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Response to Pennsylvania's Request for Information
#OB 2015-1 – Pay for Success Initiative

Proposed Area for PSF Contracts in PA

The Design and Implementation of Innovative, Interdisciplinary, and Dual-Generation Plans of Safe Care for Infants

Background

It has been two decades since Pennsylvania Governor Robert Casey, a Democrat, put his signature on legislation creating Act 65 of 1993.[1] This legislation, initiated by the late Pennsylvania Senator Roxanne Jones, directed the Department of Health to fund "residential drug and alcohol treatment and related services for pregnant women, mothers and their dependent children and mothers who do not have custody of their children where there is a reasonable likelihood that the children will be returned to them if the mother participates satisfactorily in the treatment program." Jones fought for the legislation advocating, "Saving the family, that's the important thing….we're going to have a whole lost generation."[2]

As Jones' legislation was winding its way through the state legislature, Deb Beck, leader of the Drug and Alcohol Service Providers Organization of Pennsylvania, reinforced why the focus must be on both mother and baby. She helped policy makers to better understand that many pregnant and parenting moms battling the chronic health condition of addiction refuse treatment "fearing they will lose custody of their children."[3]

Pennsylvania has been ahead of the curve establishing a proven track record on early childhood care and education well before it became the vogue thing for states to do. It was Republican Governor Tom Ridge who launched PA's smart investment in evidence-based home visiting services through the Nurse-Family Partnership (NFP) program. Then Governor Ed Rendell, a Democrat, created a dual office for early childhood demonstrating

[1] Act of Jul. 8, 1993, P.L. 451, No. 65, retrieved at http://www.legis.state.pa.us/cfdocs/Legis/LI/uconsCheck.cfm?txtType=HTM&yr=1993&sessInd=0&smthLwInd=0&act=65
[2] Jones Is Doubtful On Bills To Aid Drug-using Mothers, By Russell E. Eshleman Jr., Inquirer Harrisburg Bureau, March 15, 1988. Retrieved at http://articles.philly.com/1988-03-15/news/26276111_1_alcohol-service-providers-organization-gaudenzia-drug-and-alcohol
[3] Ibid.

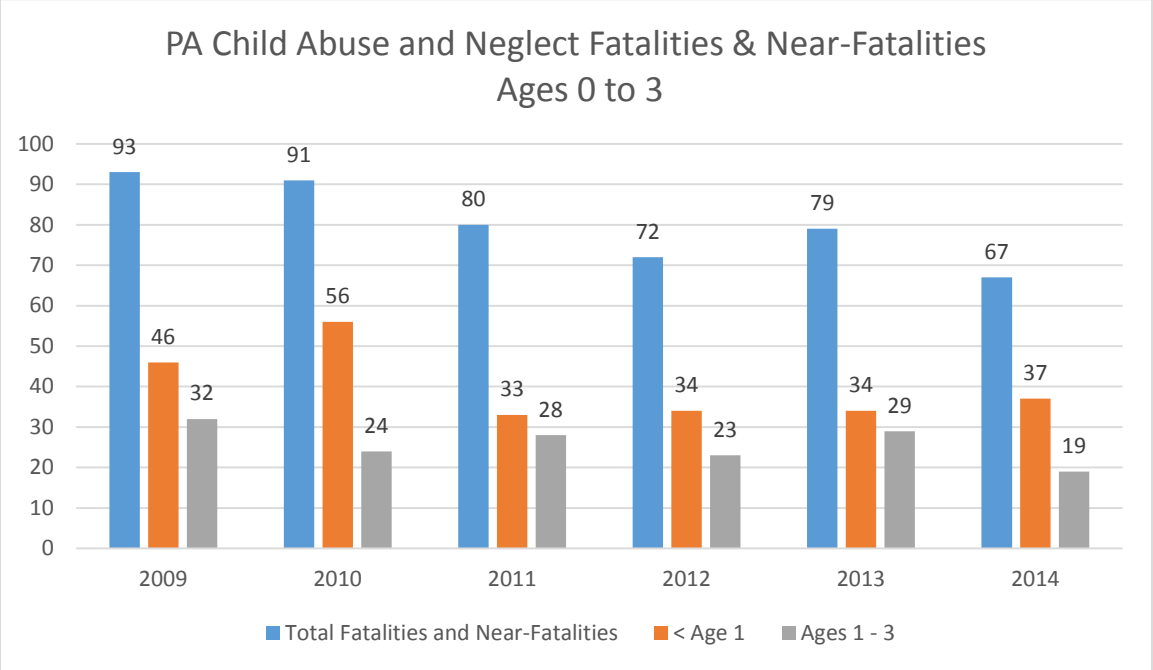
the Commonwealth would work to connect the dots between infant and child health, safety, well-being, permanency and early learning.

