Plans of Safe Care

Case Scenario 2

Panel Discussion *(3 minutes per panelist)*	
Perinatal Coordinator: Katie White, RNC-LRN Wentworth-Douglass	Mention development of Perinatal Coordinator (PC) role • Increasing numbers of SEN being born at WDH • Need for collaboration from OB, Pediatric Hospitalists, MAT, WDH, PCP/Pediatrician • Evolving science - Finnegan to ESC **What strategies would you use to connect and engage with this patient during the pregnancy? How about during the birth hospitalization?** During Pregnancy: ✓ Referral to Coordinator/SWS (WDH) from OB or monthly High Risk OB meeting - verbal or written consult ✓ Connect with patient via phone or email to offer tour of WMCH and discuss POC/prenatal. If unscheduled by 3rd trimester, OB notified to offer Coordinator + SWS to come to OB office ✓ Offer comfort care classes/Wellness Series to iMAT/residential treatment. ✓ Initiate SPOC document during tour or earlier (working document) During Hospitalization: ✓ Daily rounding with team: Review goals set/discussed in prenatal meeting ✓ Provide NuRoo as gift to promote STS, optimal feeding and bonding ✓ Provide emotional support with rapport formed in pregnancy+ praise behavior and bonding ✓ Initiate and engage Child Life Specialist and OT consults to help educate on developmental needs, stimulus, sibling involvement **What supports would you offer to the patient during these time periods to help her be most successful in safe and healthy parenting?** During Pregnancy: ✓ Praise recovery efforts, encourage breastfeeding, identify barriers to care, i.e transportation, lack of insurance, access to care, educate on smoking cessation and MJ use ✓ Offer Doula scholarship and or anesthesia consult to discuss pain management ✓ Provide early follow-up to newly established MAT patients when initiated on WMCH ✓ Use language that is supportive to caregivers being first line of treatment During Hospitalization: ✓ Daily check in by Coordinator and SWS to review POC and plan from the day ✓ Schedule follow up appointments and provide written list of MOB and infant's f/u appts w/ OB, MAT, PCP/Pediatrician. Discuss problem list w/Pediatrician (ie Hep C+ MOB) ✓ Provide phone numbers of Coordinator/SWS to address concerns of emotional physical changes/concerns provided ✓ Advocate for maternal rest while rooming in- Cuddler Volunteer program, MamaRoo swing. ✓ Advocate for MOB and Infant - Period of Purple Crying education, safe sleep education, ESS/CAP/WIC/DCYF

Home Visitor: Maryann Evers, LICSW Waypoint	**How would you assess home safety and education for this patient and her family if you were able to perform a home visit during pregnancy? How about only after the baby was born?** ✓ Please refer when early (preferably when Mom is still pregnant)…we can better help prepare Mom (and Dad) for the birth of their new baby. ✓ Our service meets families where they are in their journey, suspends judgment and focuses on helping prepare concretely for the arrival of the child with access to goods like food, furniture, clothing, housing supports, applications for benefits, etc. ✓ We get most of our referrals from OB GYN offices where moms may already be receiving medication assisted treatment or are new to it. We often meet with these moms in the OB office initially. During Pregnancy: ✓ As we get to know a family we are learning about their strengths and needs and observing their capacity to follow through with things like treatment, referrals, work ✓ As we assess the family's readiness to parent the new born we are looking at things like; housing stability; outstanding legal issues, interpersonal issues (with partners, family, friends, professionals); income streams. We assess these issues with an eye towards where there are relative to strengths to build on and where there are needs to support and address. ✓ As the birth of the baby nears, we might bring a mom to the hospital to see the maternity ward and to seek her permission (release) to communicate with the social worker at the hospital. After Pregnancy: ✓ Once the baby is born, we will continue to look at the aforementioned elements of their lives but will now also have the added ability to view the ways in which the parents respond to the needs of their new baby. When indicated and agreed, we will refer these families to ongoing supportive home visiting programs like Healthy Families America. We pay close attention then to the parent-child interactions and work to build on parent's ability to recognize and respond to their baby's needs. ✓ Waypoint is fortunate to have a close working relationship with Concord Hospital, Concord OB GYN and Dartmouth Hitchcock OB GYN practices and we have worked together to better coordinate our involvement. As a result, we have been more successful in helping these mothers successfully interface with DCYF and develop a workable plan to assure the safe care of their infant upon discharge. The model that we use to support these families, the NH Wrap model, offers these families a new experience, we hope, in identifying and supporting their vision for themselves and their children.

