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# A QUALITY IMPROVEMENT STUDY OF THE implimentation of the VERMONT NEWBORN PLAN OF SAFE CARE AMONG NURSING STAFF AT VERMONT HOSPITALS

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RUNNING HEAD: VERMONT NEWBORN PLAN OF SAFE CARE

A QUALITY IMPROVEMENT STUDY OF THE IMPLEMENTATION OF THE VERMONT  
NEWBORN PLAN OF SAFE CARE AMONG NURSING STAFF AT VERMONT HOSPITALS

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May 2019

# VERMONT NEWBORN PLAN OF SAFE CARE

## ABSTRACT

**PURPOSE:** The purpose of this quality improvement needs assessment was to evaluate the implementation of the Vermont Newborn Plan of Safe Care (VNPSC) since its introduction 17 months ago. These plans were created in response to federal mandates to create plans that address the needs of infants affected by substance exposure during pregnancy. A secondary goal of the study was to identify areas for improvement of its implementation by nursing staff.

**METHODS:** This study was conducted using a mixed-methods, cross sectional survey design. Data collection took place over a 3-week period and included 12 Vermont hospitals. Analysis was completed using SPSS, Excel, and Lime Survey software packages.

**RESULTS:** 10 out of 12 hospitals participated in the survey and 62% of participants were registered nurses who do not hold a management position. A majority of participants responded that they believed more training would be helpful, and that they experienced confusion and difficulty when completing the plan. Respondents also found it to be too time consuming to complete the plan when a social worker or case manager was not available to help.

**CONCLUSIONS:** This study indicates that implementation of the VNPSC would benefit from a standardized training procedure for all professionals involved in creating these plans. It also indicates that the majority of nurses who write plans for safe care would benefit from being able to consult with someone who is fully trained on the process. Future research on the effectiveness of VNPSC implementation should include a broader variety of healthcare professionals in the sample, with a focus on social workers and case managers, in addition to nursing staff.

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## List of Acronyms

<b>ACRONYM</b>	<b>DEFINITION</b>
<b>NAS</b>	Neonatal Abstinence Syndrome
<b>MAT</b>	Medication Assisted Treatment
<b>VCHIP</b>	Vermont Child Health Improvement Program
<b>ICON</b>	Improving Care of Opioid-exposed Newborns
<b>DCF</b>	Department for Children and Families
<b>VNPSC</b>	Vermont Newborn Plan of Safe Care
<b>SBIRT</b>	Screening, Brief Intervention and Referral to Treatment
<b>CARA</b>	Comprehensive Addiction and Recovery Act
<b>CAPTA</b>	Child Abuse Prevention and Treatment Act
<b>OAT</b>	Opioid Agonist Therapy
<b>NICU</b>	Neonatal Intensive Care Unit
<b>OB</b>	Obstetrician

Chapter 1. Introduction

Background

As the national opioid crisis continues to escalate, so does the number of opioid dependent mothers. The majority (55-94%) of babies born to these mothers exhibit signs and symptoms of neonatal abstinence syndrome (NAS), which occurs when they are exposed to drugs *in utero* and experience withdrawal symptoms after birth [1]. In an effort to combat this issue, Vermont has vastly improved access to medication assisted treatment (MAT) programs for opioid dependence. There is currently no waitlist to get into a treatment program, which is a huge improvement since January 2014, when there were 513 people waitlisted for opioid use disorder treatment [2]. If a woman in a treatment program becomes pregnant, she is encouraged to continue her participation in treatment. However, the infant will be exposed to the opioid substitutes during the pregnancy and in some cases will experience withdrawal symptoms after birth [1].

The Vermont Child Health Improvement Program (VCHIP) has been an active participant in combatting the opioid crisis by helping mothers find and maintain treatment so that they can receive the best treatment and support in order to succeed in being a mother to their child and to ultimately keep their children in their care. As part of these efforts, the VCHIP program, Improving Care of Opioid-exposed Newborns (ICON), created a plan for clinical management of mothers who give birth to drug-dependent newborns. The VCHIP/ICON team also developed the Vermont Newborn Plan of Safe Care (VNPSC), in collaboration with Vermont Department for Children and Families (DCF), which was a requirement of each state after the federal government signed into law the Comprehensive Addiction and Recovery Act

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(CARA), an amendment of the the Child Abuse Prevention and Treatment Act (CAPTA). (See Description of the Vermont Newborn Plan of Safe Care on page 5)

Some opioid-addicted mothers are already in treatment programs, and some are not. This distinction is very important; it determines what kind of report will be sent to DCF. A mother using illicit drugs will be reported to DCF, which results in a DCF case being opened for the mother-baby couplet, and transfers responsibility for following them to DCF. In contrast, if the mother is considered stable, an anonymous notice is sent to DCF alerting them to the the birth of a substance-exposed newborn, but a formal DCF case is not opened. Inclusion criteria for these anonymous DCF notices are, 1) enrollment in MAT, which consists of using opioid substitutes such as methadone, buprenorphine, or vivitrol, and 2) receiving counseling to assist mothers in remaining compliant and successful in their recovery efforts, or 3) The use of only prescribed opioid medications, benzodiazepines, or marijuana during pregnancy. These mothers also provide information for the VNPSC that is completed before discharge from the hospital after delivery and is sent to the infant's primary care office. Completed VNPSCs include general information about care of the infant, as well as referrals to other programs and agencies that would benefit the family.

### Evaluation of Current Situation

The VNPSC was created in November, 2017 and has been successfully implemented in hospitals across Vermont. Evaluation on where the plan is completed and by whom have not yet been developed. In addition, data on how many patients have a VNPSC and how healthcare professionals feel about the procedure and efficacy of the VNPSC have not been made available. Finally, training on the plan has not been formalized. This quality improvement study consisted of a needs assessment survey that was sent to nurses at twelve Vermont hospitals to gather



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information about the implementation of VNPSC since it was mandated. This needs assessment will serve as a preliminary study for more specific future research.

### Outline of Methodology

This survey was created in collaboration with VCHIP and ICON, as well as nurse managers from several different hospitals. We pilot-tested a paper version of the survey with nurse managers at a VCHIP-led meeting. We asked them to complete the survey and provide feedback about the questions. They offered suggestions for wording clarification, answer options, and additional questions to include. Then, it was revised and edited with help from other VCHIP personnel and additional feedback from ICON staff. When the survey draft was complete, Lime Survey software was used to create a final online data-collection form. The electronic survey was distributed to 12 hospitals around Vermont by email to nurse managers who were asked to forward the email to the appropriate nursing staff. Biweekly reminders were sent out via email for the three-week duration of the study (October 5, 2018- October 26, 2018).

The data were grouped into five categories, and responses were analyzed using SPSS and Excel. Quantitative data was analyzed using percentages, while the responses to free text questions were analyzed both quantitatively and qualitatively using the common themes that became apparent in the responses. Questions that did not have enough data to analyze were excluded. The data was shared with both ICON and VCHIP to help determine strengths of the VNPSC, areas for improvement, and indications for further research.

Chapter 2: Literature Review

Background

An opioid crisis has affected the entire nation, with 53,000 opioid-related deaths reported in the United States in 2016 [3]. In Vermont, opioid overdose deaths doubled between 2012 and 2013, while property crimes and home invasions also increased [4]. In January 2014, Governor Peter Shumlin declared that Vermont was experiencing an opioid addiction crisis in his State of the State Address [4]. The increase in opioid abuse has been attributed to two factors: prescription opioids have become harder to access, and the price of heroin has drastically declined [4].

As of 2015, Vermont began to implement measures to try to control the epidemic. Two Vermont statutes were passed; one that created a group of empaneled professionals who can share patient information that impacts child safety and second instates a 30-day child safety follow up after infant delivery by opioid-dependent women who were not in a treatment program during their pregnancy [5]. The Vermont Department of Health also created training programs for clinicians on best-practice early intervention strategies for patients reporting opioid abuse through the Screening, Brief Intervention and Referral to Treatment (SBIRT) model [5]. The Vermont Board of Medical Practice responded to the opioid crisis by issuing new regulations to prevent the overprescribing of opioid pain medications [4].