At Present Pennsylvania Governor Tom Wolf, a Democrat, is working to have Pennsylvania enter into Pay for Success (P4S) contracts targeted, in part, on maternal health, addiction services and early childhood care and education. Wolf's efforts complement a legislative P4S initiative introduced by Pennsylvania State Representative Todd Stephens, himself a Republican.[4]

Pennsylvania has consistently demonstrated that it is a state that can and will overcome partisan and philosophical divides to make smart investments in those critical first years of a child's life. These investments have also rightly sought to reflect that an infant's first protector and teacher is the parent.

Parental Substance Abuse and Pennsylvania Infants and Toddlers

Between January 1, 2009 and September 30, 2014, at least 240 Pennsylvania infants, who had not yet celebrated a first birthday, died or nearly died as a result of substantiated child abuse and neglect (CAN). The toll is also significant for children 1 to 3 years of age with 155 Pennsylvania toddlers dying from CAN in this same time period. In all, 80 percent of Pennsylvania children who died from CAN in this time period were 3 years of age or younger.[5]



[4] House Bill 1053 introduced April 27, 2015. Retrieved at http://www.legis.state.pa.us/cfdocs/billinfo/billinfo.cfm?syear=2015&sind=0&body=H&type=B&bn=1053

[5] Based on data included in Annual Child Abuse Reports issued by the Pennsylvania Department of Human Services. While the DHS report fatality and near-fatality data related to the year in which the report is substantiated as child abuse and neglect, this chart reflects data categorizing the fatalities and near-fatalities based on the year in which the incident occurred. PA's Annual Child Abuse Reports can be retrieved at http://www.dhs.state.pa.us/publications/childabusereports/index.htm

Parental substance abuse is woven into many of the life and death stories of these young children. Examples include:

- A Fayette County 3-month-old infant died March 6, 2014 "due to injuries sustained as a result of physical neglect." The Pennsylvania Department of Human Services (DHS) noted that the mother had "fresh track marks and has a long history of heroin addiction." The infant tested positive for Subutex at birth. According to DHS, "The family was not known to children and youth services."[6]

- A 3-month-old male Luzerne County infant died on February 14, 2014 as a result of physical injuries that were substantiated as child abuse. According to DHS, the county children and youth service (CYS) agency had been involved with the family since the infant's birth when "the mother tested positive for cocaine and marijuana" at the time of the infant's birth. A court order was in place, at the time of the infant's death, which "prevented the mother from having unsupervised contact with her children." DHS also notes that "Prior to the incident CYS had made referrals for services for the family for drug and alcohol, mental health, and early intervention."[7]

- A 6-month-old Cambria County infant nearly-died on February 9, 2014 "after sustaining burns to approximately 20 percent of her body." DHS reports: "The medical team noted the child had blistering on her legs, thighs, buttocks, and vaginal area and was transferred to a burn center. Upon examination at the burn center, the child was also noted to have scratches on her face and under both ears, bruising on her shoulders, bruising inside her right ear, and a contusion to her nose." The infant's family was involved with CYS in 2011 "due to allegations that the mother was using drugs and the family had inadequate shelter" the county closed the case "after it was determined that no safety threats were present." A subsequent referral was made to CYS "the day after the victim child's birth alleging concerns for drug and alcohol use by caregivers and concerns for the wellbeing of the victim child. Again, no safety threats were identified and it was determined that the children were receiving appropriate care."[8]

- A 10-month-old Indiana County infant died on May 19, 2013 "due to serious injuries sustained from physical abuse." The stepfather was caring for the victim child while the child's mother "was taken to the hospital to give birth." There was a safety plan in place for the victim child "due to a recent incident in which the child fell from a dresser and broke his femur while in the stepfather's care." The child's family had history with the CYS agency dating back to 2007 when the "mother lost custody of two of her children due to her drug use." DHS reports that "Both the mother and

[6] 3rd Quarter Fatality and Near-Fatality Report for 2014 produced by the Pennsylvania Department of Human Services. This report can be retrieved at http://www.dhs.state.pa.us/cs/groups/webcontent/documents/document/c_116043.pdf
[7] Ibid.
[8] Ibid.

