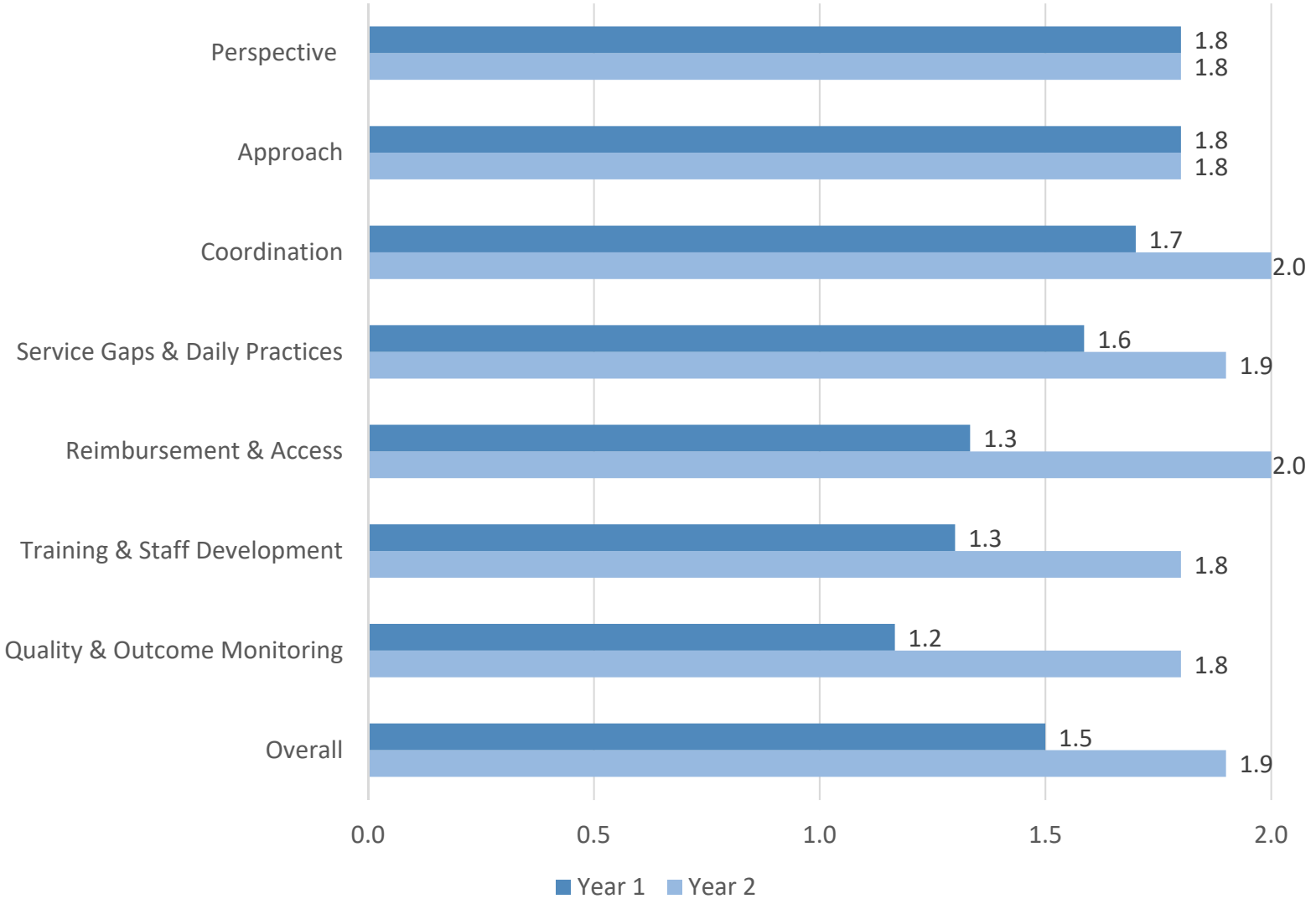


0 = Supports are not in place or status is unknown **1= Supports are somewhat in place** **2= Supports are 100% in place**

XXX MDT: SEI Framework Fidelity Scores

Mean Scores by Cross-System Policies and Practices

(Source: MDT members surveyed in 2020 (n=8) and 2021 (n=13))