In 2016, in response to the national opioid epidemic and increase in exposure of infants to opioids *in utero*, the federal government signed the CARA amendment to CAPTA. This new legislation has four parts. 1) Each state had to develop policies and procedures to address the needs of infants affected by substance exposure during pregnancy (known maternal use or withdrawal signs after birth). 2) Healthcare providers caring for these infants are required to notify the applicable state child protection agency. 3) That agency must report data annually to

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the Children's Bureau. 4) A Plan of Safe Care must now be developed to address the needs of the infant and family after birth. Each state was tasked with developing infrastructure to meet these requirements.

### Description of the Vermont Newborn Plan of Safe Care

This study focuses on the VNPSC, which was collaboratively developed by DCF, VCHIP, and ICON project in response to the federal CARA/CAPTA requirements. The VNPSC aims to identify existing community supports and any new referrals for opioid-dependent mothers prior to hospital discharge. It both facilitates communication to the infant's primary care provider and acts as a resource for families. In addition, the VNPSC details the multidisciplinary treatment options that have been discussed and/or referred for the mother, including a plan for entering treatment, if not currently in a program, or continued care for those that are in treatment. The overall goal is to facilitate continuity and communication between hospital staff, primary care providers, and community supports, so that mothers and newborns receive the best possible treatment and support for success as new families.

### Opioid Abuse in Pregnancy

Although the opioid crisis affects all areas of the general population, a group of specific interest is opioid-dependent mothers and their newborns [6]. Of infants exposed to opioids *in utero*, 55-94% will develop signs of NAS [1]. Symptoms vary between individuals, and are affected by the substance(s) to which the infant is exposed, the amount of the substance(s) used, the rate of maternal and infant metabolism [1], neonatal health, and environmental factors [7]. The symptoms of NAS range in severity from minor to significant, and include central and autonomic nervous system irritability, respiratory changes, and gastrointestinal dysfunction [1]. Common

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symptoms include increased muscle tone, tremors, irritability, vital sign changes, feeding problems, diarrhea, and rarely, seizures [7]. Aside from NAS in the newborn, opioid use during pregnancy can lead to additional negative outcomes for both mother and baby, such as birth defects and altered brain development [8], premature rupture of membranes and preterm labor [9], sporadic prenatal care that can result in increased neonatal morbidity and increased length of hospital stay [6], maternal infection, and lack of a safe or healthy living environment [10]. Maternal opioid-dependency also puts a significant financial burden on the healthcare system to care for newborns affected by NAS, as seen by the average three-fold increase in expenditure for infants affected by NAS compared to their non-affected counterparts [5, 11].

### Comorbidity with Substance Abuse

Women with opioid-use or dependency during pregnancy are often using additional substances such as alcohol and nicotine [10]. Comorbidities associated with substance abuse during pregnancy include psychiatric illness [12-14], particularly mood or anxiety disorders [13, 14], and an unsafe living environment and/or partner [15].

These problems affect not only the mother, but also her newborn. Women who experience unhappiness within their relationship, or feel a lack of social support are at higher risk for “postpartum blues” [16]. Postpartum blues, in turn, put a woman at higher risk for maternal depression [17]. This disorder negatively impacts the child as shown by an increase in behavioral and emotional disturbances, as well as non-typical frontal brain activity in the child [18].

Adequate treatment of substance abuse in pregnancy may help prevent or mitigate the associated problems that can result in a negative impact on the children of these mothers. The VNPSC hopes to prevent these negative consequences by supporting the mother in all areas of her health and wellbeing on her path to recovery.

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### Opioid Abuse Treatment During Pregnancy

The literature has shown the best way to treat opioid-dependent mothers during their pregnancy and after delivery is to offer them medication-assisted treatment (MAT) rather than an acute treatment plan such as detoxification or promoting abstinence [5, 10, 15]. MAT usually includes opioid agonist therapy (OAT) such as methadone or buprenorphine [5]. By providing mothers with an alternative to opioids, they can maintain a more stable physiology than they would by withdrawing multiple times throughout pregnancy while attempting to achieve complete abstinence [5]. This stability is associated with fewer preterm births and underweight newborns, and better prenatal care [15] [5].

In contrast, treatment of drug dependence by acute detoxification causes both emotional and physiological stress for the mother and fetus [6], and usually results in multiple relapses over the course of the pregnancy [15]. It can also deter a mother who might want to seek treatment but does not feel willing or capable of achieving abstinence [10] [15]. The fetus often undergoes withdrawal along with his or her mother, which can cause stress-induced intrauterine death or meconium aspiration syndrome [6]. It is important to note that OAT should not be reduced in an attempt to wean the mother off before week 12 due to the risk of spontaneous abortion [6], or after week 32 due to the risk of preterm labor [10]. In most cases, pregnant women require increased doses of opioid agonist near the end of pregnancy to compensate for increased metabolism [10].

Aside from physiological stability and cessation of illicit opioids, other advantages of MAT during pregnancy include: more participation by the mother in prenatal care, earlier discharge of the newborn after birth, the creation of a social environment that is healthier and

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more stable for both mother and newborn, and the monitoring of mother and baby throughout her treatment [6].

### Multi-Disciplinary Treatment During Pregnancy

Although MAT is shown to be the best way to treat substance abuse, it is important to realize that factors underlying this disorder must also be treated to achieve lasting recovery [5, 15]. The use of a multi-disciplinary approach that addresses all factors of substance abuse and dependence is crucial for long term recovery and stabilization.

Providing mothers with both treatment and resources that increase the perception of social support helps to counteract feelings of social stigma, anxiety, and depression related to their substance abuse and leads to more successful recovery [19]. Proctor, Wainwright, and Herschman (2017) conducted a systematic examination of a multi-component continuing care plan and found that the patients with a higher level of adherence to treatment were significantly more successful in abstaining from drugs and reported a higher quality of life than the less adherent group [20].

A more focused study by Newman et al. (2015) showed that multi-disciplinary treatment not only increases likelihood of substance abuse recovery for mothers, but also benefits their newborn children [21]. By incorporating Neonatal Intensive Care Unit (NICU) nurses, pediatricians, community-based primary care workers, social workers, and nurse practitioners into the care of an opioid affected mother-baby couplet, they were able to successfully provide rooming-in care to the infant experiencing NAS [21]. This rooming-in program allows newborns to be in the same room as their families for the duration of their hospital stay, including during routine newborn procedures such as vaccination, rather than in the nursery. Rooming-in requires a highly multi-disciplinary approach, and showed itself to be greatly beneficial to both mother

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and baby by significantly shortening newborn length of stay in the hospital (7.9 days vs. 24.8 days), decreasing the need for oral morphine therapy (3 of 21 newborns vs. 20 of 24 newborns), and increasing breastfeeding duration and infant-mother bonding when compared to the couplets whose care took place only in the NICU [21]. This program is very extensive and may not be possible in every healthcare setting due to barriers such as insufficient staffing, financial burden, or lack of familial interest. However, encouraging mother-infant bonding through breastfeeding alone has a very positive effect on the NAS infant; which can be accomplished with as little as a lactation consult before the mother is discharged [22].

There are many ways to approach a multi-disciplinary care plan, but regardless of how it is accomplished, one of the first steps is to identify the problems and provide a platform for communication between providers which will result in more continuity of care. The VNPSC could be that platform, and this study will explore quality improvement opportunities for the document and its implementation to help providers best care for their patients.

## Chapter 3: Methods

### Purpose

The purpose of this quality improvement study was to complete a needs assessment of the implementation of the VNPSC. This assessment gathered general information about the status and implementation of the VNPSC since it was mandated in order to determine strengths and areas of improvement, and serve as a building block for more specific quality improvement efforts in the future.

### Study Design

This study utilized a cross-sectional survey design to conduct a needs assessment of the implementation of the VNPSC. In this type of design, data is collected at one point in time [23]. The survey was completed by registered nurses in Vermont hospitals who care for women and their babies in the postpartum period.

### Participants

Participants for this survey were nurses working at the twelve hospitals in Vermont who offer birthing services. VCHIP provided email contacts for the nurse managers at each hospital, which included nurses from small rural hospitals as well as larger more urban facilities. We included all hospitals in order to obtain data that would provide a better representation of statewide data.