stepfather received methadone treatment." The mother was able to regain custody of the victim child's older siblings in 2011 and CYS closed the case.[9]

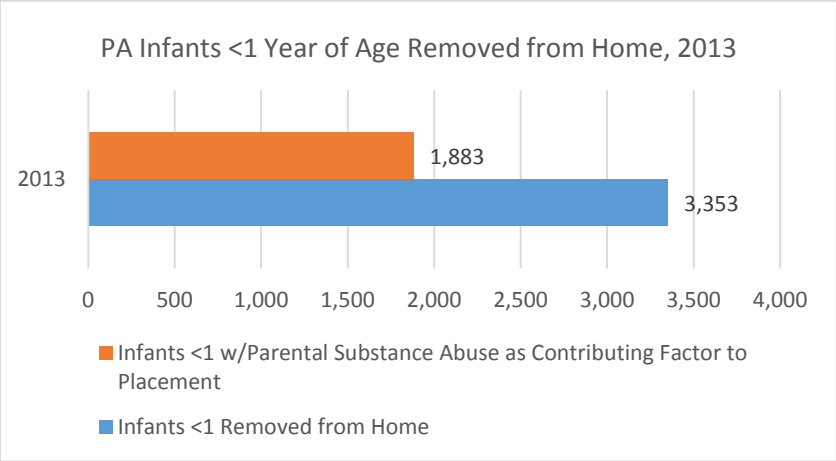
- A 1 year old child and her 3-year old brother nearly died in Blair County on June 20, 2013 "due to poisoning as a result of a lack of supervision." The child discovered "several psychiatric medications in a baby-wipe container in their bedroom and ingested the medications." The family was known to CYS beginning in 2010 "due to domestic violence, mother's alcohol use, inappropriate environmental conditions in the home and possible neglect" of the older child. They received services until they relocated to California in 2011. When they returned to Blair County in 2012 again they were the subject of a general protective services referral related to "unstable living conditions, inappropriate discipline, and suspected neglect." The county assisted the mother in applying for public benefits (e.g., food stamps and cash assistance) and closed the case in "early July 2012." A sixth GPS referral was received in December 2012 "when mother tested positive for marijuana at the birth of her youngest child and then left the hospital with the baby before meeting with social services." CYS assisted the mother in receiving home nursing care as well as Head Start for the older child and the referral was closed at the end of January 2013. A seventh and eighth GPS referral were received with the last arriving in March 2013 related to an allegation that the 3-year-old child "choked on a penny" and the mother and paramour did not intervene. They were referred to parenting education and counseling and the case was closed in April 2013.[10]

- A 2-month-old Philadelphia infant died on April 10, 2013 "as a result of blunt force trauma sustained during physical abuse." The child "had clavicle and rib fractures of varying ages, as well as internal injuries and bleeding." The family had a history with both Philadelphia and New Jersey child welfare authorities. In January 2013, there was a referral in New Jersey "after the mother tested positive for marijuana and amphetamines during her pregnancy." The infant was born with Neonatal Abstinence Syndrome (NAS) "and was prescribed Phenobarbital." The infant's drug screen, at birth, was also "positive for amphetamines and marijuana. DHS reports that "no services were planned for the family, as the mother was receiving substance abuse treatment." The infant was released to his parents' custody from the hospital on March 3, 2013. At the time of the infant's death, a new report to CYS was pending, as a result of a missed medical appointment for the infant.[11]

There are too many examples of other Pennsylvania infants and toddlers who died or nearly-died in similar circumstances. And yet it wouldn't matter if there were ten or one hundred more because Pennsylvania should commit itself to saying one, just one, child dying from child abuse and neglect is too many.

[9] 2013 Annual Child Abuse Report published by the Pennsylvania Department of Human Services.
[10] Ibid.
[11] Ibid.

Additional Pennsylvania infants and toddlers live in families where parental substance abuse are a factor, but they do not experience a fatal or near-fatal event. Still others do intersect in the formal child welfare system.



