Nevada Perinatal Health Initiative

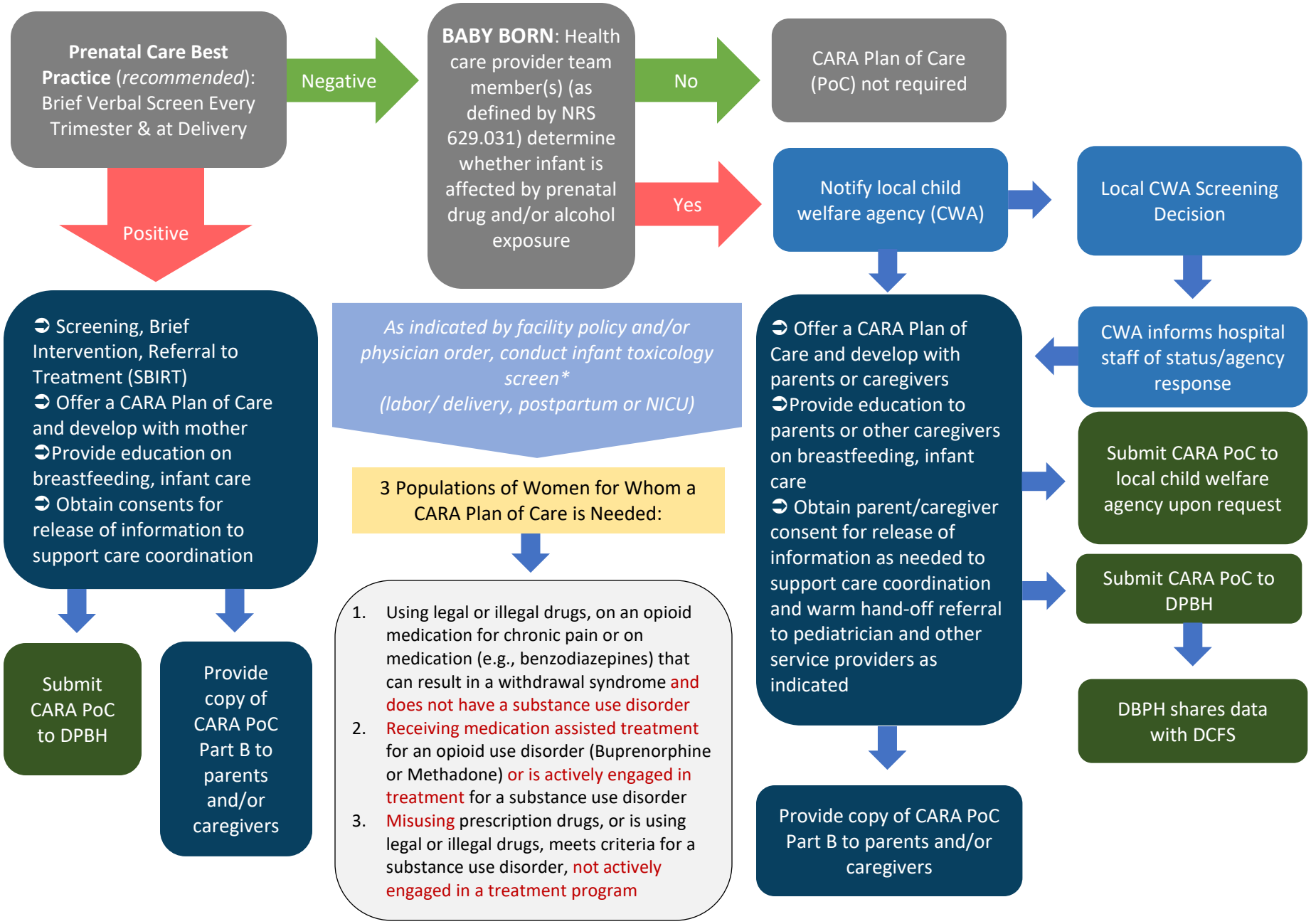
CARA Plan of Care Flowchart

Background

Since November of 2018, Nevada has been participating in the Association of State and Territorial Health Officials (ASTHO) Opioid Use Disorder, Maternal Outcomes, and Neonatal Abstinence Syndrome Initiative (OMNI). As part of this work, the Nevada Perinatal Health Initiative developed an Action Plan to guide statewide efforts. Workgroups were established to accomplish activities within the Action Plan. In 2020, the Nevada Perinatal Health Initiative's Comprehensive Addiction and Recovery Act (CARA) workgroup reviewed the steps necessary to identify and provide services to women with substance use issues and infants with prenatal substance exposure who may benefit from receiving a Plan of Care. Plans of Care are intended to identify services and supports that address maternal substance use and the effects of prenatal substance exposure on infants.