Professional nurses were chosen as the sample because of their close contact with patients. They have a unique perspective because they care for both mother and baby, usually for an entire shift. Because of this long duration of time spent with the patient, and the fact that nurses a very trusted group of professionals, they tend to form close relationships with patients



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[24]. We also realized that although the VNPSC may be completed more commonly by social workers in larger hospitals, smaller hospitals do not always employ these professionals.

However, nurses are employed at every hospital and are likely to at least come into minimal contact with the VNPSC. Pediatricians would be another interesting sample for future research, but because of the recent implementation of the document and uncertainty if they were successfully receiving the completed plans, we decided that hospital-based nurses would be the most likely to have concrete information about the new document.

### Instrument

The instrument was created to gather general data about the implementation of the VNPSC from the perspective of nurses. The tool was not reviewed by the University of Vermont Institutional Review Board (IRB) because this survey is part of VCHIP's quality improvement work and does not require review. (These guidelines can be found in Appendix A).

Survey questions were formulated through collaboration with both VCHIP and ICON, as well as nurse managers who completed a pilot survey. The survey contained unique questions that gathered data about demographic information, training procedures, implementation, time, and sharing of the VNPSC with the infant's primary care provider. These questions included nine multiple choice questions, three free text, and 13 questions using a 5-point Likert scale with the options of "strongly disagree, somewhat disagree, neither agree nor disagree, somewhat agree, strongly agree". The survey utilized branching logic for some questions in order to gather more information if the answer provided was less than or equal to "somewhat disagree". (See Appendix B for a full copy of the survey). Face validity was established by a review from experts at VCHIP, ICON, and nurse managers who completed a pilot survey. Upon review, we

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added more questions pertaining to implementation and training, and made edits to the questions and answers for clarity.

The final version of the survey was created using the Lime Survey online survey software and was intended to take twenty minutes or less, and could be closed and resumed later. For the purpose of time, we only included three fill in the blank questions. In order to encourage sharing of information, the participant responses were anonymous. Although this limited our ability to track respondents, we accepted this limitation because this was a quality improvement study and not a research study.

The survey provided quantitative and qualitative data regarding the usage of the VNPSC, nurses' opinions on the procedure, understanding and comfort with the VNPSC, and efficacy of the VNPSC.

### Procedure

All hospitals in Vermont that provide childbirth services were included in the recruitment process. Surveys were distributed via email to labor and delivery and postpartum nurse managers or their counterparts, who were asked to forward the survey to their staff nurses. Some of the smaller facilities do not have designated birthing centers, in which case the surveys were distributed to whomever fills the role of postpartum nurse. These contacts were provided by VCHIP staff. Facilities included were Brattleboro Memorial Hospital, Central Vermont Medical Center, Gifford Medical Center, North Country Hospital, Northwestern Medical Center, Northern Vermont Regional Hospital, Porter Medical Center, Rutland Regional Medical Center, Springfield Hospital, Southwestern Vermont Medical Center, University of Vermont Medical Center, and Copley Hospital.

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The original email included general information about the quality improvement project and the goals of the survey, and email reminders that included the link to the survey were sent out on Monday and Friday of each week that the survey was active (October 5, 2018-October 26, 2018). We chose not to send out the survey until October because this would give hospitals almost a year to integrate the VNPSC into their policy, and give nursing staff time to become familiar with the document and form opinions about it. Part way through this period we saw that many responses were not complete, so we began emphasizing in the reminder emails that the survey was anonymous and could be stopped and resumed at any time. By the end of the collection period we had 20 complete and 17 incomplete responses, for a total of 37. Because this study was a needs assessment, and it was a cross-sectional design, we decided to manually analyze all questions in the survey that had at least nine responses, including responses from partially completed surveys.

### Analysis

Quantitative data was reported as percentages, and data from free text responses was analyzed using thematic analysis. Responses were stored in Lime Survey and then exported into SPSS. We grouped all of the questions in the survey, except for the free text questions, into five categories which included; “utilization”; “demographics”; “education, training, implementation”; “time”; and “ease of sharing with primary care provider”. From there, we used SPSS to analyze responses and copied these tables into Excel for formatting and to make them more visually appealing. To find themes within the free text question responses, we looked for common words, phrases, and ideas that occurred throughout the participant’s responses.

Chapter 4: Results

The results of this needs assessment showed that many registered nurses do not have experience completing a VNPSC and feel that more training would be helpful. Importantly, the study also found that most families who should have a VNPSC in place, do have one, according to labor and delivery and postpartum nurses.

Demographic Data

Demographic information showed that 62% of participants were registered nurses, and not directors, clinical managers, or nurse managers (n=34) (Figure 1), and 92% (n=25) of the hospitals deliver between 11 and 30 total babies per month on average (Figure 2).

Of the 12 hospitals included in the survey, 10 of them had at least one participant. There were 17 partial responses and 20 complete responses for a total of 37 responses.

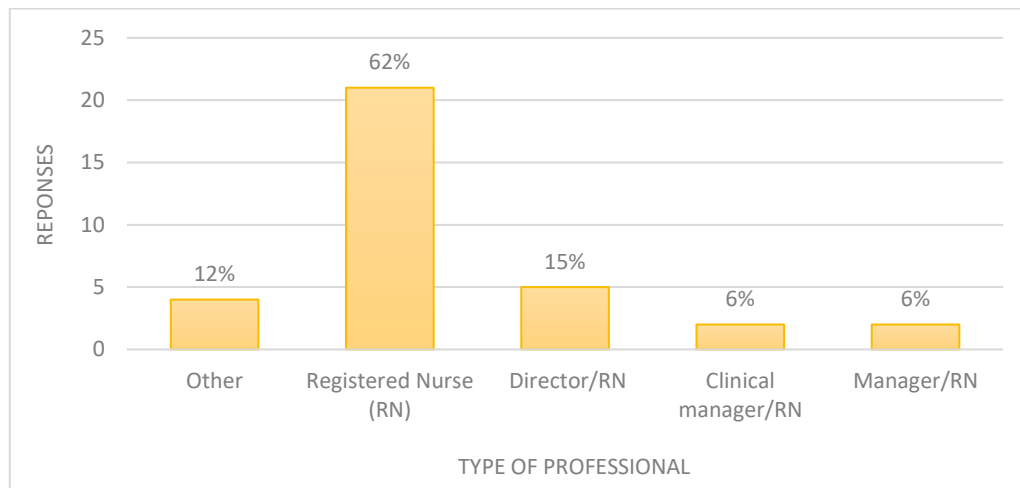


Figure 1. The healthcare profession of participants (n=34).

Free text specification for “other” response was not an option for this question.

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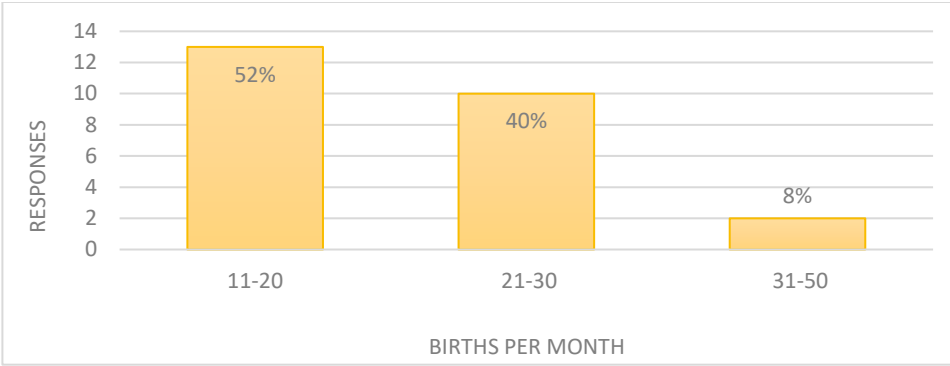


Figure 2. Average number of babies delivered per month at participant's healthcare facility (n=25)

### Utilization

The large majority (88%, n=24) of participants were not aware of any families who should have filled out a VNPSC but did not. Most participants (52%, n=23) responded that the average number of VNPSC completed per month in their healthcare facility is between 1-2 (Figure 3).