Consider that, according to data submitted by Pennsylvania to the Adoption and Foster Care Analysis and Reporting System (AFCARS), 3,353 infants under the age of one were removed from their home in 2013. Fifty-six percent (n=1,883) were recorded as having parental substance abuse as a contributing factor to the out-of-home placement.[12]

Leveraging State and Federal Statutes and Funding Streams to Support Mothers and Babies

Pennsylvania Act 4 of 2014 [13] requires that substance exposed infants be referred, by health care providers, to a county children and youth service (CYS) agency when the health care provider is has been involved in the delivery or care of a child under age one who is "born and affected by" any of the following:
"(1) Illegal substance abuse by the child's mother.
(2) Withdrawal symptoms resulting from prenatal drug exposure.
(3) A Fetal Alcohol Spectrum Disorder."

Act 4 outlined the duties then of the CYS agency including initiating a safety assessment or risk assessment or both for the child toward determining if the child is in need of child protective or general protective services. A representative of the CYS agency must also physically see the infant within 48 hours of the referral after having contacted the parents of the infant within 24 hours of the referral. Finally, state law directs the CYS agency to "provide or arrange reasonable services to ensure the child is provided with proper parental care, control and supervision."

This state law is responsive to a federal provision contained within the Child Abuse Prevention and Treatment Act (CAPTA). This CAPTA requirement, known as a Plan of Safe Care, was placed in federal statute by former Pennsylvania Congressman Jim Greenwood.

During a 2002 Congressional debate, then Congressman Greenwood demonstrated the struggle that still exists. "These babies are born in hospitals, they are frequently underweight, and they are frequently frail. Much money and effort is devoted to bringing them to health. These children do not meet any definition of child abuse, and probably they

[12] Children and Family Futures, Unpublished data, Analysis of the AFCARS dataset, 2013.
[13] Act of Jan. 22, 2014, P.L. 6, No. 4. Retrieved at http://www.legis.state.pa.us/cfdocs/legis/li/uconsCheck.cfm?yr=2014&sessInd=0&act=4

should not, but what happens is they are sent home from hospitals every day in this country and it is only a matter of time in so many instances until they return back to the hospital abused, bruised, beaten, and sometimes deceased. That is because we have not developed a system in this country to identify these children and intervene in their lives."[14]

In 2001 while Congress was considering enacting the plan of safe care provision, the Washington Post wrote a series (*'Protected' Children Died as Government Did Little*)[15] addressing the deaths of 11 "drug-exposed or medically frail newborns" that had died between 1993 and 2000. The Post traced how the infants "were released to parents whose troubles were well documented by hospitals and social workers." The series underscores the challenge in 2001 and still today in 2015: "The babies got lost in a system where no one assumes direct responsibility for them. Vague legal definitions and poor communication among caregivers hamstring those who would like to help."

To be in compliance with CAPTA and to receive CAPTA funding as well as federal Children's Justice Act (CJA) resources, states must provide assurances in the form of policies and procedures that will refer an infant affected by with prenatal drug- or alcohol exposure to child protective services (CPS) and "the development of a plan of safe care for the infant born and identified as being affected by illegal substance abuse or withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder." [16]

Pennsylvania receives approximately $2.7 million annually in CJA and a pool of CAPTA funding.

Even as state and federal law stipulate that these plan of safe care referrals are not child abuse reports, advocates for women, clinically appropriate treatment services, and children rightfully remain unsettled. Experience has demonstrated that too often systems respond punitively with a heavy hand seeing the mother as unfit further contributing to her existing struggle to recover from a chronic health condition – addiction. On the other hand, systems may downplay the risk for the infant, as well as the opportunity, that exists to actively and effectively engage the mother and her infant with support services that can keep both safe and healthy.

Beyond CAPTA and Pennsylvania's Act 4, other state and federal statutes and funding streams invite PA to intentionally plan, deliver research-informed and evidence-based services, and track outcomes across all child-serving systems.

Beyond the obvious opportunities for expanded access, innovation and parity that is built into the Affordable Care Act (ACA), Pennsylvania is among the states with a Title IV-E Child Welfare Demonstration Waiver[17] that is intended to rebalance child welfare funding and initiatives toward more fully supporting parents at the front-end versus putting money into the backend when safety threats have resulted in the child being placed in out-of-home care.