The following flowchart is intended to depict the processes for developing a CARA Plan of Care for infants who are affected by substance use and their caregivers to facilitate linkage to services and care coordination for those families. Included as companion documents to the flowchart are the CARA Fact Sheet for Health Care Providers, an excerpt of Nevada Revised Statue (NRS) 629.031 defining health care providers in Nevada, and best or recommended practices developed in consultation with CARA workgroup members and subject matter experts.

Nevada CARA Plan of Care Flowchart



*Informed consent needed for maternal toxicology screen; consent not required for infant toxicology screen.

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References

COMPREHENSIVE ADDICTION AND RECOVERY ACT (CARA)

A FACT SHEET FOR HEALTH CARE PROVIDERS

WHAT IS CARA?

The federal government passed the Comprehensive Addiction and Recovery Act of 2016, (CARA) which added requirements for states through the Child Abuse Prevention and Treatment Act (CAPTA), to focus on the effects of substance abuse on infants, children and families.

CARA requires a CARA Plan of Care to be developed when an infant has been identified by a health care provider as affected by substance abuse or as having withdrawal symptoms resulting from prenatal drug exposure or Fetal Alcohol Spectrum Disorder (FASD). **The purpose of the CARA Plan of Care is to identify the needs and services for the infant and family.**

In Nevada, health care providers who deliver or provide medical services to an infant in a medical facility and who identify the infant as being substance affected are responsible for ensuring a CARA Plan of Care is established for the infant before the infant is discharged from the medical facility pursuant to Nevada Administrative Code (NAC) 449. The goal of CARA is not to remove children or punish mothers for substance use, but to ensure child safety and address the health and substance use disorder treatment needs of both the affected infant and family or caregiver.

HOW IS NEVADA DEFINING A SUBSTANCE AFFECTED INFANT?

A parent will be offered a CARA Plan of Care when an infant, defined as a child less than one year of age, has been determined to be affected by a legal or illegal substance and/or whose mother has a substance use disorder. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), "substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school or home."

The consensus definition of a **"substance affected infant"** is an infant:

- Whose mother is receiving medication assisted treatment for a substance use disorder and/or is actively engaged in treatment for a substance use disorder; or
- Whose mother is misusing prescription drugs, or is using legal or illegal drugs, and meets criteria for a substance use disorder, but is not actively engaged in a treatment program; or
- Who is experiencing symptoms of withdrawal; or is likely to experience symptoms of withdrawal, based on chronic, habitual, regular or recurrent use of a controlled substance by the mother during pregnancy; or
- Who displays the effects of a Fetal Alcohol Spectrum Disorder (FASD).

WHO DECIDES IF AN INFANT IS AFFECTED?

A qualified health care provider will determine if an infant is substance affected and should use the definition above to guide them in making the determination.

DO HOSPITALS COMPLETE A CARA PLAN OF CARE WHEN ONLY THE MOTHER'S URINE DRUG SCREEN IS POSITIVE AND THE INFANT'S SCREEN IS NEGATIVE, WITH NO WITHDRAWAL SYMPTOMS OR SIGNS OF FASD?

A CARA Plan of Care is completed when the health care provider determines if the infant is substance affected as defined above.

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IF A POSITIVE DRUG TEST (MECONIUM, CORD BLOOD) IS RECEIVED AFTER THE MOTHER AND INFANT ARE DISCHARGED HOME, IS THE HOSPITAL STAFF RESPONSIBLE FOR CONTACTING THE FAMILY POST-DISCHARGE TO COMPLETE THE CARA PLAN OF CARE?

The hospital is responsible for completion of the CARA Plan of Care prior to discharge for all infants who are identified as substance affected. A positive toxicology result is not required to establish a CARA Plan of Care. The CARA Plan of Care's purpose is to provide appropriate services that aid the health, development and safety needs of the infant, the mother and family members; it is distinct from Child Protective Services (CPS) role.