The VNPSC is most often started in the prenatal healthcare office and finished in the hospital after delivery (50%, n=30), or completed entirely in the hospital after delivery (37%) (Figure 4).

The document is most often completed by social workers (33%, n=27) (Figure 5).

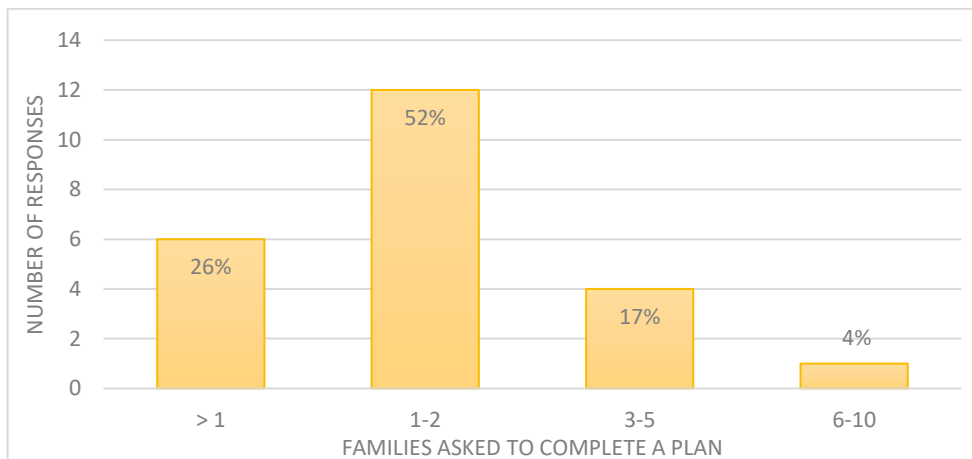


Figure 3. Average number of VNPSC completed at healthcare facility per month (n=23).

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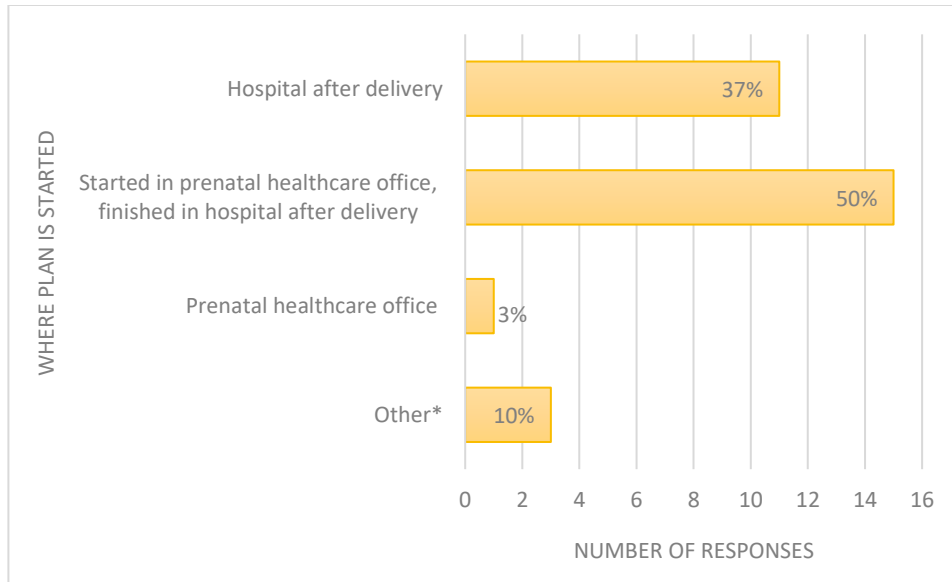


Figure 4. Location at which the VNPSC is most often completed (n=30).

“Other” responses included: “started prenatally, updated in hospital after delivery”; “have not seen one personally yet but have been told OB office and then finished in hospital as needed”.

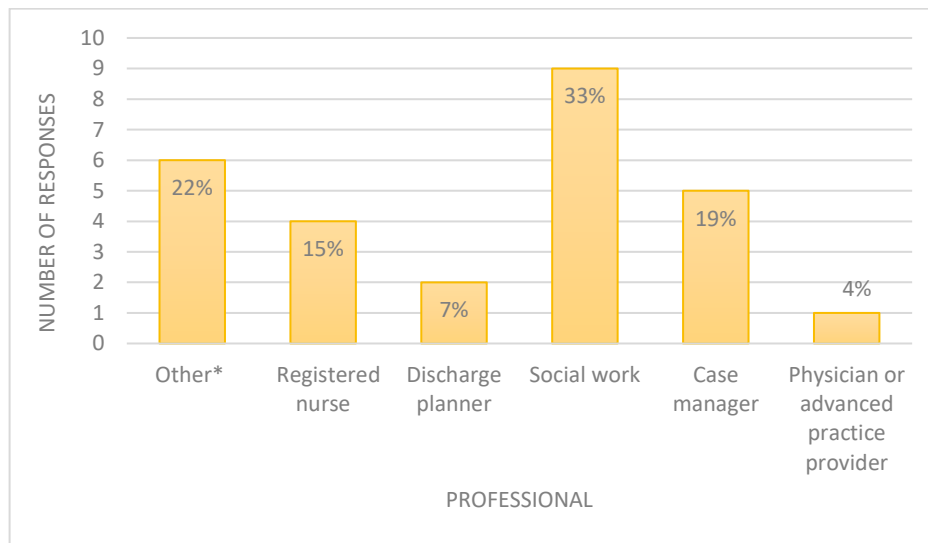


Figure 5. Healthcare professional who most often completes the VNPSC (n=27).

“Other” responses included: “RN, social work, DCF”; “collaboration between social work and RN inpatient”; “nurse manager”; “office social work”; “not sure”; “social work starts, RN finishes”.

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When asked if all families who could benefit from a VNPSC were completing one, 48% (n=23) of respondents either “somewhat agreed”, or “strongly agreed”, and 40% “neither agree nor disagree”. (Figure 6). There was not enough data to analyze the final question regarding why any families were being missed.

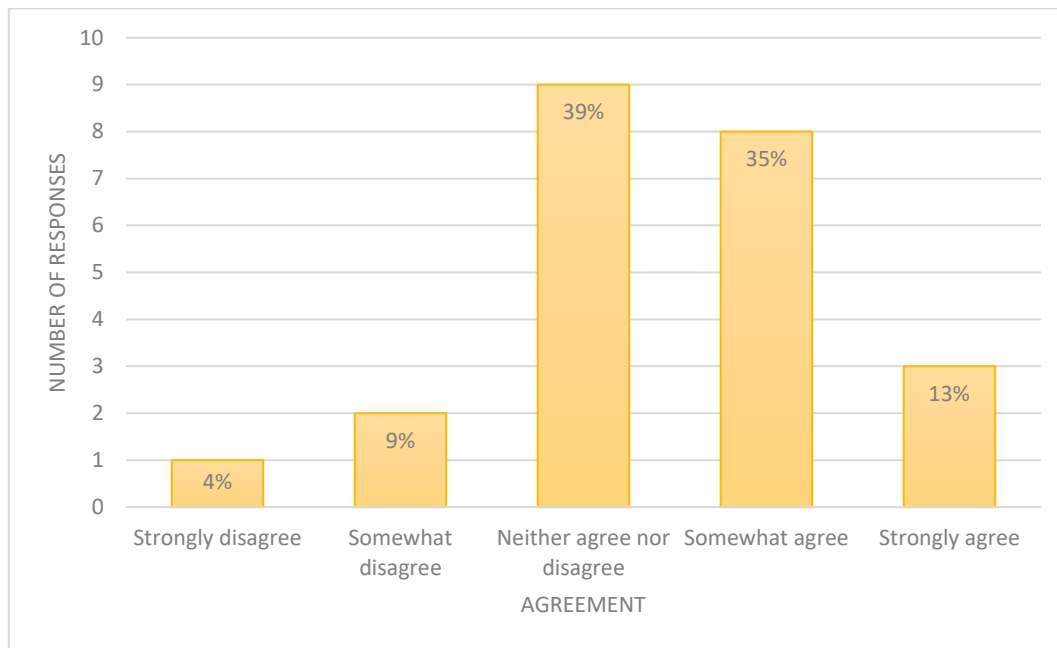


Figure 6. Whether or not every family who could benefit from a VNPSC is completing one (n=23).