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[14] Congressional Record Volume 148, Number 46 (Tuesday, April 23, 2002). Retrieved at http://www.gpo.gov/fdsys/pkg/CREC-2002-04-23/html/CREC-2002-04-23-pt1-PgH1502-5.htm
[15] http://www.washingtonpost.com/wp-dyn/content/article/2007/06/29/AR2007062901407.html
[16] 42 U.S. Code § 5106a - Grants to States for child abuse or neglect prevention and treatment programs
[17] http://www.pacwrc.pitt.edu/ChildWelfareDemoProject.htm

Also, the federal Substance Abuse Prevention and Treatment Block Grant (SABG) designates substance-abusing pregnant women as the "number one priority population," and states must spend at least 20 percent of the funding on substance abuse prevention strategies.[18] Pennsylvania received approximately $58 million in SABG funds in federal fiscal year (FFY) 2014.[19]

Pennsylvania has been awarded $12.8 million in formula and competitive funds through the federal Maternal, Infant, Early Childhood Home Visiting (MIECHV) Program.[20] The state has previously received formula and competitive MIECHV funding, but little attention has been focused on the role of MIECHV and other evidence-based home visiting services as a component of intentional plans of safe care for infants.

PA's MIEHVC Needs Assessment submitted in December 2014 does address the implications of smoking and prenatal substance use on infants.[21] "Women with the most frequent rates of alcohol and drug use were the least likely to abstain from usage during pregnancy, thus further increasing the likelihood of poor birth outcomes in births to these mothers due to the frequency and quantity of usage. Drinking alcohol during pregnancy has not only been linked to poor birth outcomes such as preterm birth and low birth weights, but also to more lasting effects such as heart, brain, and other organ defects, vision or hearing problems, learning disabilities, speech and language delays, and behavioral problems."

Defining and Determining the Scope of the Challenge and Opportunity

Children and Family Futures (CCF), which provides technical assistance to Pennsylvania, projects that if plans of safe care were developed and implemented for American newborns with prenatal substance exposure, "as many as 500,000 infants would receive the care and services they need."[22] In their recent testimony before the National Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF), CCF highlighted that "Out of an estimated 500,000 babies born with prenatal substance exposure, only 22,000 pregnant women were admitted to publicly funded treatment in 2011." They also demonstrated the difficulty in predicting the overall number if the narrower criteria of "affected by illegal substance abuse or withdrawal symptoms or a fetal alcohol spectrum disorder" is applied.

Below is a chart illustrating (with limitations) the number of live births in PA where the infant was exposed to illegal drugs prenatally or FASD.

Pennsylvania live births exposed to illegal drugs or with FASD (2002-2014)[23]

[18] What is the Substance Abuse Prevention and Treatment Block Grant (SABG)?, Substance Abuse and Mental Health Services Administration (SAMHSA) retrieved at http://www.samhsa.gov/grants/block-grants/sabg

[19] Substance Abuse and Mental Health Services Administration, Justification of Estimates for Appropriations Committee, FY 2016, pp. 246–7.

[20] http://www.hrsa.gov/about/news/2015tables/homevisiting/

[21] Pennsylvania's Maternal, Infant and Early Childhood Home Visiting Needs Assessment, Revised December 2014.

[22] Testimony of Dr. Nancy K. Young, Executive Director, Children and Family Futures (CFF) presented to the National Commission to Eliminate Child Abuse and Neglect Fatalities on April 28, 2015.

[23] Prepared from data submitted by Pennsylvania hospitals to the Department of Health. Retrieved at http://www.portal.state.pa.us/portal/server.pt?open=514&objID=596752&mode=2

Year (July 1st – June 30th)[1]	Live births exposed to illegal drugs before birth	Live births with Fetal Alcohol Syndrome
2013-2014[2]	3,119	37
2012-2013	2,706	33
2011-2012	2,686	20
2010-2011	2,586	16
2009–2010	2,588	---
2008–2009	2,356	19
2007–2008	2,728	42
2006–2007	3,288	29
2005-2006	3,092	32
2004–2005	2,389	50
2003-2004	2,325	32
2002–2003	2,533	24

Pennsylvania Preemie Network, which is a program of the he Pennsylvania Chapter of the American Academy of Pediatrics,[24] demonstrated the extensive and interdisciplinary concern about Neonatal Abstinence Syndrome (NAS) and its impact on the care and management of the addicted mother and her baby. In spring 2014, more than 600 individuals attended a symposium sponsored by the Network with support from the March of Dimes and The AmeriHealth Caritas Family of Companies.

NAS refers to "a constellation of typical signs and symptoms of withdrawal that occurs in infants that have been exposed to and have developed dependence to certain illicit drugs or prescription medications during fetal life."[25] The constellation of signs and symptoms can be "behavioral and physiological." An infant with "clinical features of NAS" can experience "neurological excitability" (e.g. tremors, seizures, high-pitched crying, irritability) and/or gastrointestinal dysfunction (e.g., poor weight gain, nasal stuffiness, diarrhea, poor feeding).