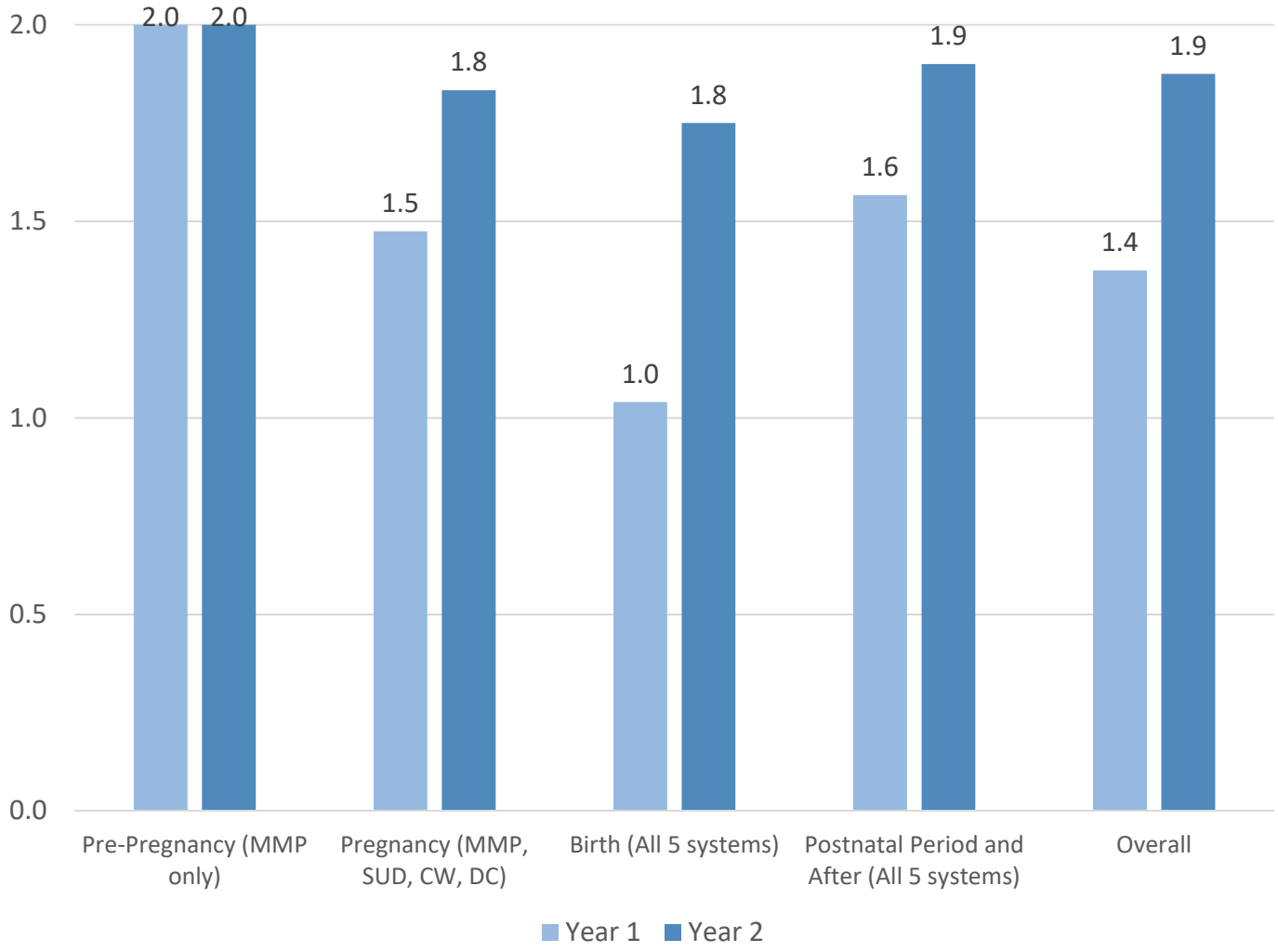


0 = Supports are not in place or status is unknown **1= Supports are somewhat in place** **2= Supports are 100% in place**

XXX MDT: SEI Framework Fidelity Scores

Mean Scores by Pregnancy Phase

(Source: MDT members surveyed in 2020 (n=8) and 2021 (n=13))



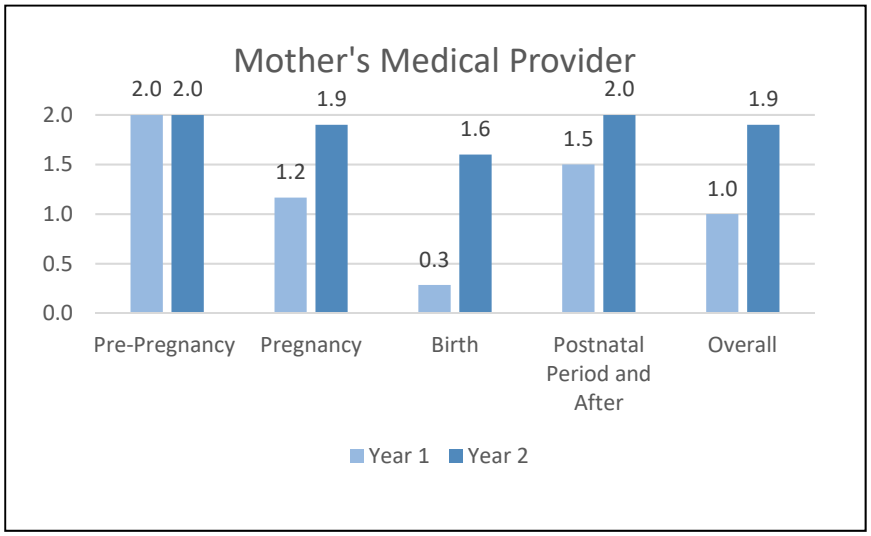
0 = Supports are not in place or status is unknown **1= Supports are somewhat in place** **2= Supports are 100% in place**

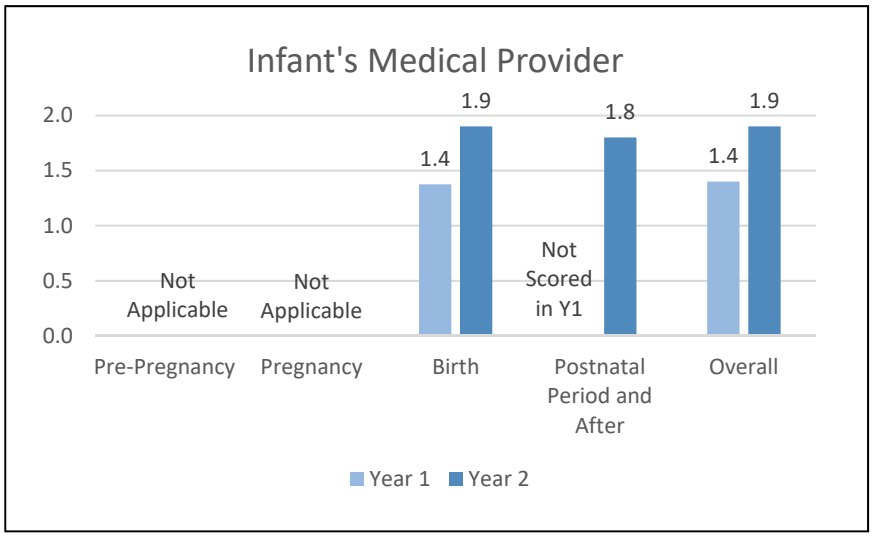
XXX MDT: SEI Framework Fidelity Scores

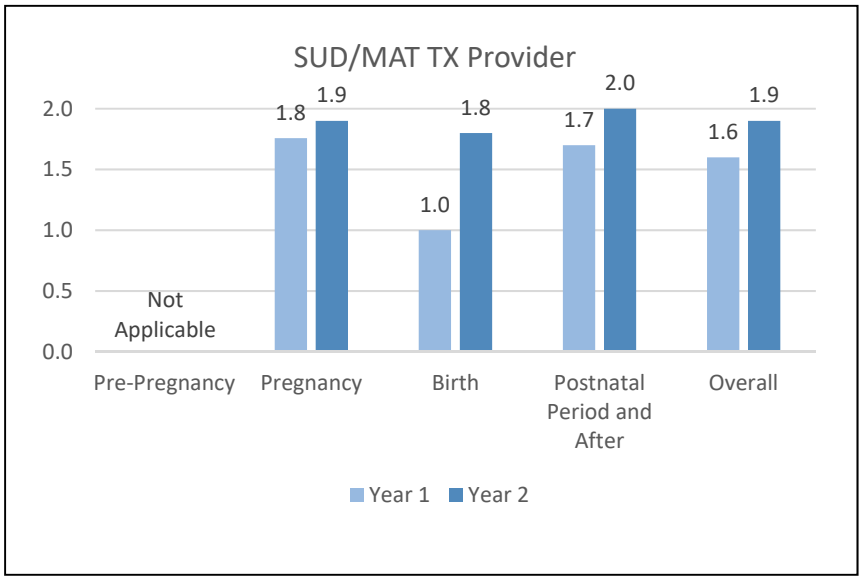
Mean scores by Pregnancy Phase and MDT Role