### Education, Training, Implementation

We grouped questions 10, 11, 12, 14, 15, 16, 17, and 22 to form a category examining the overall satisfaction with the education, training and implementation of the VNPSC. These eight questions together had a total of 188 responses. In this category, all of the questions were positive statements, and 60% (n=188) of respondents answered either “somewhat agree” or “strongly agree” (Figure 7). The questions that did not use this scale were analyzed independently. The results showed that no participant indicated that families are “not involved”

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with the VNPSC process and that 37.8% (n=24) of families are “very involved”, and 27% are “somewhat involved” (no data shown).

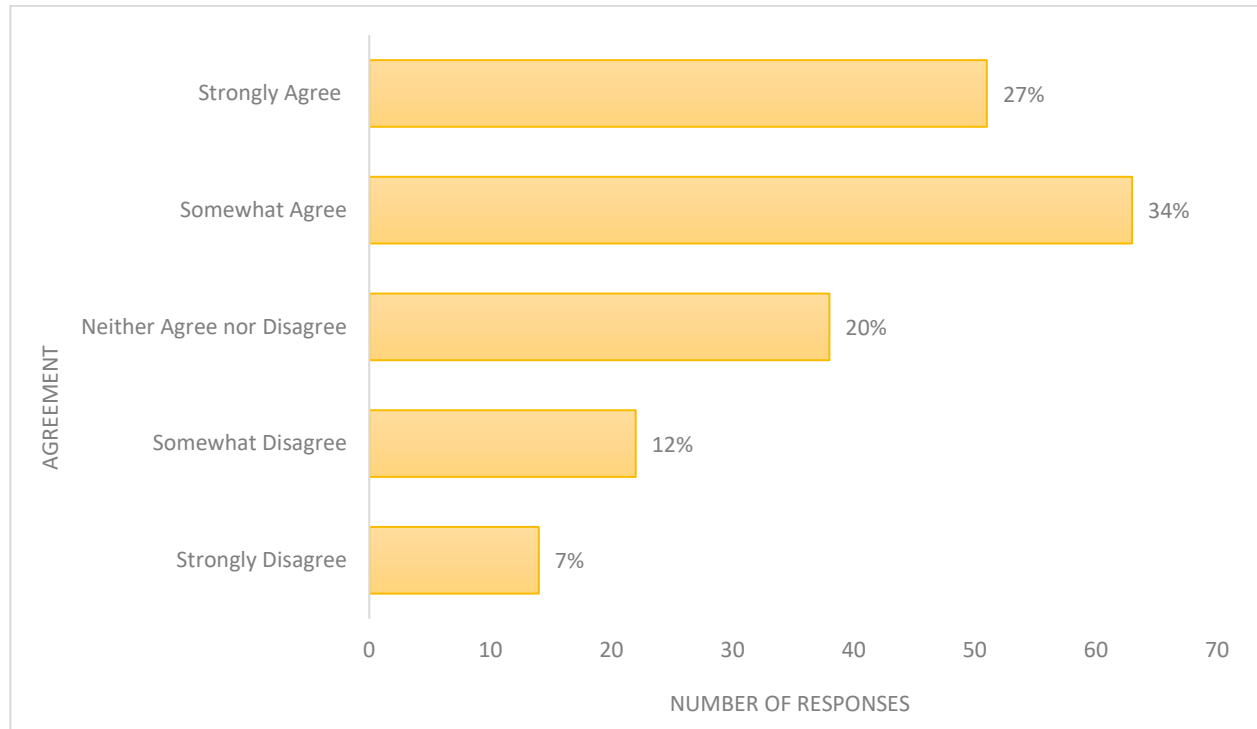


Figure 7. Overall satisfaction with the education, training, and implementation of the VNPSC (n=188).

Of those who responded, 89% (n=9) of the people answered “yes” to the question asking whether more training would be helpful (no data shown) and 40% (n=10) of participants responded that they were not trained (Figure 8). It is important to note that 80% (n=30) of participants have never filled out a VNPSC with a family (Figure 9), and that 28 of the participants who began the survey had stopped participating at the point of this question. The question asking what other resources would be helpful could not be analyzed due to a lack of data.



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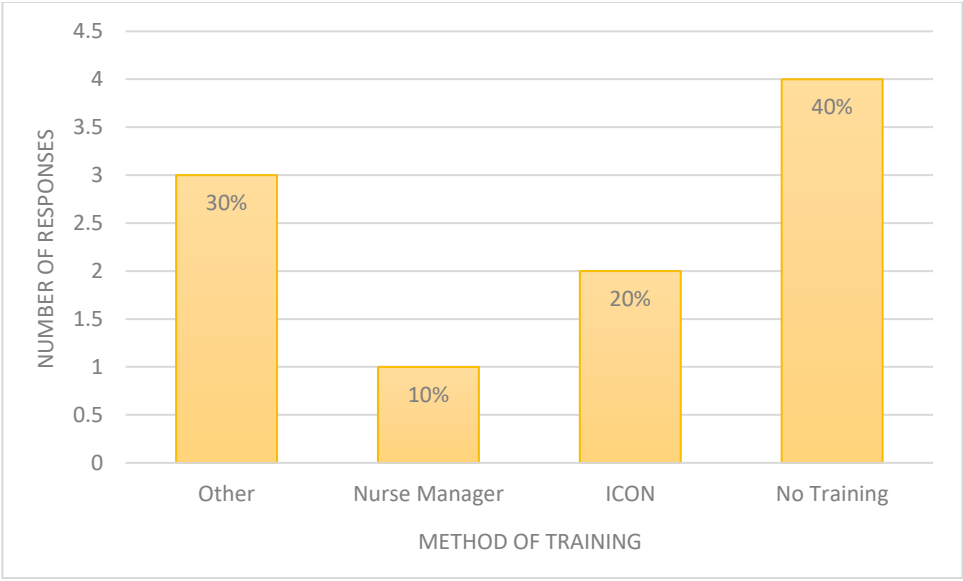


Figure 8. How participants were trained on the VNPSC (n=10).

“Other” responses included: “review of info online (DCF webpage)”; “statewide manager meeting and Vermont Department of Health webinars”; “the first 3”.

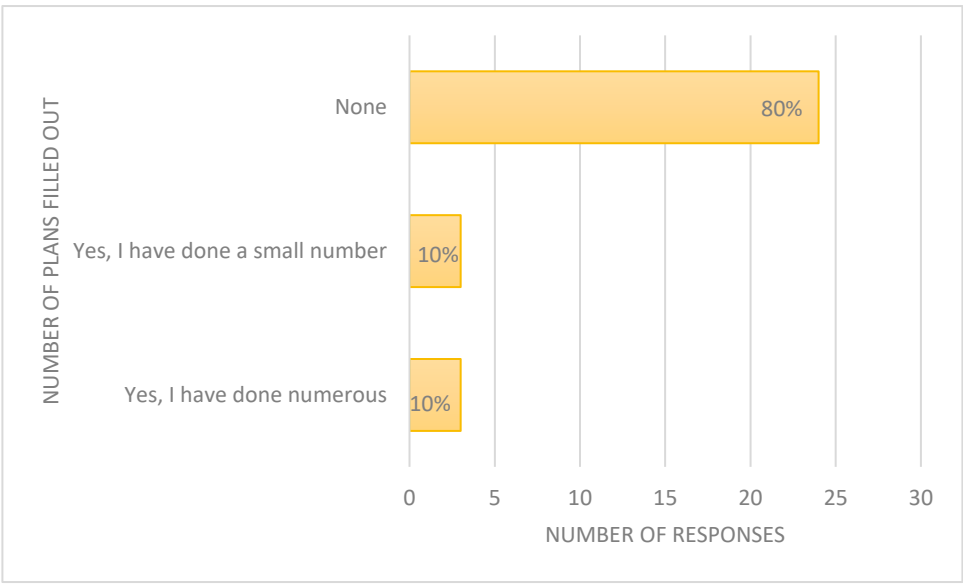


Figure 9. Experience filling out VNPSC with families (n=30).

