Plans of Safe Care Sprint

FINAL REPORT

PROGRAM OVERVIEW

The Plans of Safe Care Sprint aimed to engage a diverse audience of professionals who work with substance-exposed dyads throughout their pregnancies and into the postpartum period. Sharing information about evolving legislation and plans of safe care implementation tools, this quality improvement program sought to strengthen understanding and collaboration across sectors engaged with plans of safe care. The Plans of Safe Care Sprint consisted of three 1-hour webinars covering:

- Plans of Safe Care (POSC) 101: The Landscape of POSC in Minnesota
- Operationalizing POSC: Practical Strategies for Hospitals and Community Systems
- Dissolving Silos: Cross-System Collaboration in POSC Implementation

Subject matter experts from Federal and State government partners, clinical staff from MN and MA, and community organizations shared their expertise and innovative strategies for POSC implementation. Through this structure, the audience gained a comprehensive understanding of POSC processes during the pregnancy & postpartum period and strengthened their own capacity to champion implementation within their facility.

To measure the impact of this Sprint, both a pre- and post-program survey were administered to program participants. This survey measured the effectiveness of the program by assessing the knowledge gained and the change in perceived self-efficacy in implementing POSC through participation in this Sprint. Both surveys gathered feedback regarding barriers to implementation, areas of improvement, and future topic suggestions that MNPQC plans to utilize in order to tailor future programming to our audience's needs. This executive summary shares the results of these surveys along with MNPQC's plans to continue education on Plans of Safe Care.

PARTICIPANT DEMOGRAPHICS

Total Registrants: 240

Session Attendance

Session 1	118
Session 2	59
Session 3	57
Total	234

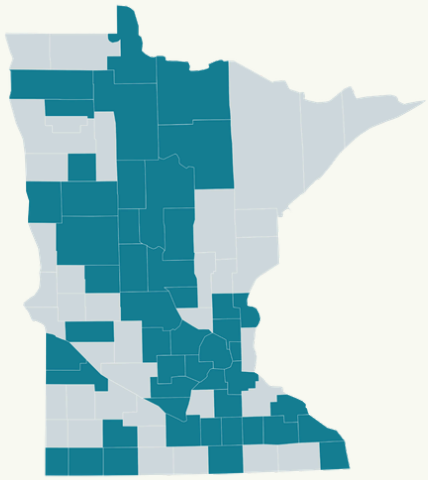
Work Setting

Clinical	106
Non-Clinical	134

Geographic Distribution

7-County Metro	72
Greater MN	95
Statewide	61
Out of State	12

MN Counties Represented by Sprint Participants:



JULY 2026

PRE-SURVEY RESPONDENTS

92 Total Respondents

57% of those who implement POSC, indicated that their workplace **does not have a standardized protocol** (n = 42)

POST-SURVEY RESPONDENTS

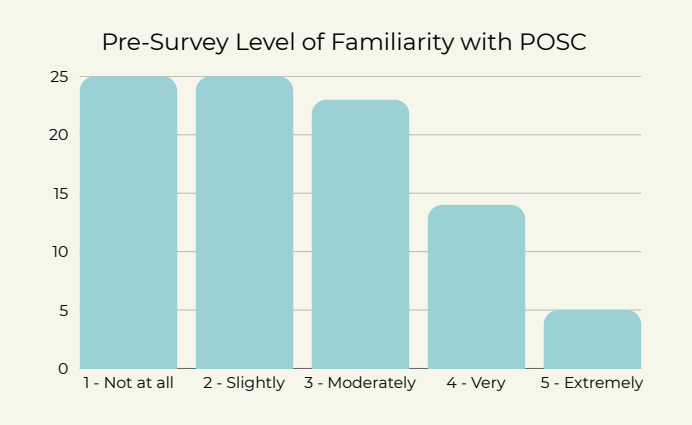
29 Total Respondents

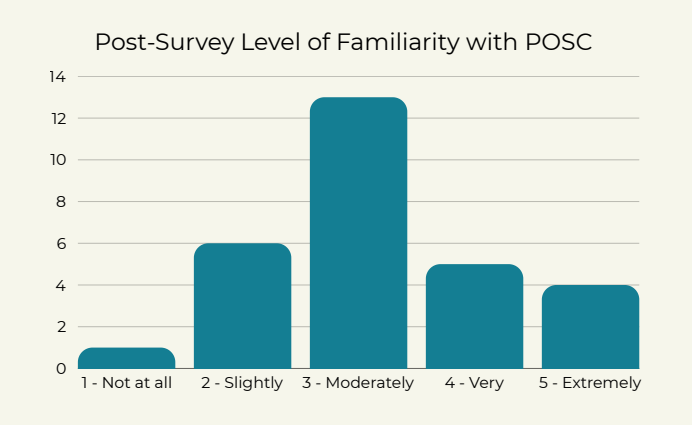
69% of respondents indicated **high comfort levels in explaining the difference between screening & testing** (n=29)