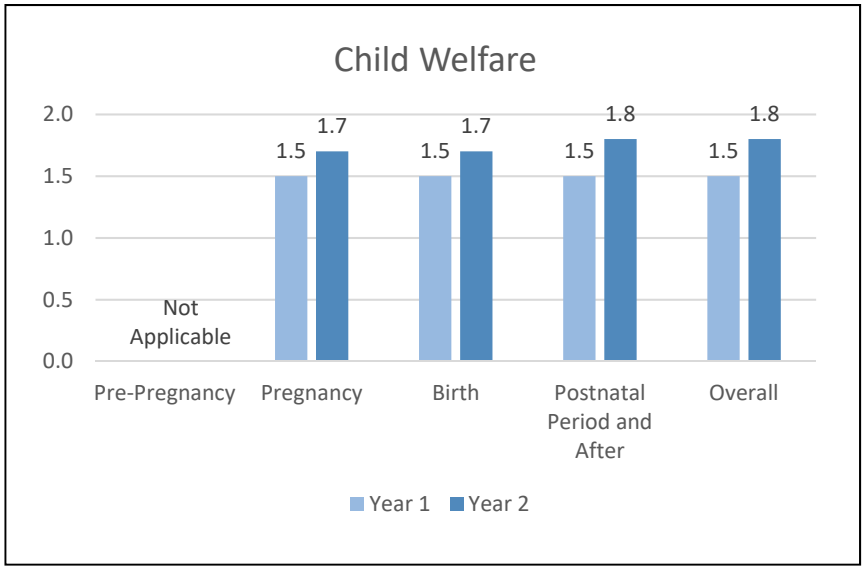
(Source: MDT members surveyed in 2020 (n=8) and 2021 (n=13))

SCALE: **0 = Supports not in place or status is unknown 1= Supports somewhat in place 2= Supports are 100% in place**









XXX MDT: SEI Framework Fidelity Scores in Detail

SCALE: **0 = Support not in place or status is unknown** **1= Support is somewhat in place** **2= Support is 100% in place**

Supports	Year 1	Year 2
Cross-System (n=8 [Y1], n=13 [Y2])	**1.5**	**1.9**
Perspective	**1.8**	**1.8**
1. MAT is accepted TX for pregnant and post-partum women (PPW)	1.8	1.8
Approach	**1.8**	**1.95**
2. Policies and protocols for MAT access	1.8	1.9
3. Evidence-based (EB) & trauma informed approach	1.8	2.0
Coordination	**1.7**	**1.9**
4. Culturally responsive approach	1.4	1.8
5. Good working relationships	1.9	2.0
6. Formalized care coordination	1.8	1.8
7. Understanding of what info to share with MDT	*Not asked*	*Not asked*
Service Gaps & Daily Practices	**1.6**	**1.9**
8. PPW with SUD are identified	1.9	1.8
9. MAT for PPW	1.8	2.0
10. Specialized pre-natal care during MAT	0.9	1.9
11. Appropriate levels of SUD care	1.6	1.7
12. Full range of SUD services	1.8	1.8
13. Substance exposed Infants (SEI) are identified	1.6	2.0
14. Ongoing care & monitoring for SEI	1.5	2.0
Reimbursement & Access	**1.3**	**1.8**
15. Assistance with financial obstacles to SUD TX	1.8	1.8
16. Priority and preferred access to SUD	1.8	1.8
17. Assistance with financial obstacles to SEI services	0.4	1.8
Training & Staff Development	**1.3**	**1.7**
18. Core providers knowledgeable about care	1.3	1.7
Quality & Outcome Monitoring	**1.2**	**1.8**
19. Shared understanding of outcomes	1.6	1.9
20. Data is tracked and shared	0.8	1.6
21. Quality assurance methods	1.1	1.8

Supports	Year 1	Year 2
Mother's Medical Provider (n=1 [Y1], n=3 [Y2])	**1.0**	**1.9**
Pre-Pregnancy	**2.0**	**2.0**
1. All women of childbearing age receive routine SUD/OUD screenings	2.0	2.0
2. Women using opioids are educated about prenatal risks and offered contraceptives.	2.0	2.0
3. Women with OUD are linked to TX services	2.0	2.0
Pregnancy	**1.2**	**1.9**
4. All pregnant women are screened for substance use	2.0	1.7
5. Non-judgmental staff	2.0	2.0
6. Staff understand & support MAT as an EBP for OUD during pregnancy	2.0	2.0
7. Protocols & screening tools for identifying substance use during pregnancy	0.0	2.0
8. Substance use testing & screening policies provided at 1st prenatal visit	0.0	1.7
9. Protocols for referrals to SUD TX and MAT	2.0	2.0
10. Specialized prenatal care	0.0	2.0
11. Protocols for info sharing/service coordination	2.0	2.0
12. Reducing prenatal exposure to HIV & other illnesses	0.0	2.0
13. Birth plan includes OUD considerations	0.0	2.0
14. PPW input on decisions	2.0	2.0
15. Protocols for child welfare (CW) referrals	2.0	2.0
Birth	**0.3**	**1.6**
16. Hospital OUD screening protocol includes asking for mother's permission	0.0	No response
17. Hospital staff address needs of women with OUD	0.0	1.5
18. Hospital staff support mother-infant bonding	0.0	2.0
19. CW referrals are made for SEIs/newborns	2.0	2.0
20. Support for mother during CW referral	0.0	2.0
21. Hospital involvement in Safe Care plan development	0.0	1.3
22. Systems for monitoring and tracking outcomes	0.0	1.0
Postnatal Period and After	**1.5**	**2.0**
23. Mothers receive contraceptives	2.0	2.0
24. Care coordination (healthcare & social services)	1.0	2.0

Characteristic	Year 1	Year 2
Infant's Medical Provider (n=1 [Y1], n=3 [Y2])	**1.4**	**1.9**
Birth	**1.4**	**1.9**
1. Staff understand and support MAT	2.0	2.0
2. Protocols for identifying and treating NAS	2.0	2.0
3. Hospital has pediatrician experienced with SEI & OUD	0.0	1.7
4. Parent education on supporting SEI in hospital or home	2.0	2.0
5. Support for breastfeeding/other mother-infant bonding	2.0	2.0
6. CW referrals for SE newborns	2.0	2.0
7. Support for mother during CW referral	0.0	1.7
8. Follow-up plan to ensure safe discharge	1.0	1.7
Postnatal Period and After	***Not scored***	**1.8**
9. Access to specialized pediatric care & early intervention	*No response*	2.0
10. Care coordination (healthcare & social services)	*No response*	1.7
SUD/MAT Treatment Provider (n=3 [Y1], n=3 [Y2])	**1.6**	**1.9**
Pregnancy	**1.8**	**1.9**
1. Care coordination (SUD TX, medical & CW)	1.3	1.7
2. Validated EB assessments for PPW with OUD	2.0	2.0
3. MAT Prescribers ensure access to BH services	2.0	2.0
4. Non-prescribing SUD TX providers ensure access to MAT	2.0	2.0
5. Priority and preferred access for PPW	2.0	2.0
6. Support for preparing for birth process	1.7	2.0
7. Safe Harbor Laws	1.3	*No response*
Birth	**1.0**	**1.8**
8. SUD TX programs have slots for PPW & SEIs	0.7	1.7
9. Involvement in Safe Care plan development	1.3	2.0
Postnatal Period and After	**1.7**	**2.0**
10. Care coordination (healthcare & social services)	1.7	2.0