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### Time and Ease of Sharing with Primary Care Provider

When asked if they had enough time to complete the VNPSC, 52% (n=23) of participants responded “somewhat agree” or “strongly agree”, and 40% responded “neither agree nor disagree” (Figure 10). In regards to ease of sharing the VNPSC with the infant’s primary care provider 61% (n=23) of participants responded that they “somewhat agree” or “strongly agree” and 26% “neither agree nor disagree” (Figure 11).

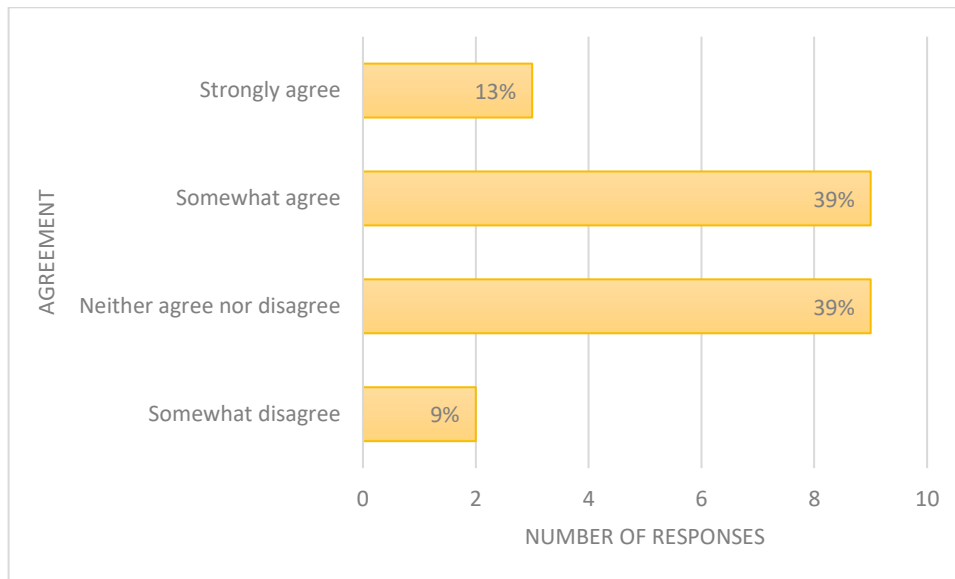


Figure 10. Whether or not participants have enough time to complete the VNPSC (n=23).

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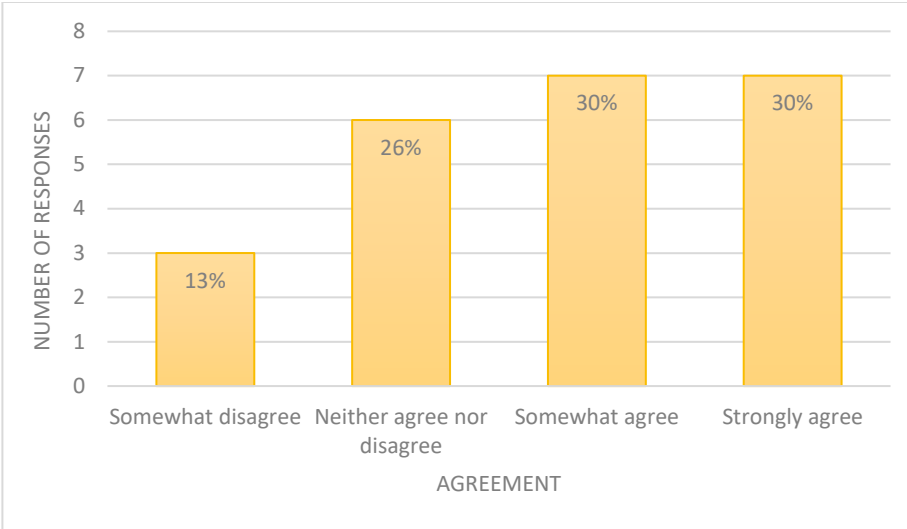


Figure 11. Whether or not participants find it easy to share the VNPSC with primary care provider (n=23)

### Free Text Responses

There were three “free text” response questions included in the survey (see Appendix D for full responses). The first question asked participants to record how much time the VNPSC takes them to complete. The written responses from this question fell into three groups:

1) “depends/varies” (15%, n=20); 2) “do not know/unsure” (55%); and 3) “5-20 minutes” (20%).

For example, one participant stated that it depends on “how involved, the needs of the patient, if it was started in the [obstetrician] office or at the MAT clinic”, which was very similar to the other responses within this theme. In the “do not know/unsure” category, five participants responded that they simply had “no idea” or “don’t know”. Other participants went into more detail and explained that it “happens in [obstetrician] office and [social work] at hospital finishes”; or “[social work] does most of it”.

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The second question asked participants how the VNPSC could be made more useful but analysis could not be conducted as an insufficient number of participants responded (n=3; see Appendix D for responses).

The third question asked for any additional comments, concerns, and/or suggestions for the VNPSC procedure. Based on the data from the nine participants who responded, themes for areas of improvement included: 1) “unsure if PCP is receiving and/or using the plan” (22%); 2) “confusion about if/when/by whom the plan should be completed” (33%); and 3) “time consuming/ difficult to complete when social work/care management not available” (33%). The first theme was exemplified by statements such as “department is still trying to see the value in the information that is being sent. Seems it goes nowhere”, and “I am not sure if pediatricians are really using the tool”. We found that many participants felt confusion about the VNPSC such as one participant who responded with “sometimes uncertain if also being done by DCF”, another who said “the [VNPSC] information/FAQs on the DCF webpage does not match what our local DCF office was told... additionally, we were confused about when DCF accepts a report or has an open case, but is NOT related to substance use, who should do the [VNPSC]”. Finally, participants reported that it was time consuming and difficult to complete the VNPSC without highly trained personnel to help. One participant stated that “this is still a challenging process that we are all working through. Our providers are having [social work] do most of this work. Still educating staff for when [social work] is not available”, and another that “our social worker currently starting the [VNPSC] is a grant funded position. If the grant is not extended or the clinic does not have funding for the position, we will need to find a replacement for the [VNPSC] initiation which is time consuming and involved if done correctly”.

Chapter 5: Discussion and Recommendations

Discussion

Initially, it appeared that there was a significant need for more training as a majority of participants indicated that more training would be helpful. However, slightly over half of participants who responded to the survey did not know how long it takes to complete a VNPSC, and most of participants did not have any experience completing a VNPSC. The majority of participants responded to the free response questions in the categories: “do not know/unsure”; “confusion about if/when/by whom the plan should be completed”; and “time consuming/difficult to complete when social work/care management not available” when asked about the completion of the VNPSC. However, when eight questions were combined we found that participants were generally satisfied with the training, education, and implementation of the VNPSC. Taken together, these findings indicate that the lack of knowledge about the VNPSC is more likely a result of inexperience rather than deficient training. Participants would need to have experience completing the VNPSC before it could be possible to determine if there is a need for more training.

Registered nurses, not in management positions, made up a majority of the respondents, while just over half of respondents stated that either social work or case management completes the VNPSC. However, some participants stated that the document was completed through the collaboration of different healthcare professionals, including registered nurses. This data indicates that although social work/care management most often completed the VNPSC, registered nurses were involved in some parts of the process. However, there does not seem to be a consistent protocol across Vermont hospitals. This can also be seen in the free text responses to the question of how much time the VNPSC took, and in the question that asked about additional

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comments. Therefore, a compelling explanation of the low response rate could be due to participants' complete lack of experience with the VNPSC in some cases, while in other cases the participant may have only known the answer to some questions but not others. This could be the reason that many of the question responses were left blank or answered with "neither agree nor disagree".

Another possible explanation is that the survey instrument asked questions that were too specific or did not have the proper response options for the sample of registered nurses. Perhaps there would have been a higher rate of completion if questions focused on participation in the process of completing the VNPSC, rather than strictly completion. Additionally, a response option of "I don't know" for questions 6, 8, 9, 13.5, 18, 19, 20, and 21, and "does not apply" for questions 13, 14, 14a, 15, and 22 may have resulted in a completed answer rather than the participant skipping the question altogether.