[1]Chart compiled from annual hospital data specific to Infant/neonatal services and utilization. Information can be retrieved at http://www.portal.state.pa.us/portal/server.pt?open=514&objID=596752&mode=2

[2] Act 4 of 2014 was signed into law on January 22, 2014 with an effective date of 90 days. Act 4 required reporting of any child, up to age one, affected by "(1) Illegal substance abuse by the child's mother, (2) Withdrawal symptoms resulting from prenatal drug exposure, (3) A Fetal Alcohol Spectrum Disorder."

[24] http://www.paaap.org/programs/papn

[25] Neonatal Abstinence Syndrome Clinical Management Document, Gateway Health Plan, August 2010. Retrieved at https://www.gatewayhealthplan.com/sites/default/files/documents/PAMA_neonatal.pdf

Part of the symposium featured presentations from Jean Ko, PhD, an epidemiologist with the Centers for Disease Control and Prevention (CDC) and Elisabeth Johnson, PhD from the University of North Carolina at Chapel Hill who spoke about the mother-baby dyad.

Johnson framed her presentation by enlisting the words of Donald Woods Winnecott: "There is no such thing as a baby – meaning that if you set out to describe a baby, you will find you are describing a baby and someone. A baby cannot exist alone but is essentially part of a relationship."

Johnson stressed throughout her presentation that "parents need continued education and support at home" underscoring that the infants can often "be difficult to sooth, irritable, have difficulties transitioning and maintaining sleep." She also highlighted that parents often return to situations that are "highly stressful," including returning to a situation where intimate partner violence has and continues to exist.

A panel discussion was held to think through strategies that "will decrease variations in practice and foster safe discharge." Medical professionals from Magee Womens Hospital, Children's Hospital of Pittsburgh UPMC, Jefferson University Hospital, Penn State Children's Hospital, Janet Weis Children's Hospital at Geisinger Health System, Crozer-Chester Medical Center and UPMC Hamot Women's Hospital participated.

Both prior to and during the event, 10 hospitals shared data about trends and treatment options. Among the highlights:

- None engage in universal screening of mothers;
- Half offer a "special program for pregnant women who are using narcotics, methadone, subutex, illicit drugs;"
- 6 said they have a postpartum program for "drug using/abusing women."
- 4 responded that babies may be discharged on medication and all then said that there is "follow-up" when discharged home. Even when a child is discharged without medication, the majority (7) said that there is some follow up with the family;
- Half of the hospital keep an infant in the hospital for observation for five or more days if they have observed "signs and symptoms of NAS." Three keep the infant in the hospital for 3 or fewer days.[26]
- Five said that they refer "all NAS admissions" to children and youth services, while 4 said they make the referral on "selective NAS admissions." Among the considerations as to whether the referral is made: use of drugs other than methadone, non-prescription substance abuse, positive neonatal meconium toxicology screen.
- Thomas Jefferson University serve "more than 100 pregnant patients on methadone per year" with 40 pregnant patients treated at any given time.
- Magee Women's Hospital UPMC treated 200 infants for NAS in 2012, 52 infants were treated in a pediatric specialty hospital at the Children's Home of Pittsburgh – a program that serves as a "bridge to home."

[26] During Dr Ko's presentation she noted that the "onset of signs" of narcotic NAS may be delayed until 5 to 7 days.

- Penn State had 17 infants admitted with NAS, Geisinger Health System 23, Crozer Chester had 50 and UPMC Hamot Women's Hospital in the Erie region had 44 NAS admissions in 2013.

It is instructive to look at the data from Tennessee, which has implemented a mandatory public health surveillance reporting system related to infants born with a diagnosis of NAS. By making NAS a reportable disease, TN is gaining (close to real-time) data [27]about the incidence of NAS. The NAS data is tracked by communities permitting more targeted prevention and intervention strategies.