Characteristic	Year 1	Year 2
Child Welfare (n=1 [Y1], n=2 [Y2])	**1.5**	**1.8**
Pregnancy	**1.5**	**1.7**
1. Support for MAT as an EBP for PPW with OUD	2.0	2.0
2. Clear policy on MAT	0.0	2.0
3. Trainings on SUD & EBPs, incl MAT	1.0	1.5
4. Understand that best MAT outcomes occur w/BH care	2.0	2.0
5. Understand PPW SUD TX priority & preferred access	2.0	1.5
6. Interventions & assessments for PPW receiving MAT	2.0	1.0
Birth	**1.5**	**1.7**
7. Goals support mother & infant remaining together	2.0	2.0
8. Clear protocol provides on SEI removal & opening cases	2.0	2.0
9. Protocols guide development of Safe Care plan	1.0	1.5
10. SEI protocols: developmental screenings, early intervention	2.0	2.0
11. Number of SEI cases and their outcomes are tracked	0.0	2.0
12. Support for attachment opportunities	2.0	2.0
Postnatal Period and After	**1.5**	**1.8**
13. Assessments incl. medical, clinical & social support needs	2.0	2.0
14. Facilitated access to family supports for long-term stability	2.0	2.0
15. Protocol for reunification & case closure decisions	1.0	1.0
16. Families referred to SUD TX receive MAT	1.0	2.0
Dependency/Family Court (n=3)	**1**	**1.5**
Pregnancy	**1**	**1.5**
1. Support for MAT as an EBP for PPW with OUD	1	1.5
2. Facilitated access to MAT for PPW with OUD	2	2
3. Acceptance of TX recommendations of medical and SUD TX professionals	0	1
Birth	**1**	**1.5**
4. Provider input is considered during safety, placement & permanency decisions	1.5	2
5. Support for SEI care to be provided and coordinated	1.5	1.5
6. Involvement in Safe Care plan development	1	1.5
7. Familiarity w/best practices for attachment during MAT	0	1
Postnatal Period and After	**1**	**1.5**
8. Mothers on MAT remain eligible for family drug treatment court, where available	1	1.5

XXX MDT: SEI Framework Fidelity Scores with Notes

Domain 1: Cross-System (Mean score: 1.9. ⇧ from 1.5 in Y1)

Characteristics	Mean	Definitions	Comment or Justification for Score
Perspective	**1.8**	*No change from Y1.*	
1. MAT as accepted TX for pregnant and post-partum women (PPW)	**1.8**	Medication assisted treatment is understood and accepted as an evidence-based treatment for pregnant women	No change from Y1.
Approach	**1.95**	*⇧ from 1.8 in Y1.*	
2. Policies and protocols for MAT access	**1.9**	Policy and protocols that facilitate access to MAT for pregnant women with opioid use disorders are in place.	*⇧ from 1.8 in Y1.* **Protocols, practices, etc. that facilitate or discourage pregnant women from accessing MAT:** Pregnant women with OUD are a prioritized population. Same-day appointments with MAT prescription. Dedicated PPW peer mentor for the pregnant and post-partum population. CNM certified in MAT helps determine if MAT is a good fit for patient, gets them established, & monitors how they are doing on the therapy.
3. Evidence-based (EB) and trauma informed approach	**2.0**	Our approach is guided by principles that are evidence based and trauma informed.	*⇧ from 1.8 in Y1.*
Coordination	**1.9**	*⇧ from 1.7 in Y1.*	
4. Culturally responsive approach	**1.8**	Our approach is culturally responsive.	*⇧ from 1.4 in Y1.*
5. Good working relationships	**2.0**	Our agency has a good working relationship with the other key agencies.	*⇧ from 1.9 in Y1.* **Areas of strength:** Strong relationship and coordinated care with multiple in/outpatient facilities. Collaborative relationships with Child Welfare, Self-Sufficiency and other treatment providers.
6. Formalized care coordination	**1.8**	A formalized system of care coordination between systems is in place (e.g., information sharing agreements, MOUs).	*No change from Y1.* Program has formal MOUs with all the agencies who participate in the Multidisciplinary Team and weekly meetings for care coordination.

Characteristics	Mean	Definitions	Comment or Justification for Score
7. Understanding of what info to share with MDT	*Not asked*	A formalized system of care coordination between systems is in place (e.g., information sharing agreements, MOUs).	*This measure was inadvertently left out of the web survey. It was not included in the calculations of average scores.*
Service Gaps and Daily Practices	**1.9**	*⇧ from 1.6 in Y1.*	
8. PPW with SUD are identified	**1.8**	Pregnant women with substance use disorders are identified.	*⇩ from 1.9 in Y1.*
9. MAT for PPW	**2.0**	MAT for pregnant women is available.	*⇧ from 1.8 in Y1.*
10. Specialized pre-natal care during MAT	**1.9**	Specialized prenatal care (e.g., obstetricians who are knowledgeable in addiction medicine) is available for pregnant women with opioid use disorders.	*⇧ from 0.9 in Y1.* PCP and new Certified Nurse Midwife (added in Y2) both provide combined prenatal care and addiction treatment (MAT)
11. Appropriate levels of SUD care	**1.7**	The appropriate levels of care (e.g., residential substance use Treatment programs) for pregnant women are available.	*⇧ from 1.6 in Y1.* Program works with additional providers to access residential treatment, but shortages in beds and staffing present barriers to care, especially for PPW with children. Local residential programs could use more training in developmentally appropriate practice when children are placed in these programs.
12. Full range of SUD services	**1.8**	The full range of services (e.g., individual and group counseling, residential, etc.) is provided in conjunction with MAT.	*No change from Y1.* Program works closely with local SUD agencies to provide a full-range of services. Participation in these other services is not required to access MAT
13. Substance exposed Infants (SEI) are identified	**2.0**	Newborns and infants who have been prenatally exposed to opioids are identified.	*⇧ from 1.6 in Y1.* "If the mother has been identified, the infant will be identified."
14. Ongoing care & monitoring for SEI	**2.0**	Ongoing care and monitoring is available for infants who have been prenatally exposed to opioids.	*⇧ from 1.5 in Y1.* Program has a Pediatric Nurse Practitioner on staff who does follow up for substance-exposed infants.

Characteristics	Mean	Definitions	Comment or Justification for Score
Reimbursement & Access	**1.3**	*⇧ from 1.3 in Y1.*	
15. Assistance with financial obstacles to SUD TX	**1.8**	Policies are in place to assist pregnant women who have financial obstacles when trying to access and maintain services for the treatment of opioid use disorders (e.g., MAT; outpatient or residential treatment; individual and group counseling; other services).	*No change from Y1.* **How MAT & other TX services are made available:** Program accepts Medicaid and have sliding scale fees for services. Two on staff Oregon Health Plan assistors enroll uninsured patients into Medicaid and assist them in accessing appointments. **How the point in time or case specifics affect access:** The biggest barrier for patients is when they go to jail and lose insurance which often takes some time to re-establish. Per policy, Child Welfare does not become involved until the baby is born.
16. Priority and preferred access to SUD	**1.8**	Priority and preferred access to substance use treatment and MAT for pregnant women[1] is enforced.	*No change from Y1.* Pregnant women with OUD are seen for same day appointments for MAT when they present to care. On-site CADC conducts ASAM assessments on the day of presentation. Local residential SUD programs also prioritize pregnant women for treatment.
17. Assistance with financial obstacles to SEI services	**1.8**	There are policies in place to address funding obstacles in providing ongoing care (e.g., following hospital discharge) to infants who are prenatally exposed.	*⇧ from 0.4 in Y1.* All children are enrolled in OHP shortly after birth, often at the hospital and if not at first well-child visit. On-site Pediatric Nurse Practitioner works with the children and family in making sure they are healthy and monitored.
Training & Staff Dev	**1.7**	*⇧ from 1.3 in Y1.*	
18. Core providers are knowledgeable about care	**1.7**	The core service providers are knowledgeable on the treatment of opioid use disorder in pregnancy and on the care and treatment of prenatally exposed infants.	*⇧ from 1.3 in Y1.* Most of the core service providers are knowledgeable about MAT and the treatment of OUD.