WHAT ABOUT LEGAL SUBSTANCES (E. G, MARIJUANA, PRESCRIBED MEDICATION, ALCOHOL, ETC)?

Specific substances are not included or excluded in the definition of a substance affected infant. The definition should be used as guidance when determining if an infant is substance affected by any substance, whether legal or illegal. If an infant is determined to be substance affected by any substance, a CARA Plan is required to be offered.

WHAT IF THE MOTHER REFUSES THE CARA PLAN OF CARE?

The CARA Plan of Care is voluntary. If the mother refuses to participate in the development of a CARA Plan of Care, this should be noted on the form that is submitted to the Department of Public and Behavioral Health (DPBH). A notification to CPS will still need to be made as the infant was identified as substance affected.

WHEN DOES THE CARA PLAN OF CARE NEED TO BE SUBMITTED BY HOSPITAL STAFF?

The CARA Plan of Care needs to be completed prior to discharge and is required to be given to the caregiver prior to the infant being discharged from the hospital. The plan must then be submitted to DPBH upon discharge but not later than 24 hours following discharge.

DOES THE HOSPITAL UPLOAD POSITIVE TOXICOLOGY REPORTS ON THE MOTHER AND BABY?

No. Only the CARA Plan of Care form needs to be uploaded.

HOW DOES CARA IMPACT MY MANDATED REPORTING OBLIGATION?

When an infant is determined to be substance affected a notification to CPS is required. Nevada Revised Statute (NRS) 432B.220 outlines abuse or neglect reporting requirements for persons who deliver or provide medical services to newborn infants. The health care provider is responsible for both completion of the CARA Plan of Care and notification to CPS. A CARA Plan of Care is not the same as a notification to CPS nor does the completion of a CARA Plan of Care negate the mandated reporting obligation to CPS. A notification to CPS may also be made if a health care provider has any concerns about the family or safety of the infant, regardless if the infant was determined to be substance affected.

DO I NEED TO NOTIFY CPS BEFORE A BABY IS BORN?

No, CPS is notified after a child is born.

WILL CPS INVESTIGATE EVERY NOTIFICATION?

No. Prenatal substance exposure, in and of itself, does not constitute maltreatment. CPS will take into consideration many risk factors to determine if an assessment should be initiated. Risk factors may include, immediate safety concerns, mother's attentiveness to infant in the hospital setting, mental health history, mother's participation in substance use treatment, prior CPS reports on the family, ability to meet the infant's basic, medical and developmental needs, support system and willingness to engage in services that address the well-being and safety of the infant.

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DOES THE HOSPITAL PROVIDE CPS WITH THE CARA PLAN OF CARE?

CPS may request it directly from the health care provider pursuant to NRS 432B.230 , NRS 432B.270 and NAC 449.

DO I NEED TO CREATE AN INFANT PLAN OF CARE IF THE INFANT IS DISCHARGED DIRECTLY TO CPS CUSTODY?

Yes. Even when CPS assumes custody of the infant, there must be a CARA Plan of Care in place prior to the infant's discharge. The CARA Plan is provided to the family as well as CPS when there is an open case.

FOR MORE INFORMATION AND RESOURCES RELATED TO THE CARA PLAN OF CARE, PLEASE VISIT:

Department of Public and Behavioral Health – Perinatal Substance Use Treatment Network

A Public Health and Child Welfare Partnership to Support CARA Plan of Care

Updated June 03, 2020

Provider of Health Care Defined

NRS 629.031 "Provider of health care" defined. Except as otherwise provided by a specific statute:

1. "Provider of health care" means:

(a) A physician licensed pursuant to chapter 630, 630A or 633 of NRS;
(b) A physician assistant;
(c) A dentist;
(d) A licensed nurse;
(e) A person who holds a license as an attendant or who is certified as an emergency medical technician, advanced emergency medical technician or paramedic pursuant to chapter 450B of NRS;
(f) A dispensing optician;
(g) An optometrist;
(h) A speech-language pathologist;
(i) An audiologist;
(j) A practitioner of respiratory care;
(k) A licensed physical therapist;
(l) An occupational therapist;
(m) A podiatric physician;
(n) A licensed psychologist;
(o) A licensed marriage and family therapist;
(p) A licensed clinical professional counselor;
(q) A music therapist;
(r) A chiropractor;
(s) An athletic trainer;
(t) A perfusionist;
(u) A doctor of Oriental medicine in any form;
(v) A medical laboratory director or technician;
(w) A pharmacist;
(x) A licensed dietitian;
(y) An associate in social work, a social worker, an independent social worker or a clinical social worker licensed pursuant to chapter 641B of NRS;
(z) An alcohol and drug counselor or a problem gambling counselor who is certified pursuant to chapter 641C of NRS;
(aa) An alcohol and drug counselor or a clinical alcohol and drug counselor who is licensed pursuant to chapter 641C of NRS; or
(bb) A medical facility as the employer of any person specified in this subsection.