The TN data indicates that approximately 1,000 infants were born with NAS in both 2013 and 2014 and the about 60-70% of these NAS infants were born to mothers who are using "at least one substance prescribed by a health care provider (e.g., opioid pain relievers or maintenance medications for opioid dependency)."[28]

Also of interest is that in 2011, Tennessee's Medicaid program (TennCare) covered the birth and hospitalization costs of 528 infants born with NAS. Twenty-two percent (n=120) of the infants were in the "custody" of the TN Department of Children Services within a year of the infant's birth.[29]

PA data retrieved from the Office of Clinical Quality Improvement within the Office of Medical Assistance Programs (OMAP) reveals that in 2012, Medicaid covered the birth and hospitalization costs for 1,122 infants diagnosed with NAS at a total cost of approximately $17.3 million or average per child cost of $15,400.00.

Moving from Punitive to Preventative

In 2011, the federal Administration for Children and Families (ACF) within the Department of Health and Human Services (HHS) answered a question from a state about what entity is responsible for this plan of safe care. ACF noted that the federal statute did not specify whether it is the formal child welfare agency or another entity (e.g., hospital, community-based providers) that develop and implement this plan of safe care. ACF did emphasize, in its response, that this plan of safe care "should address the needs of the child as well as those of the parent(s), as appropriate, and assure that appropriate services are provided to ensure the infant's safety." [30]

This response demonstrates the challenge and opportunity in that Congress and subsequent federal guidance suggest there is no concrete directive. Instead there appears to be important flexibility in designing and implementing plan of safe cares beyond the formal child welfare system.

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[27] http://health.tn.gov/mch/nas/nas_summary_archive.shtml
[28] Mortality and Morbidity Weekly Report, 2015 Feb 13; 64(5):125-8.
[29] Ibid.
[30]Child Welfare Policy Manual produced by the Children's Bureau, an Office of the Administration for Children and Families. Question 2.1F.1 CAPTA, Assurances and Requirements, Infants Affected by Illegal Substance Abuse, Plan of Safe Care. Retrieved at http://www.acf.hhs.gov/cwpm/programs/cb/laws_policies/laws/cwpm/policy_dsp.jsp?citID=351

The Commonwealth should use this flexibility with PFS contracts to more intentionally prioritize the health, safety, well-being and permanency of infants across generations and a continuum of child-serving systems.

Through PFS contracts, Pennsylvania can aid local communities in designing and implementing intentional, measurable, and accountable public/private plans of safe care for infants exposed prenatally to or born affected by maternal drug use and Fetal Alcohol Syndrome Disorders (FASD).

Governor Tom Wolf should harness the urgency surrounding Pennsylvania's drug epidemic to cultivate the use of carefully crafted and measured interdisciplinary plans of safe care within a broader continuum of services aimed at reducing and responding to prenatal exposure. This would aid in achieving the objectives set forth by the PA Department of Drug and Alcohol Programs (DDAP) in its 2014-2015 plan for pregnant women and women with children including:

> Pregnant women and women with children: Increase access to care, to reduce the burden and entrance into the foster care system.

DDAP indicated they will work with the Office of Children, youth and Families (OCYF) within PA's DHS "to maximize women and children's drug and alcohol treatment program resources as a more effective alternative solution to breaking up families and placing children in foster care." Also set forth as a Pennsylvania goal to "decrease the risk of addicted babies or fetal alcohol affected babies by increasing use of women and children's drug and alcohol treatment programs for pregnant women in need of residential drug and alcohol treatment."

Pennsylvania has the opportunity to leverage PFS contracts to move beyond simple statutory compliance toward becoming a national leader prioritizing the health, safety, well-being and permanency of infants and toddlers.

Pennsylvania has a special opportunity to consider using plans of safe care as part of a broader continuum of services aimed at reducing and responding to prenatal exposure which significantly affects caseloads in many state and local CYS agencies.

A P4S or SIB model could effectively capitalize on private and/or philanthropic investments at the front-end to expand prevention services. Program outcomes would be calculated over time and the government pays back the principal and a rate of return depending on the level of performance achieved. Ongoing statewide technical assistance efforts supported by the National Center on Substance Abuse and Child Welfare are also focusing on prenatal substance exposure as well as the likelihood that children who have been prenatally exposed will eventually enter the child welfare system and other caseloads.

Implementing a P4S option and expanding the focus on plans of safe care would serve as the first building block in a continuum of care for this population of children who often become students and adults facing significant obstacles to their lifelong economic, social, and cognitive stability. Where needed, such plans could dovetail with the individual family

support plans that are required for all children accepted by early intervention services under Part C of the Individuals with Disabilities Education Act (IDEA).