[1]As required by the Substance Abuse Prevention and Treatment Block Grant and opioid treatment program certification standards.

Characteristics	Mean	Definitions	Comment or Justification for Score
Quality & Outcome Monitoring	**1.8**	*⇧ from 1.2 in Y1.*	
19. Shared understanding of outcomes	**1.9**	Partners have a shared understanding of outcomes that includes both the mother and the infant (e.g., the overall goal includes mother, infant, and family well-being).	*⇧ from 1.6 in Y1.*
20. Data is tracked and shared	**1.6**	Data is tracked & shared between systems to monitor outcomes.	*⇧ from 0.8 in Y1.* Electronic Prescription Drug Monitoring Program (PDMP) collects/shares data on prescription fills for controlled substances statewide. All patients have records in Epic (EMR) which is shared with the two local hospital systems. Child welfare does not have access to medical systems. Information regarding care can only be accessed if mother signs an ROI.
21. Quality assurance methods	**1.8**	Programs and service providers have implemented quality assurance methods.	*⇧ from 1.1 in Y1.* **QA procedures:** Program regularly checks the PDMP for prescriptions, has a Certified Recovery Mentor who outreaches to patients who have not been in regular contact, and monitors well-child visits and vaccination status for pediatric patients. Program also conducts anonymous surveys of patients to see how patients are doing, how they like the program elements, and if there is anything that is not working for them.

Domain 2: Mother's Medical Provider (Mean score: 1.9. ⇧ from 1.0 in Y1)

Supports	Mean	Definitions	Comment or Justification for Score
Pre-Pregnancy	**2.0**	*No change from Y1.*	
1. All women of childbearing age receive routine SUD/OUD screenings	**2.0**	All women of childbearing age are screened for substance use, including opioid use and abuse at routine visits (e.g., primary care, well-woman, and family planning visits).	*No change from Y1.* XXX clinic provides routine SUD/OUD screenings. Community prenatal care providers in general do NOT do this as a standard of care.
2. Women using opioids are educated about prenatal risks and offered contraceptives.	**2.0**	Women identified to be using opioids are educated about the risk of use during pregnancy and offered contraceptives.	*No change from Y1.*
3. Women with OUD are linked to TX services	**2.0**	Women identified to be misusing or dependent on opioids are linked to treatment services.	*No change from Y1.*
Pregnancy	**1.9**	*⇧ from 1.2 in Y1.*	
4. All pregnant women are screened for substance use	**1.7**	All pregnant women are screened for substance use (e.g., universal screenings vs. selective screening).	*⇩ from 2.0 in Y1.* At XXX, ALL of the women in care must have a substance use disorder in order to be seen. Some prenatal sites provide screenings as well.
5. Non-judgmental staff	**2.0**	Staff are nonjudgmental and supportive of pregnant women with opioid use disorders.	*No change from Y1.*
6. Staff understand & support MAT as an EBP for OUD during pregnancy	**2.0**	Staff understand and are supportive of medication assisted treatment as an evidence-based treatment for opioid use disorders during pregnancy.	*No change from Y1.*
7. Protocols & screening tools for identifying substance use during pregnancy	**2.0**	Protocols and screening tools are in place to determine how substance use during pregnancy is identified (e.g., SBIRT).	*⇧ from 0.0 in Y1.* **Protocols and tools used:** Program does not use SBIRT, but talks to all patients every visit about SUD. XXX health clinic specializes in the treatment of SUD and almost all adult patients have a history of SUD.
8. Substance use testing & screening policies provided at 1st prenatal visit	**1.7**	Women are informed about our screening and testing policies at the first prenatal visit and on how the information will be used (e.g., mandated reporting under criminal and civil child welfare laws).	*⇧ from 0.0 in Y1.* Women with SUD in pregnancy are advised of Child Welfare policies and reporting and the ways this might affect them during pregnancy and post-partum.

Supports	Mean	Definitions	Comment or Justification for Score
9. Protocols for referrals to SUD TX and MAT	**2.0**	Protocols are in place to ensure that women are referred to medication assisted treatment and other substance use treatment services (e.g. SBIRT).	*No change from Y1.* **Policies and protocols that facilitate access to treatment:** Clinic offers same-day access for MAT for all identified patients.
10. Specialized prenatal care	**2.0**	Specialized prenatal care is available (e.g., OB/GYNs who are knowledgeable in working with pregnant women with opioid use disorders). Describe how specialized prenatal care and other services are provided (e.g. specialty clinics).	⇧ *from 0.0 in Y1.* Clinic is a specialty primary care for patients with SUD. On-staff Certified Nurse Midwife is an MAT provider and knowledgeable about SUD and local systems.
11. Protocols for info sharing/service coordination	**2.0**	Protocols are in place to coordinate services and share information with the mother's other medical, behavioral, and substance use treatment providers (e.g. information on medication doses is shared)	*No change from Y1.* Clinic utilizes the most common EMR in local area, Epic, and meets regularly with SUD treatment providers. On-site mental health therapist sees patients as needed.
12. Reducing prenatal exposure to HIV & other illnesses	**2.0**	Programs and services are in place to help reduce the fetus's exposure to HIV and other communicable diseases.	⇧ *from 0.0 in Y1.* **List programs and services.** All pregnant women are given full STI screenings at the initial prenatal visit and appropriate treatment offered.
13. Birth plan includes OUD considerations	**2.0**	The mother's birth plan includes considerations* specific to opioid use disorders. *Considerations include preparing the mother for the potential impact of prenatal exposure on the newborn and supporting and preparing the mother to cope with safely taking any needed medication for pain management during the labor and postpartum phases.	⇧ *from 0.0 in Y1.* Women are advised of the risk of Neonatal Abstinence Syndrome and expectations. Program speaks regularly with delivering OB hospitalists to ensure appropriate use of MAT and adequate pain control.
14. PPW input on decisions	**2.0**	Decisions are made with the woman's input.	*No change from Y1.*
15. Protocols for child welfare (CW) referrals	**2.0**	Protocols are in place to make a child welfare referral if a pregnant woman has other children and safety concerns exist.	*No change from Y1.* **CW Referral protocol and criteria:** Program reports all child safety concerns to Child Welfare as a mandatory reporting agency.