SUD Treatment Program Provider: Kristen McGuigan, LICSW Families in Transition-New Horizons	**How would you engage this patient within your treatment program?** ✓ Our belief is that all parents want to do well by their children. We use the motivation of motherhood as a way to connect, holding the view that parenting this baby can be successful. ✓ Motivational interviewing (MI) is used to connect and build rapport - MI allows staff to be helpers in the change process, using a client centered approach to express acceptance of clients. This model is a true partnership with self-motivating goals. ✓ Parent-Child Psychotherapy-is a therapy model that focuses on the dyad from the beginning of pregnancy around building attachment. Infants use their primary caregivers to understand relationships and to develop a sense of safety in the world. Our team would provide education to this mother on this model and use the dyad as a starting point for treatment. ✓ We never give up - We are trained that our jobs are always to work to engage clients, that's our job, not the clients job to engage with us. We work to build trust; showing the client I will follow through. ✓ TOOLS if family is not engaging: • Incentive programs - relational model. Provide baby supplies and essentials as a way to support mothers to begin to attach to baby. • Leaving hand-written notes to check-in, "thinking of you and your family"-reminder cards. Increases connection and rapport in a personal manner. **What resources will be most important to help this woman be successful in her recovery and parenting?** ✓ Substance use treatment options - complete ASAM assessment which would determine the appropriate level of care for substance use. Offer Peer Recovery support. ✓ Provide Safe Sleep education, our staff members are safe sleep ambassador. ✓ Encourage prenatal care - self-care of mothers ✓ Parenting education - Our team offers parenting groups for pregnant mothers and new mothers to provide education and encourage positive peer connection.

Medication Assisted Treatment Provider: Molly Rossignol, DO Catholic Medical Center	**How would you approach discussing the patient's use of marijuana in the context of her substance use disorder, and in parenting?** ✓ There is a saying that "Addiction is Addiction" meaning that the disease of addiction implies that there are brain changes that have taken place as a result of exposures, genetics or environmental experiences. The substance of 'choice' or "no choice" as it may be, is a symptom of the brain disease. ✓ When someone has a diagnosis of a substance use disorder, they are at higher risk of being addicted to or will misuse other substances. The 'addiction track' is there. Therefore, though you may have a diagnosis of an "opioid use disorder" there is the risk that use of other addictive substances can result in pursuit of that particular substance despite consequences, needing to use more to get the same effect, experiencing withdrawal and craving, etc. The same behaviors and feelings that one sees in a person with addiction to opioids can be seen with any other addictive substance. This can be very tragic "even if it is just pot". ✓ One of the effects of marijuana I see is increased anxiety. Patients sometimes report that they use marijuana to 'take the edge off'. What they don't realize is that they are perpetuating repeated episodes of anxiety which are likely related to anticipation of use or withdrawal from marijuana. ✓ While I am treating a patient for an opioid use disorder with medication (ie, buprenorphine) I inform the patient that I do not stop the medication as a consequence of use of other substances but might refer her for further treatment. This might include addiction counseling, peer support, IOP or other community resources to help her to understand her vulnerability and avoid use. ✓ In the context of parenting, psychoactive substances can take away from important aspects of caring for a child who has significant dependence on a parent. It is important to be responsive to the baby and get to know his/her cues. It is ever so important for the baby to have an attentive parent who is at the ready for when he/she needs them and using marijuana could jeopardize this crucial response. ✓ Marijuana (THC) is excreted into breast milk in rather high amounts and at this time we are looking at potential effects of this on the brain and the rest of organ development in babies. Any exposure to substances in a developing brain can have long lasting and deleterious effects.