### Limitations

Limitations of this project include a lack of professional diversity in the sample, the low participation and completion rate, short time period that the survey was available, and the opportunity for selection bias. The sample was comprised of only registered nurses in hospitals which hinders the ability to generalize the findings of this study to non-hospital healthcare facilities, such prenatal healthcare offices, and other professionals. The low completion rate resulted in a small amount of data, and some questions could not be analyzed at all. This could have been due in part to the time that the survey was available, and more data may have been collected if it had been longer. Email addresses for the nurse managers who received the original survey invitation could have been outdated or missing additional participants that should have been included. We relied on nurse managers to forward the survey to their floor nurses which

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increased the probability of selection bias. We also did not have information regarding who or how many people the nurse managers forwarded the survey to. This made it impossible to determine an accurate response rate for the survey.

### Recommendations

Future research on the VNPSC should include social work and case management personnel in the sample. This study made it clear that they are most commonly responsible for the VNPSC completion, so they would likely have more incentive to complete a survey and more information to provide. At the time of this study, only 12.5% of respondents were aware of a family who should have completed a VNPSC but did not. This indicates that although nurses are not completing the VNPSC, they do believe that most families who would benefit are completing one. In light of this finding, a second needs assessment might be more beneficial if it is not conducted until healthcare facilities have had more time to create effective policies for the implementation of the VNPSC.

This quality improvement needs assessment found that participants feel that more training would be helpful, and although the majority of this data comes from professionals who have never actually completed a VNPSC, it does indicate a perceived need. We believe that a standardized training protocol on the VNPSC would be beneficial in ensuring that all people who are involved in its completion have the same basic level of understanding about the document and its use. We also found that although social work or case management personnel are most often responsible for completing the VNPSC, participants expressed concern about completing the document when these professionals were not available. We recommend that healthcare facilities fully train at least one other staff member to fill this knowledge gap and ensure that the VNPSC is being completed successfully.

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## Appendix A: Institutional Review Board Guidelines for Quality Improvement at VCHIP

### OVERVIEW OF DIFFERENCES BETWEEN RESEARCH UNDER REGULATIONS AND QUALITY IMPROVEMENT OR PROGRAM EVALUATION

	Research	Quality Improvement	Program Evaluation
Intent/Purpose	Intent of project is to develop or contribute to generalizable knowledge (e.g., testing hypotheses)	Intent of project is to improve a practice or process within a particular institution or ensure it confirms with expected norms	Intent of project is to improve or assess a specific program
Deviation from Standard Practice	May involve significant deviation from standard practice	Unlikely to involve significant deviation from standard practice	
Design	May involve randomization of individuals to different treatments, regimens or educational practices	Generally does not involve randomization to different treatments, or practices	Does not involve randomization of individuals, but may involve comparison of variations in programs
Effect on Program or Practice Evaluated	Findings of the study are not expected to directly affect institutional or programmatic practice	Findings of the study are expected to directly affect institutional practice and identify corrective action(s) needed	Findings of the evaluation are expected to directly affect the conduct of the program and identify improvements
Population	Usually involves a sample of the target population- universal participation of an entire clinic, program, or department is not expected; statistical justification for sample size is used to ensure endpoints can be met	Information is collected on all or most of the target population	Information on all or most participants in the program
Risks/Burdens	May put participants at risk	Does not increase risk to participants, with exception of possible privacy or confidentiality concerns	No risks to participants expected
Dissemination of Results	Intent to publish or present generally presumed	If the results are publicized, they are described as "quality improvement" in public presentations, academic curriculum vitae, publications, etc.	Intent to disseminate the information to program stakeholders and participants is assumed  This may be publicly posted (e.g., website) to ensure transparency of results

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### Appendix B: Vermont Newborn Plan of Safe Care Survey Instrument

Please choose the correct response to the following questions:

1) What type of healthcare professional are you?

- a) Registered Nurse
- b) Registered Nurse Director
- c) Registered Nurse Clinical Manager
- d) Registered Nurse Nurse Manager
- e) Other (please specify)

2) What healthcare facility do you work for/at?

- a) Brattleboro
- b) Copley
- c) CVMC
- d) Gifford
- e) North Country
- f) Northwest Medical Center
- g) NVRH
- h) Porter
- i) RRMC
- j) Springfield
- k) SVMC
- l) UVMMC

3) In your experience, where does the Plan of Safe Care most often get completed?

- a) Prenatal healthcare office

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- b) Started in prenatal healthcare office, finished in hospital after delivery
  - c) Hospital after delivery
  - d) Pediatrician's office after delivery
  - e) Other (please specify)
- 4) Have you ever filled out a Plan of Safe Care with a family?
- a) Yes, I have done numerous
  - b) Yes, I have done a small number
  - c) No
- 5) In your experience, which healthcare professionals most often collect the information for and file the Plan of Safe Care?
- a) Registered nurse
  - b) Discharge planner
  - c) Social work
  - d) Case manager
  - e) Care Coordinator
  - f) Physician or advanced practice provider
  - g) Other (please specify)
- 6) How involved are the families with completing the Plan of Safe Care?
- a) Very involved—participate in the whole process
  - b) Somewhat involved—give input for some of the Plan
  - c) Not involved—health care staff do all of it without family input—from chart

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**Please choose the correct range of numbers for the following questions:**

7) On average, how many births take place per month in your healthcare facility?

- a) Less than 10
- b) Between 11 and 20
- c) Between 21 and 30
- d) Between 31 and 50
- e) Over 50

8) On average, how many families do you ask to complete a Plan of Safe Care per month at your healthcare facility?

- a) Less than 1
- b) Between 1 and 2
- c) Between 3 and 5
- d) Between 6 and 10
- e) Over 10

9) Are you aware of any cases where a Plan of Safe Care should have been completed but was not?

- a) yes
- b) no

**Please rate how strongly you agree or disagree with the following statements:**

10) I understand the purpose/reason for the Plan of Safe Care.

Strongly disagree    Somewhat disagree    Neither agree or disagree    Somewhat agree    Strongly agree

11) It is clear to me which families need to complete a Plan of Safe Care and which do not.

Strongly disagree    Somewhat disagree    Neither agree or disagree    Somewhat agree    Strongly agree

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12) It is clear to me whose responsibility it is to tell the family about the Plan of Safe Care and collect the information in order to fill it out.

Strongly disagree    Somewhat disagree    Neither agree or disagree    Somewhat agree    Strongly agree

*Only answer 12a and 12b if the answer to 10, 11, and/or 12 was somewhat disagree or strongly disagree:*

12a) How were you trained on the Plan of Safe Care?

- a) By a Nurse Manager
- b) By a Nurse Educator
- c) ICON
- d) I was not trained
- e) Other

12 b) Would more training be helpful to you?

- a) Yes
- b) No

13) I have enough time to complete the Plan of Safe Care.

Strongly disagree    Somewhat disagree    Neither agree or disagree    Somewhat agree    Strongly agree

13.5) How much time on average does it take to complete the Plan of Safe Care?

Free text:

14) I have enough resources to complete the Plan of Safe Care.

Strongly disagree    Somewhat disagree    Neither agree or disagree    Somewhat agree    Strongly agree

*Only answer 14a if answer to 14 is somewhat disagree or strongly disagree:*

14a) What other resources would be helpful?

- a) Dedicated staff for Plan of Safe Care
- b) Plan of Safe Care built in to the EMR

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- c) Social Work support in completing
- d) Other

15) I feel comfortable asking families for the information I need to complete the Plan of Safe Care.

Strongly disagree    Somewhat disagree    Neither agree or disagree    Somewhat agree    Strongly agree

16) I feel confident explaining the *purpose* of the Plan of Safe Care to families.

Strongly disagree    Somewhat disagree    Neither agree or disagree    Somewhat agree    Strongly agree

17) I feel confident explaining what the Plan of Safe Care is *used for* to families.

Strongly disagree    Somewhat disagree    Neither agree or disagree    Somewhat agree    Strongly agree

18) All families who could benefit from a Plan of Safe Care are completing one.

Strongly disagree    Somewhat disagree    Neither agree or disagree    Somewhat agree    Strongly agree

*Answer 18 a if answer to 18 is somewhat disagree or strongly disagree:*

18a) Why do you believe the families are being missed?