Criteria for Plan of Safe Care PFS Contracts

The following criteria warrants consideration as PSF contracts for plans of safe care are envisioned:

1. Provide services within the five-stage framework set forth in the 2009 SAMHSA report on substance-exposed infants, as endorsed by the 2012 ONDCP Strategy document.[iii] While the primary focus is screening during pregnancy and at birth, all five stages need to be part of a comprehensive reform: pre-pregnancy public education, prenatal screening, screening at birth, screening and assessment during infant and toddler stages (0-3 years) and support for pre-school developmental care and education.
2. Develop and implement from an interdisciplinary and cross-systems understanding of the complex, yet inter-related, needs of young children and their parents that extend well beyond the formal child welfare system. This more diverse child protection framing should invite involvement and resources of early childhood, maternal and child health, home visiting, and substance abuse and mental health treatment agencies.
3. Demonstrate vision and capacity to design, implement, and measure plans of safe care that are both child- and parent-focused, recognizing that parents' ability to do their part in carrying out such a plan will be as equally important as any role for public or private services.
4. Require universal prenatal screening for substance use using a validated and reliable tool should be implemented 30 days prior to birth and at birth. A positive toxicological screen 30 days prior to birth or at birth, or enrollment of an infant under the age of one year in the substantiated child abuse and neglect caseload should result in a plan of safe care.
5. Access to continuous screening and assessment, including family risk and safety assessments as well as family strengths assessments to ensure services are coordinated to meet the family's needs.
6. Availability of plans of safe care online with the appropriate privacy safeguards, and an interagency memoranda of agreement should include provisions about sharing data regarding the strengths and needs of this population of children and families.
7. Identify specific details about services needed as well as the availability of those services. These details should be based upon an updated inventory of services within the community including the eligibility criteria to receive those services.
8. Demonstrate understanding of and a plan to connect infants and families to existing publicly funded services (e.g., evidence-based home visiting).

Plans of Safe Care as the Basis for Social Investments

Including fully implemented plans of safe care, as outlined above, in PFS financing enables communities to better achieve positive and concrete measureable outcomes, thus allowing the pay back of advanced front-end funding to service delivery and avoiding future costs to

public systems. This social financing pay back should include provisions that require the following:

1. Tracking children and parents receiving specific services for longer periods of time, from birth to school enrollment.
2. Decisions about whether time frames of 2-3 years, or time frames as long as 5-10 years, should be used as the basis with appropriate involvement of the full range of state and local agencies collecting the data needed to track child and family benchmarks. At a minimum, this would require maternal and child health and early childhood agencies to join with child welfare and substance abuse and mental health treatment agencies in monitoring an agreed-upon set of outcomes and indicators.
3. Partner and stakeholder agreement on the outcomes to be measured, identifying the agencies and staff responsible for collecting outcome measures, and identifying where the added resources for this monitoring and evaluation will be based. The designation of a lead or convener agency will also be essential.
4. Decisions about the outcomes resulting from fully implemented plans of safe care and utilizing these outcomes to develop a continuum of care for children who have been prenatally substance exposed, including:
    a. Preventing children from entering or returning to the child welfare caseload (against baselines for such children if they are available)
    b. Reducing the entry of children in special education caseloads who have been prenatally exposed
    c. Ensuring children who have been prenatally substance exposed enter kindergarten ready to perform at baseline levels, using school readiness measures already in place in the state, including enrollment in quality early childhood education programs
    d. Ensuring this population of children have a medical home, have health insurance coverage, and are current with necessary checkups and immunizations (under Early and Periodic Screening, Diagnostic, and Treatment where relevant)
    e. Ensuring that parents who need substance abuse treatment enroll in either short- or long-term care or services and successfully complete treatment
    f. Tracking costs of the continuum of care involved with plans of safe care, including cost avoidance, using a compilation of available cost information about Newborn Intensive Care Unit care for prenatally exposed infants, Medicaid costs incurred for such infants, special education and other projected costs based on the cost studies that have been done for the past twenty years in the US and Canada. This cost data is critical to explaining the need for and the potential payoffs from a social financing approach to plans of safe care.[iii]

[i] Substance-Exposed Infants: State Responses to the Problem. Retrieved from https://www.ncsacw.samhsa.gov/files/Substance-Exposed-Infants.pdf

[ii] National Drug Control Strategy 2012. Retrieved from https://www.whitehouse.gov/sites/default/files/ondcp/2012_ndcs.pdf

[iii] A compilation of these estimates and cost data is being prepared by CFF.