Supports	Mean	Definitions	Comment or Justification for Score
Birth	**1.6**	*⇧ from 0.3 in Y1.*	
16. Hospital OUD screening protocol includes asking for mother's permission	No response	The labor and delivery hospital's protocol on screening for opioid use (e.g. drug testing) includes asking for the mother's permission.	*Score was 0.0 in Y1.* **Protocol:** Respondents were unsure of the hospital OUD screening protocol.
17. Hospital staff address needs of women with OUD	**1.5**	The labor and delivery hospital staff know how to address the needs of women with opioid use disorders (e.g., pain management, caring for a newborn who has been prenatally exposed, and breast-feeding guidelines).	*⇧ from 0.0 in Y1.* There have been some trainings for labor and delivery staff however more work needs to be done.
18. Hospital staff support mother-infant bonding	**2.0**	The labor and delivery hospital staff support mother-infant bonding for cases involving prenatal opioid exposure (e.g. rooming together, breast-feeding).	*⇧ from 0.0 in Y1.* All infants room with the mother and breastfeeding is encouraged.
19. CW referrals are made for SEIs/newborns	**2.0**	A referral* is made to child welfare in situations involving newborns who are prenatally exposed. *As required by the Child Abuse Prevention and Treatment Act (CAPTA).Describe the protocol, practice, etc. Is it different for cases involving illicit substances, MAT for opioid use disorders, use or misuse of prescription medications?	*No change from Y1.*
20. Support for mother during CW referral	**2.0**	Mothers are notified and provided support when a referral to child welfare is made.	*⇧ from 0.0 in Y1.* Certified Recovery Mentor works with all women during pregnancy and post-partum.
21. Hospital involvement in Safe Care plan development	**1.3**	A representative from the birth hospital is involved in the development of a plan of safe care* (e.g., safe discharge to parents' home after the infant's inpatient treatment is complete).*As required by CAPTA	*⇧ from 0.0 in Y1.* Plans of care are in development, but have not yet been implemented at the hospital.
22. Systems for monitoring and tracking outcomes	**1.0**	Systems are in place to monitor and track cases involving prenatal exposure (e.g., birth and well-being outcomes that are associated with opioid use disorders).	*⇧ from 0.0 in Y1.* Systems are being developed, but have not yet been formalized. Local Medicaid payor does not always cover PATS referrals.

Supports	Mean	Definitions	Comment or Justification for Score
Postnatal Period and After	**1.5**	⇧ *from 1.5 in Y1.*	
23. Mothers receive contraceptives	**2.0**	Mothers receive contraceptive services, if appropriate.	*No change from Y1.* All women of child-bearing age are offered contraception and choice is listed on the problem list and verified each visit.
24. Care coordination (healthcare & social services)	**2.0**	Ongoing care is coordinated across health and social service systems (e.g. women are referred to medication assisted treatment and other substance use treatment services, or services are coordinated if the woman is already receiving treatment).	⇧ *from 1.0 in Y1.* **How services are coordinated:** XXX is in weekly contact with Child Welfare, Community Justice, Self-Sufficiency and the SUD treatment providers through their Multidisciplinary Team in which patients are staffed and care coordinated.

Domain 3: Infant's Medical Provider (Mean score: 1.9. ⇧ from 1.4 in Y1)

Supports	Mean	Definitions	Comment or Justification for Score
Birth	**1.9**	*⇧ from 1.4 in Y1.*	
1. Staff understand and support MAT	**2.0**	1. We are supportive of and understand medication assisted treatment as an evidence-based treatment approach for the treatment of opioid use disorders during pregnancy.	*No change from Y1.*
2. Protocols for identifying and treating NAS	**2.0**	2. We have a protocol on identifying and treating infants with neonatal abstinence syndrome (NAS).	*No change from Y1.* **How a NAS diagnosis is made and treatment provided:** Both area hospitals utilize Eat-Sleep-Console for the identification and treatment of opioid-exposed infants
3. Hospital has pediatrician experienced with SEI & OUD	**1.7**	3. The labor and delivery hospital has a pediatrician available who is experienced in working with infants with NAS and women with substance use disorders.	*⇧ from 0.0 in Y1.* Pediatric Hospitalists and NICU Physicians have experience with working with infants with NAS, less experience with women with SUD
4. Parent education on supporting SEI in hospital or home	**2.0**	4. Parents are educated about what to expect after delivery and how to support the prenatally exposed infant in the hospital or at home.	*No change from Y1.* All women with OUD are educated prior to birth regarding expectations and then at follow up appointments. XXX Certified Recovery Mentor is in training to also be a doula, offering further support.
5. Support for breastfeeding &/or other mother-infant bonding	**2.0**	5. We support breastfeeding (when appropriate) and other practices that support mother-infant bonding for situations involving prenatal opioid exposure.	*No change from Y1.* Women on MAT are encouraged to breastfeed. Lactation consultation is available. Participants are educated about the risks of illicit substances while breastfeeding
6. CW referrals for SE newborns	**2.0**	6. A referral is made to child welfare* in situations involving newborns who are prenatally exposed.*As mandated by the Child Abuse Prevention & Treatment Act (CAPTA)	*No change from Y1.*

Supports	Mean	Definitions	Comment or Justification for Score
7. Support for mother during CW referral	**1.7**	7. Mothers are notified and provided support when a referral to child welfare has been made.	⇧ *from 0.0 in Y1.* All women who receive prenatal care at XXX are supported with a Recovery Mentor, although this is not true for all the women who deliver at area hospitals.
8. Follow-up plan to ensure safe discharge	**1.7**	8. We ensure that a follow-up plan is in place to ensure the infant's safe discharge (CAPTA plan of safe care).	⇧ *from 1.0 in Y1.* **How safe care plan is developed:** We are in the process of developing safe plans of care to implement with the hospital systems. **How CW and other providers are involved:** Hospital social worker tracks DHS involvement prior to discharge.
Postnatal Period and After	**1.8**	*Not scored in Y1*	
9. Access to specialized pediatric care & early intervention	2.0	9. Access to specialized pediatric care (e.g., ongoing NAS treatment) and early intervention services are available and facilitated.	*No rating was provided in Y1.*
10. Care coordination (healthcare & social services)	1.7	10. Ongoing care is coordinated across health and social services.	*No rating was provided in Y1.* **How services are coordinated:** Services are coordinated through XXX, including coordination with Early Intervention. Ongoing to care is offered in the form of home visiting, but it is voluntary and not often accepted by the family. **Funding mechanisms that support coordination:** Currently, this coordination is grant funded and finding on-going funding is of concern.