IMPROVEMENT THROUGHOUT THE POSC SPRINT

Results from both the pre and post-program surveys were compared to measure improvement in knowledge and understanding of POSC policies and implementation practices. Identified areas of program impact include:

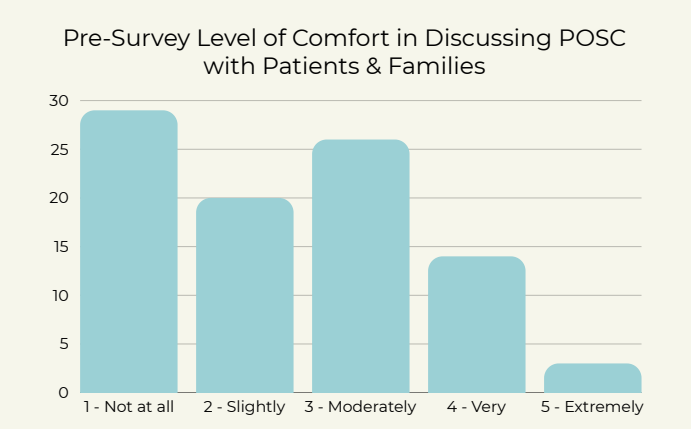
FAMILIARITY WITH PLANS OF SAFE CARE

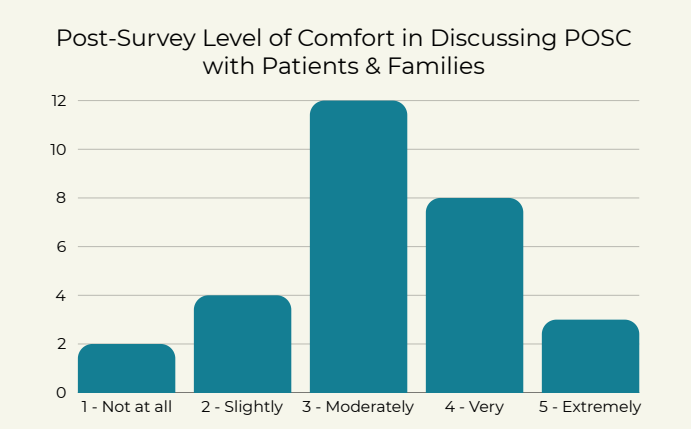




Respondents were asked to rate their familiarity with Plans of Safe Care prior to, and after the conclusion of the Plans of Safe Care Sprint. Results demonstrate a 10% increase in respondents indicating high familiarity with POSC (levels 4 & 5), with an overall shift towards more familiarity across all respondents in the post-survey

COMFORT LEVEL IN DISCUSSING POSC WITH PATIENTS & FAMILIES





Respondents were asked to rate their level of comfort when discussing POSC with their patients, clients & families. Pre-survey results indicated that 53% felt either slight, or no comfort, in these discussions (n=92). This percentage decreased to 21% at the conclusions of the sprint (n=29)

AREAS FOR FUTURE IMPROVEMENT

While the Plans of Safe Care Sprint proved educational, evaluation results indicate the need for continued programming that promotes sustainable changes. The evaluation showed that there was **no change in the percentage of respondents indicating that their facility has a standardized POSC process or protocol.** This indicates that more time, increased collaboration across systems and additional provider tools are needed in order to spur systemic change. Additionally, **51% (n=29) of respondents in the post-survey indicated that the POSC Sprint did not lead to the implementation of new processes** or protocols to address care of pregnant and postpartum women with SUD and their newborns.

These challenges to POSC implementation are echoed in the qualitative feedback below:

"Silo work between departments, difficulty with collaborative communication"

"Initiating prior to admission, educating on next steps as different counties have different action steps"

"Accessibility to POSC documentation. Consistency with application"

"Overcoming parents fear of removal if SUD is admitted"

"Getting referrals from care providers"

"I want to ensure we have a consistent plan that is free from bias to help staff support our patients."

PLANS FOR FUTURE PROGRAMS

Based on the POSC Sprint feedback, the need for continued quality improvement programs on POSC is clear. To meet the needs of our participants, MNPQC plans to continue POSC programming through the following avenues:

- **2026 Perinatal Improvement Summit:** Breakout session on POSC, highlighting a panel of professionals working with POSC in various sectors
- **MNPQC Perinatal Education ECHO Series:** In 2027, a series of 3 ECHOs on POSC will be offered
- Ongoing communication & partnership with DHS to monitor legislative changes and need for additional programming

PROGRAM MATERIALS

- Plans of Safe Care (POSC) Sprint Page
- POSC Session 1 Snapshot
- POSC Session 2 Snapshot
- POSC Session 3 Snapshot

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CONTACT INFORMATION

Please contact MNPQC at QI@minnesotaperinatal.org with any questions