Legal: Lucy Hodder, JD UNH/Institute for Health Policy & Practice	**Does the hospital need to develop a Plan of Safe Care with this mother?** ✓ Yes. Under New Hampshire statute, RSA 132:10-e and f, when an infant is born with and identified as affected by substance use or withdrawal symptoms, the health care provider must develop a Plan of Safe Care with the mother. The best practices, however, are to use the Plans to develop supported care for all mothers and infants. It is also recommended by the providers involved in the development of the Plan, to start engaging mothers early, even before birth, in planning for supports. The Plan is intended to be a living document. **How does the mother's use of marijuana factor into the hospital's need to make a report of suspected abuse or neglect to DCYF in this case scenario?** ✓ Marijuana use and its effects will be one of the facts and circumstances the provider needs to consider when planning for the care and treatment of mother and infant, and in determining whether or not there is a reason to suspect child abuse and neglect. Marijuana use alone does not warrant a mandatory report under any NH law or regulation. Marijuana use is not legalized in NH except under state law consistent with medical marijuana regulations. In NH mandatory reporting is required whenever there is a reason to suspect child abuse and neglect. A neglected child is one who is without care necessary for the child's health when the child's health has suffered or is likely to suffer serious impairment due to physical or mental incapacity of the parent. The provider will need to assess the impact on the child and the risk of harm. In a perfect world, a report to DCYF allows for additional and voluntary supports and services.

Division for Children, Youth and Families: Kali Giovanditto, BA	**Does the hospital need to make a report of suspected abuse or neglect to DCYF in this case scenario? What factors and circumstances might it depend upon?** ✓ Agree with Lucy ✓ Exposure alone at any time during the pregnancy does not mandate reporting. Marijuana use alone does not warrant a mandatory report under any NH law or regulation. ✓ The provider will need to assess the impact on the child and the risk of harm. The hospital should assess the mother's willingness to remain engaged in treatment after discharge. The fact that she is using so late in her pregnancy, and is demonstrating a potential lack of commitment to recovery puts her at risk. ✓ A report to DCYF allows for additional and voluntary supports and services. DCYF would assist the mother with support to stay engaged in treatment and make sure she has appropriate services in place to ensure the safety of the baby after discharge.

Recovery Coach: Cheri Bryer Dartmouth-Hitchcock Medical Center	**How would you help support this patient?** ✓ Meet mother exactly where she is at. Whatever her truth and story is, that is hers, and I would have to work with that. ✓ Give her resources, offer Moms in Recovery (MORE), always explain what we have to offer here at DHMC/MORE. ✓ Answers any questions she may have, see her at prenatal visits, offer support in that way, visit on the Birthing Pavilion. ✓ Closer to delivery, give them my contact information, say I am available anytime. ✓ Talk about MORE, that we strive to keep moms and babies together, and help reunify if they are separated. ✓ If they are in a community MAT program, help them connect with a community health worker, who is able to stay in contact with them outside the clinic. They can help with Medicaid, housing, food stamps… ✓ If a mom is not quite ready to talk about recovery or not making it to appointments, would just show my face, say I am here to support you, you can call /message me anytime ✓ In pregnancy with mom missing visits: Luckily we are so integrated at MORE, I can see them at group and check in. If they are missing appointments, I can send a message "Hi. I'm thinking of you. How are you doing?

Pediatrician: Steve Chapman, MD Dartmouth-Hitchcock Medical Center	**How would you approach coordinating care for this mother and infant at their first newborn visit? How about at the 2-week visit? And in between visits during the first year of life?** ✓ First few visits about building rapport and trust, "I am so glad you are here. Congrats on having a baby, so wonderful to become a parent again." Quickly ask "How are you doing? How is your other child doing at home? What is the most important thing for you and how can I help?" Get some bearings for where mom is at for this visit. ✓ It is also important to say that there is every reason to expect your baby will grow happy, healthy, and normally with proper supports and care. And we can help. **How would you approach discussing coordination of care in relation to the Plan of Safe Care with this mother?** ✓ If POSC available, I would use that to begin a discussion "Who is in your circle, not just in your home? Who would you turn to?" It's important to understand strengths and available supports. If no POSC available, start with discharge summary or whatever is available. ✓ Review social determinants of health, "Where are you living? Are you happy in this living situation and do you feel safe?" explore transportation, food insecurity, and income insecurity. ✓ What services and supports are in place? • WIC, VNA, Family Resource Centers, common helpful resources • Establish priorities, use time well • Sign releases • Set up Follow up • Establish between visit supportive phone calls. • We have invited family resource centers in to clinic to enroll families • Ongoing comprehensive care management if at all possible. ✓ This is a document that often mom will own.