Domain 4: SUD/MAT Treatment Provider (Mean score: 1.9. ⇧ from 1.6 in Y1)

Supports	Mean	Definitions	Comment or Justification for Score
Pregnancy	**1.9**	*⇧ from 1.8 in Y1.*	
1. Care coordination (SUD TX, medical providers, & CW)	**1.7**	We coordinate care with mother's OB/GYN, other medical providers, and child welfare. (e.g., sharing information on the mother's progress in developing the mother's birth plan, including pain management considerations).	*⇧ from 1.3 in Y1.*
2. Validated EB assessments for PPW with OUD	**2.0**	We use validated and evidence-based assessments to determine the optimal treatment plan for pregnant women with opioid use disorders.	*No change from Y1.*
3. MAT Prescribers ensure access to BH services	**2.0**	For OTPs & Independent Physicians: We ensure access to psychosocial/behavioral health services.	*No change from Y1.* **How care is coordinated:** *No comments provided.*
4. Non-prescribing SUD TX providers ensure access to MAT	**2.0**	For substance use treatment providers who do not provide medication-assisted treatment: We ensure access to medication-assisted treatment.	*No change from Y1.* **How access to MAT is ensured and care is coordinated with MAT providers:** If the mother is pregnant and not on MAT, MDT partners refer them to an x-waivered medical care provider.
5. Priority and preferred access for PPW	**2.0**	We provide priority and preferred access for pregnant women*.*as required by the Substance Abuse Prevention and Treatment Block Grant and OTP certification standards.	*No change from Y1.*
6. Support for preparing for birth process	**2.0**	We support mothers to prepare for the birth process (e.g., pain management considerations for labor and delivery, the potential impact for prenatal opioid exposure, breastfeeding guidelines).	*⇧ from 1.7 in Y1.*
7. Safe Harbor Laws	*No response*	We have Safe Harbor laws, which can facilitate access to treatment by protecting against liability or penalty, as long as set conditions have been met.	*Score was 1.3 in Y1.*

Supports	Mean	Definitions	Comment or Justification for Score
Birth	**1.0**	*⇧ from 1.0 in Y1.*	
8. SUD TX programs have slots for PPW & SEIs	**1.7**	Our residential and other treatment programs have slots for mothers with opioid use disorders and their babies who may have neonatal abstinence syndrome.	*⇧ from 0.7 in Y1.* Team reports that slots are not held because need in community is too high to maintain empty beds. "We don't hold slots, but have designed our female residential unit to serve mothers and their babies who may have neonatal abstinence syndrome. We have preferred entrance to these mothers." "Dependent on hospital recommendations."
9. Involvement in Safe Care plan development	**2.0**	We have a role in developing a plan of safe care* for the infant.*As required by Child Abuse Prevention and Treatment Act (CAPTA).	*⇧ from 1.3 in Y1.* The development of a safety plan comes from Child Welfare. MDT follows their guidelines.
Postnatal Period and After	**2.0**	*⇧ from 1.7 in Y1.*	
10. Care coordination (healthcare & social services)	**2.0**	Ongoing care is coordinated across health and social services (e.g., information is shared on the mother's treatment, MAT progress, and relapse).	*⇧ from 1.7 in Y1.* **Protocols, strategies, etc., that facilitate care coordination:** MDT team members each share progress, relapses, behaviors during our team meetings. Each agency shares information they have for that client. **Funding mechanisms that support coordination (e.g., participation on a child safety team):** MDT member agencies.

Domain 5: Child Welfare (Mean score: 1.8. ⇧ from 1.5 in Y1)

Supports	Mean	Definitions	Comment or Justification for Score
Pregnancy	**1.7**	*⇧ from 1.5 in Y1.*	
1. Support for MAT as an EBP for PPW with OUD	**2.0**	Our agency supports and understands medication assisted treatment (MAT) as an evidence-based approach for the treatment of opioid use disorders during pregnancy.	*No change in score from Y1.* **Policy and inter agency communication/work flow:** *No comments provided.*
2. Clear policy on MAT	**2.0**	Our agency's policy on medication assisted treatment is clear to the other systems.	*⇧ from 0.0 in Y1.* Team reports that MAT is accepted as medically advised treatment. Unknown whether written DHS policy exists.
3. Staff trainings on SUD & EBPs, incl MAT	**1.5**	Staff receive training on evidence-based treatment for substance use disorders, including MAT.	*⇧ from 1.0 in Y1.* **Training protocol/ training agenda:** *No comments provided.*
4. Staff understand that best MAT outcomes occur with BH care	**2.0**	Staff understand that best outcomes for pregnant women on MAT occur when they are also engaged in psychosocial/ behavioral health services.	*No change in score from Y1.*
5. Staff understand SUD TX priority and preferred access for PPW	**2.0**	Staff understand that pregnant women should receive priority or preferred access* to publicly funded, MAT and other SUD treatment services.*As required by the Substance Abuse Prevention Block Grant and OTP certification standards	*No change in score from Y1.*
6. Interventions & safety assessments for PPW receiving MAT	**2.0**	We can provide supportive intervention and safety assessments for women during pregnancy who are receiving MAT and other treatment services.	*No change in score from Y1.* **Policies, practices, & programs that facilitate interventions during pregnancy:** Child welfare, per policy, do not provide services until after the baby is born.
Birth	**1.7**	*⇧ from 1.5 in Y1.*	
7. Goals support mother & infant remaining together	**2.0**	Our goal is to maintain the safety of the infant, while supporting the ability of mothers and infants to remain together.	*No change in score from Y1.*
8. Clear protocol provides on SEI removal & opening cases	**2.0**	We have a protocol that provides clear guidance on child removal and opening cases in situations involving prenatal exposure to opioids (e.g., referrals from hospitals as required by CAPTA).	*No change in score from Y1.* **Protocol:** *No comments provided.*

Supports	Mean	Definitions	Comment or Justification for Score
9. Protocols guide development of Safe Care plan	**1.5**	Our protocol on responding to cases involving prenatal exposure includes guidance on developing the CAPTA plan of safe care.	⇧ *from 1.0 in Y1.* Team reports that safe care plan for infant is developed by CW, input from MDT partners is considered during plan development and recommended changes are considered. Unclear whether process is this guided by written DHS protocol.
10. Protocols for SEIs include developmental screenings & early intervention	**2.0**	Our protocol on responding to cases involving prenatal exposure includes a referral* for a development screening and early intervention services for children ages 0-3.*As required by CAPTA	*No change in score from Y1.* Developmental screenings & early intervention occur in the hospital.
11. Tracking SEI cases and their outcomes	**2.0**	We track the total number of cases involving prenatal exposure and their outcomes. List types of outcomes tracked. Are there other outcomes that would be helpful to track?	*No change in score from Y1.*
12. Support for attachment opportunities	**2.0**	We support attachment opportunities for infants and mothers with opioid use disorders, such as rooming together and breastfeeding, when these opportunities are not contraindicated.	*No change in score from Y1.*
Postnatal Period and After	**1.8**	⇧ *from 1.5 in Y1.*	
13. Assessments include medical, clinical & social support needs of family	**2.0**	We ensure that our assessments address the full range of medical, clinical and social support needs experienced by our families (e.g., during the investigation, to develop the case plan, to prepare the family for reunification).	*No change in score from Y1.* **Assessment criteria:** *No comments provided.* **Accountability standards:** *No comments provided.*
14. Facilitated access to family supports for long-term stability	**2.0**	We understand and are equipped to facilitate access to the supports that families need for long-term stability (e.g., ongoing MAT and other SUD treatment services, early intervention services for infants, home visiting services).	*No change in score from Y1.* **How care coordination is facilitated** (e.g., ongoing communication with TX providers on mother's progress in recovery):
15. Consistent protocol for reunification and case closure decisions	**1.0**	We use a consistent protocol for making decisions on reunification and case closure.	*No change in score from Y1.* **How decisions are made:** *No comments provided.*
16. Families referred to SUD TX receive MAT	**2.0**	For agencies that use a differential response program: Our agency has a system to ensure that families referred to community agencies to address opioid use disorders receive MAT and other needed treatment services.	⇧ *from 1.0 in Y1.*