- a) Family was not recognized soon enough
- b) A DCF report was filed
- c) The family was discharged too soon
- d) The family declined participation
- e) Other

19) The Plan of Safe Care is useful to *families* who complete it.

Strongly disagree    Somewhat disagree    Neither agree or disagree    Somewhat agree    Strongly agree

20) The Plan of Safe Care is useful to *healthcare professionals* who view it.

Strongly disagree    Somewhat disagree    Neither agree or disagree    Somewhat agree    Strongly agree

*Only answer 20a if answer to 19 and/or 20 is somewhat disagree or strongly disagree:*

20a) How can the Plan of Safe Care be made more useful?

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Free text:

21) It is easy to share the Plan of Safe Care with the infant's primary care provider.

Strongly disagree    Somewhat disagree    Neither agree or disagree    Somewhat agree    Strongly agree

22) I am satisfied with the overall procedure in my workplace for the Plan of Safe Care.

Strongly disagree    Somewhat disagree    Neither agree or disagree    Somewhat agree    Strongly agree

23) Please provide any additional comments, concerns, and/or suggestions for the Plan of Safe

Care:



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Appendix C: Vermont Newborn Plan of Safe Care Document

**Vermont Newborn Plan of Safe Care** *(Revised 11/10/17)*

Name of infant: \_\_\_\_\_ DOB: \_\_\_\_\_ Admission date: \_\_\_\_\_ Discharge date: \_\_\_\_\_  
 Infant's PCP: \_\_\_\_\_

Household members:

Name	Age	Relationship to infant	Name	Age	Relationship to infant

Identified supports:

--

Check box(es) next to applicable criteria:

Methadone / Buprenorphine	<input type="checkbox"/>
Prescribed opioids for chronic pain	<input type="checkbox"/>
Prescribed benzodiazepines	<input type="checkbox"/>
Marijuana	<input type="checkbox"/>

Additional exposures:

Nicotine/tobacco	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>
Other	<input type="checkbox"/>
Other	<input type="checkbox"/>

Comments:

Check box(es) for all applicable services and new referrals for infant and mother/caregivers:

	Discussed	Current	New Referral	Organization	Contact person (if applicable)
Medication Assisted Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Mental Health Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Substance Abuse Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
12 Step Group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Recovery Supports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Smoking Cessation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Parenting Groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Home visiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
WIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Children's Integrated Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Housing Assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Financial Assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Childcare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Safe Sleep Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Post-discharge Family Strengths and Goals (Eg: breastfeeding, housing, smoking cessation, parenting, recovery)


Comments:

Signature of parent /caregiver: \_\_\_\_\_

Signature of staff: \_\_\_\_\_

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Appendix D: Free Text Response Questions

Question	Response
<p>How much time on average does it take to complete the Plan of Safe Care?</p>	<p>Care Manager completes and I have forwarded her this survey, I have no idea. do not know. I thought they were established over several visits</p>
	<p>I am not sure, at our facility, it seems like there is a lot of "protecting" of the families. By that I mean minimizing who discusses the safe plan of care, who fills in the background information, and who decides what is important enough to go on the form. The prenatal office social worker and obstetric care providers don't even discuss the patients with the hospital social worker or listen to input from the staff nurses.</p>
	<p>I am unsure as this is started by a social worker in the prenatal office and finished by nursing. The complexity of the plan if a great job is done would probably take over 10 hours with referrals, counseling etc. That does not include time the family would need to put into time spent with smoking cessation, drug counselors etc.</p>
	<p>I don't know because I never do them</p>
	<p>it depends on how involved, the needs of the pt., if it was started in the ob office or at the MAT clinic,</p>
	<p>It depends on the patient and where they are seeking other services. If services are within SMCS it can take appx 15 minutes to complete, services outside of SMCS can take hours to confirm.</p>
	<p>Never been involved told happens in OB office and sw at hospital finishes</p>
	<p>no idea</p>
	<p>Not sure. Done prior to arriving in Birth Center</p>
	<p>Our plans are completed by social work</p>
	<p>unsure. SW does most of it.</p>
	<p>Varies; this is the responsibility of both the OB provider and the hospital social worker. Length of time dependent on needs of the individual family unit.</p>
	<p>we review the plan with the patient, so about 15 minutes or less</p>
	<p>5-10 minutes</p>
	<p>5-10 minutes</p>
<p>? 20 minutes</p>	
<p>~1 hour</p>	

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<p>How can the Plan of Safe Care be made more useful?</p>	<p>The pediatric providers still are unsure of the form. They don't know that one has been sent.</p> <p>We complete it prenatally, which is when most of these referrals happen. That has made the plan/ documentation match what is actually happening in the offices.</p> <p>All families need a discharge plan and medical home. We are treating these families differently and using a lot of resources. Yes they are more vulnerable but maybe DCF needs to provide the support not clinics and labor and delivery nurses. These families have chosen their way of life, it is not ideal but as a labor and delivery nurse they consume our time so we do not have time for other families.</p>
<p>Please provide any additional comments, concerns, and/or suggestions for the Plan of Safe Care.</p>	<p>It can be time consuming, care management not always available to help out. I feel it is a pieced together type of support. We are working hard to collaborate with all areas involved. It seems that not everyone understands what is being done. Sometimes uncertain if also being done by dcf (? duplication). I am not sure that pediatricians are really using the tool</p> <p>This process is initiated during the prenatal period in the clinic and is developed by the OB provided, social worker and the client. All three parties collaborate during the inpatient admission to complete and communicate the plan to all appropriate parties. Nursing does not complete this document; however, their input and concerns are shared with the provider and the social worker.</p> <p>In our facility social work should complete this. As for usefulness - the PCP should be completing this portion of the survey. My main concern is those DCF reports that get declined - now have no safe plan at discharge....so our facility has implemented a comprehensive transitions of care plan done on 100% of newborns regardless of risk factors which will be sent to their pcps</p> <p>This is still a challenging process we are all working through. Our providers are having SW do most of this work. Still educating staff for when SW is not available. Department still trying to see the value in the information that is being sent. Seems it goes nowhere.</p> <p>The PoSC information/ FAQs on the DCF webpage does not match what our local DCF office was told. When we call to make a DCF report, we won't find out then if the report is accepted; we have to call back at some point to find out. We thought this was important, since the webpage FAQs says DCF will complete the PoSC if a DCF report is MADE and ACCEPTED. However, local DCF does not think they are doing the PoSC at all. Additionally, we were confused about when DCF accepts a report or has an open case, but it is NOT related to substance use, who should do the PoSC. However, we now just assume we are doing a PoSC in all cases (where there is substance-exposed newborn) regardless of DCF involvement. Finally, it is unclear when PoSC needs to be</p>

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	<p>done around a) maternal UDS + for marijuana at first prenatal visit, but mom denies ongoing use and was not re-tested; b) maternal opioid use during labor; c) maternal cigarette smoking (probably one of the riskier drugs around during pregnancy, but we aren't doing anything about it?) I have a good idea of the answer for the latter 2 (no PoSC needed), but unsure about the first one; the FAQs don't really answer these questions, and I also know the FAQs and the local DCF are not in agreement. Finally, I suspect we will end up doing a lot of "CAPTA notifications" on cases that eventually become "DCF reports"; initially we won't know if a case has been "accepted." I don't know if this will affect any data collection going on, but it may be important info for someone.</p>
	<p>would need to have more information about it</p>
	<p>As I stated previously I believe input should be listened to from all caretakers, we have had a couple of unique situations, where not all of the background information was on the form and in one situation where DCF should have at least been contacted. The response I got was "well you call if you feel you must", making it totally adversarial and defeating the whole purpose. The reason given for not contacting them was that they were already involved with the family; that doesn't mean they have all the facts for this birth.</p>
	<p>Our social worker currently starting the safe plan of care is a grant funded position. If the grant is not extended or the clinic does not have funding for the position we will need to find a replacement for the SPOC initiation which is time consuming and involved if done correctly</p>
	<p>We are implementing a Transition of Care document that helps all parents understand the extra supports/resources available-this is an additional resource that Social work has helped to create to aid in communication and to aid in the pediatrician understanding needs after d/c.</p>