2. For the purposes of NRS 629.400 to 629.490, inclusive, the term includes:

(a) A person who holds a license or certificate issued pursuant to chapter 631 of NRS; and
(b) A person who holds a current license or certificate to practice his or her respective discipline pursuant to the applicable provisions of law of another state or territory of the United States.

(Added to NRS by 1977, 1313; A 1983, 1492; 1987, 2123; 1991, 1126; 1993, 2217; 1995, 1792; 1997, 679; 2003, 904; 2005, 69; 2007, 3041, 3050; 2009, 2942; 2011, 1092, 1510, 2678; 2013, 275, 2282; 2015, 878, 1554, 2292; 2017, 1578, 2756)

Excerpted from Nevada Revised Statutes Chapter 629 – Healing Arts Generally available at:
https://www.leg.state.nv.us/NRS/NRS-629.html

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Recommended Practices

Developed in consultation with the Nevada Perinatal Health Initiative CARA Workgroup and subject matter experts.

MATERNAL AND INFANT SCREENING, TESTING, & MONITORING

- Screening Brief Intervention and Referral to Treatment (SBIRT) in prenatal care is a recommended practice. Verbally engaging with mothers to understand their substance use is often more effective and expedient than waiting for toxicology results and can minimize the need for infant testing.
- Maternal and infant drug testing should be based on specific evidence-based criteria and medical indicators to avoid discriminatory testing. Open-ended criteria such as "clinical suspicion" are inadequate.[i]
- All mothers should be informed about proposed drug testing prospectively and the rationale for testing should be documented in the medical record. The discussion should include the nature and purpose of the test and how testing will guide care. If a woman refuses testing, document the refusal and do not test over her objection.[ii]
- When medically necessary for the proper and safe care of the infant, toxicology testing of the infant may be done without specific informed consent of the mother. This includes newborns who exhibit signs and symptoms of drug exposure and whose mothers have signs and symptoms of substance use.[iii]
- The mother-baby dyad should be maintained with minimal interruptions whenever possible as a first line of treatment.[iv]

IDENTIFICATION AND CARA PoC INITIATION

- A physician's order should not be required to develop a CARA PoC.
- Consideration of the populations defined in the flow chart above should drive decisions about when a CARA PoC is needed. Prenatal tobacco and marijuana use should not trigger a CARA PoC if there are no other health and safety concerns; however, education should be provided related to breastfeeding and risks related to exposure.
- Every effort should be made to engage a mother as a participant in developing a CARA PoC, even if the infant is going home with someone other than the mother. If mother does not consent to participate, this should be noted in the chart but should not be construed as risk for maltreatment if no other risk factors are present.

CARE COORDINATION, DCFS AND DBPH ROLES

- The primary purpose of the CARA PoC is to support the safety and health of the infant and the mother. The CARA PoC process should not increase the burden on DCFS or local child welfare agencies, since CARA PoC have a purpose that is distinct from CPS safety plans.
- Information sharing between the mother's and infant's care providers should support care coordination. For example, a hospital in Northern Nevada uses a roundtable approach to coordinate care among the hospital, CPS, pediatrician and other service providers.
- Parental consent to share select information with referral entities should be obtained to facilitate care coordination.

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[i] Stanton, E. (n.d.). NAS and the Law for the Non-Lawyer. Retrieved from: https://public.vtoxford.org/nas-legal-issues/.

[ii] Ibid.

[iii] Ohio Perinatal Quality Collaborative (2014). [PowerPoint Slides]. Retrieved from: https://opqc.net/patients-providers/provider-resources/opqc-webinar-series.

[iv] See the *Reference Guide on Labor and Delivery Complicated by Substance Use* available at https://sobermomshealthybabies.org/plan-of-safe-care/ for more information.