Domain 7:Dependency/Family Court (Mean score: 1.5. ⇧ from 1.0 in Y1)

Supports	Mean	Definitions	Comment or Justification for Score
Pregnancy	**1.5**	*⇧ from 1.0 in Y1.*	
1. Support for MAT as an EBP for PPW with OUD	1.5	We understand and are supportive of medication- assisted treatment (MAT) as an evidence-based approach for pregnant women with opioid use disorders.	
2. Facilitated access to MAT for PPW with OUD	2	We help facilitate access to MAT for pregnant women with opioid use disorders.	**Protocols, etc., that facilitate access (e.g., Safe Harbor laws):** *No comments provided.*
3. Acceptance of TX recommendations of medical and SUD TX professionals	1	We accept the clinical decisions that medical and substance use treatment professionals recommend on the treatment of opioid use disorders.	
Birth	**1.5**	*⇧ from 1.0 in Y1.*	
4. Provider input is considered during safety, placement & permanency decisions	2	We understand what information is needed from each service provider (i.e., substance use treatment, MAT treatment, child welfare, and medical providers) to make decisions regarding child safety, placement and permanency.	**Information provided to other service agencies:** *No comments provided.*
5. Support for ensuring that SEI care is provided and coordinated	1.5	We help ensure that care for infants is provided and coordinated. Describe infant care protocol.	
6. Involvement in Safe Care plan development	1.5	We have a role in shaping the plan of safe care, mandated by the Child Abuse Treatment and Prevention Act (CAPTA), for cases involving prenatal substance exposure.	Safe care plan for infant is developed by CW. Input from MDT partners is considered during plan development and recommended changes are considered.
7. Familiarity with best practices for mother-infant attachment during MAT	1	We are familiar with best practices for mother- infant attachment (e.g., breastfeeding) for women receiving MAT.	
Postnatal Period and After	**1.5**	*⇧ from 1.0 in Y1.*	
8. Mothers on MAT remain eligible for family drug TX court, where available	1.5	For communities with a family treatment drug court (FTDC): The FTDC allows new mothers to receive MAT and remain eligible to participate in the program.	Team reports that, at one time, MAT was prohibited for PPW involved in family court, but no longer.

APPENDIX: Additional Web Survey Responses:

What's the most <u>rewarding</u> thing about working with the mothers served by the MDT and their families?

- Watching them become independent and caring for their children clean and sober.
- Watching the mothers come into the program broken, hopeless and some kid-less and watch them grow into woman who get their children placed with them who have gained hope and strength and a new way to live.
- Seeing parents succeed in their treatment goals and reuniting families
- Seeing families stabilize and children remaining with their parents.

What's the most <u>challenging</u> thing about working with them?

- Getting them to make it to their scheduled appt and or getting them into treatment.
- It is often challenging to engage women who are not stable in recovery, particularly when they do not have stable housing. It makes it difficult to find women and continue to offer services.
- Lack of open beds in residential programs
- Not being able to give them the strength to see what we see in them. Some sell themselves short of what their capable of.

What would help you to do your part of the MDT better?

- Funding for an additional addiction-trained medical provider would be very helpful and allow me to spend more time on program growth rather than direct services
- Just being able to make it to more of the meetings.
- More access to treatment.
- The ability to work with mothers before the baby is born

In your opinion, what's working well with the MDT?

- All of the agencies coming together to work with each participant where they are at.
- Having the team members from each agency is great. Each member has different information … because each member plays a different role in the client's life.
- Team support and communication.
- The MDT is an excellent way to efficiency exchange information about clients and have all service providers following the same plan. It reduces the burden on clients and they feel supported by the team.

What isn't working?

- Being able to have beds available in residential programs and /or mother's with newborns being prioritized for care in the treatment facilities to prevent removal of a baby from a mother.
- It's not necessarily what isn't working. What makes it more challenging is when some clients reach a certain spot, such as graduating out of residential, we sometimes tend to see them slip away from the team. Not staying in contact, starting down a slippery slope for potential relapse. It may be hard to get the client reengaged into participation.
- Phone calls instead of in person meetings with individuals.
- The fact that the MDT is grant funded is a difficulty. Finding on-going funding is challenging because it does not fit within the normal scope of medical services.

In your opinion, what is the most valuable part of the MDT and related services for the mothers?

- Having all the team members from each agency in one room. It makes it easier for the clients when it comes to checking in. We are all full of resources and able to come together to help each client.
- Team support and being able to get frequent ongoing reports from all agencies working with the family.
- They have a core team of people to help them access their needs, discuss their case together on a weekly basis which help with a better outcome for the participant.
- Women feel supported and that they have a team of people on their side. This increases their sense of self-worth and efficacy.

In your opinion, what is the most valuable part of the MDT and related services for the infants?

- Being able to work closely with the doctor and treatment facility.
- Having Child Welfare and the doctor on the team gives us more information on the background and ongoing information with the infant that maybe would not be shared by the mother.
- The MDT helps stabilize parents. And discussions with Self-Sufficiency and Child Welfare can help get more services for infants.
- We get to communicate with the peds provider to have a better understand of what may be happening with the child's health care.

In your opinion, what is the most valuable part of the MDT and related services for any other family members affected by these services?

- Streamlining services and knowing what [support] families might qualify for.
- The accountability and access for their loved ones.

How could local services be improved to better meet the needs of women dealing with a substance use disorder while also being pregnant or parenting?

- Being [able] to work with a family before the baby is born.
- Transitional housing, not specifically treatment housing, for pregnant women with SUD.
- Transportation and housing.

Are there any types of program participants who are <u>not</u> responding well to the MDT and related services? For example, you may be serving women with a variety of family situations or women from a specific cultural or ethnic group. If YES, please explain.

- Dual diagnosis for parents with mental health and substance abuse. We need more care and support regarding the mental health needs.
- None
- Not a specific cultural group, but the most difficult are patients who return to their former social environment and relapse to use.

Are there any other partners you wish participated in your MDT or care coordination meetings?

- Nurse home visiting and early intervention would be helpful
- Someone with help to housing access

In your opinion, do your meetings occur... (n=10)

Response	Count	Percent
Not Frequently Enough	0	0%
Too Frequently	0	0%
Just Right	10	100%