CHAPIN HALL

Strengthening Plans of Safe Care Through Community Pathways

Community Pathway Blueprints Series: Issue 1

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THE ISSUE

The federal Child Abuse Prevention and Treatment Act (CAPTA), as amended by the Comprehensive Addiction and Recovery Act (CARA) in 2016, requires that a Plan of Safe Care (hereafter referred to as "POSC") be developed for any infant identified as being affected by substance use, experiencing withdrawal symptoms, or experiencing Fetal Alcohol Spectrum Disorder (FASD), to promote safety and well-being (Child Abuse Prevention and Treatment Act, 2016). POSCs were established to ensure that physical and behavioral health care, early childhood, and child welfare systems work together to support caregivers and infants early, through coordinated, family-centered services that aim to keep infants safe and families together.

A POSC is a voluntary, family-centered plan developed collaboratively between a family and a professional, or team of professionals, involved in their care to address the needs of both infant and caregiver, identify appropriate services and supports, and establish a strategy for coordinating care and follow-up.

According to the National Survey of Drug Use and Health, in 2024, over 190,000 pregnancies in the U.S. (5.3%) were exposed to drugs (Center for Behavioral Health Statistics and Quality, 2025).

Infants under one year old are the most likely single age group to enter foster care, reflecting approximately 1 in 5 entries in FFY 2024 (U.S. Department of Health and Human Services, 2025).

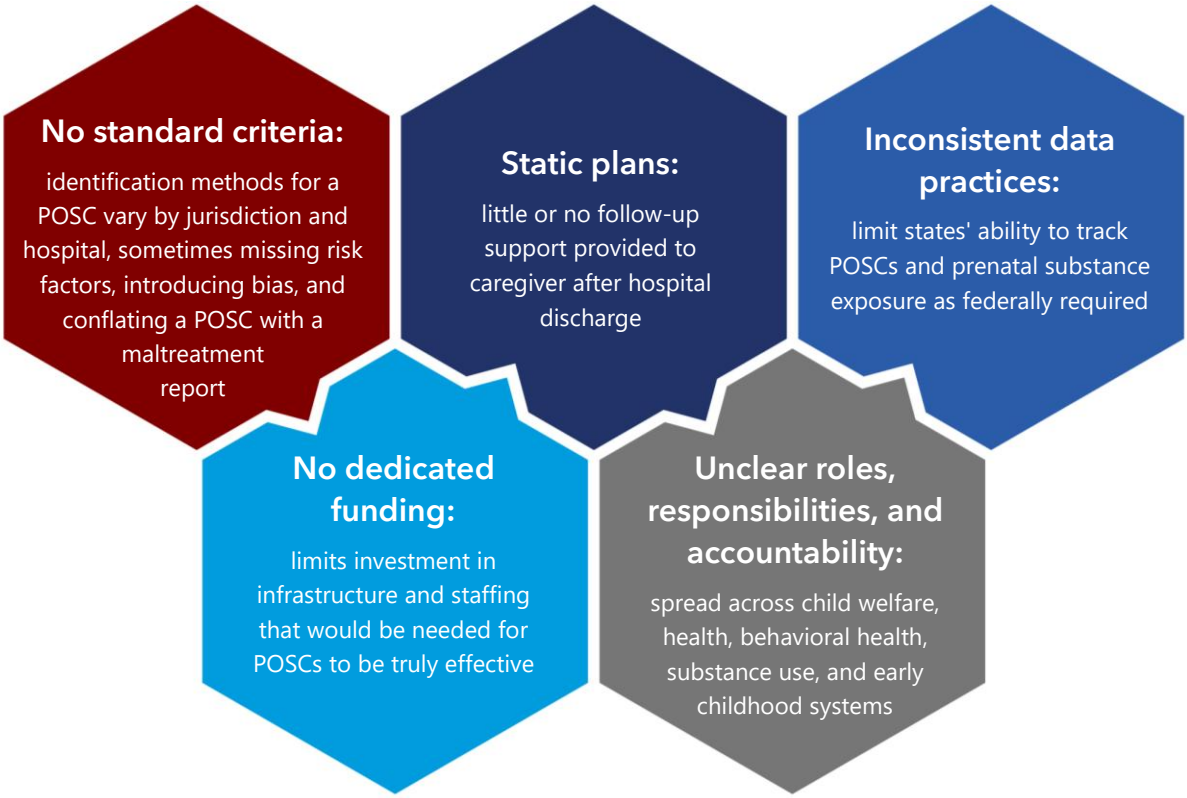
In FFY 2023, 52% of children under age one who entered out-of-home care had caretaker alcohol or drug use as a condition associated with removal (U.S. Department of Health and Human Services, 2025).

CAPTA and CARA set out four distinct state obligations:

1. A POSC must be developed, identifying services, supports, and a plan for keeping the infant safe.
2. The POSC must address the needs of both infant and caregiver.
3. Health care providers must notify child welfare of the POSC for purposes of federal reporting. Distinct from a maltreatment report to child protective services (CPS), this notification includes no personally identifiable information and does not require CPS investigation.
4. State child welfare agencies must report POSC data annually to the Administration for Children and Families (ACF). Data should include: the number of infants identified, the number for whom a POSC was developed, and the number for whom a referral was made for appropriate services, including services for the affected family or caregiver.

While all states are required to implement Plans of Safe Care, a lack of federal guidance and dedicated funding has led to wide variations in how states interpret the law and operationalize its requirements. A look across states reveals that POSC are operationalized with varying infrastructure, staffing, processes, and capacity. Moreover, these responses are also often too limited to match the scale of the need, failing to meaningfully support caregivers while sometimes introducing unnecessary child welfare involvement.

Figure 1. Key challenges in implementing POSC:



The purpose of this brief is to explore these challenges more deeply, then lay out a blueprint for operationalizing Plans of Safe Care in a manner that is robust, well resourced, keeps infants safe, and connects families to the services and supports they need. The blueprint includes the core design, governance, and financing elements, and key actions states can take to move this work forward, concluding with a profile of the state of Washington's model. With infant safety as the paramount priority, the strategies presented here are grounded in research evidence and can be used to distinguish when child welfare involvement is required—and when it's not, how best to support caregivers so they can safely care for their infants.

This approach represents a promising *community pathway*: a pathway to services and supports that keeps children safe and families together, averting unnecessary engagement with CPS. Community pathways are a component of Chapin Hall's Meeting Family Needs Framework, which offers policies, practices, and innovations to ensure that family needs are met early, through an integrated and holistic child and family well-being system (see System Change Component 2: Expand eligibility to services and supports to shift to prevention).

Background: Challenges with Plan of Safe Care Implementation Today

Documentation versus support: A Plan of Safe Care can be developed, reported, and counted while the family it was written for goes home without support.

There are several challenges to implementing Plans of Safe Care as they currently exist:

Assessment and intake: no standard criteria. CAPTA and CARA require POSCs for infants born and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder, but do not define "affected by," leaving states discretion to operationalize the requirement in statute and practice. State-by-state statutory summaries show substantial variation in what triggers a child welfare report for prenatal substance exposure and in the criteria for receiving a POSC (Lloyd et al., 2019).

This variation can produce errors in both directions. Some states rely on a toxicology test alone, which misses caregivers with a high-risk profile who test negative while flagging caregivers who present little or no risk, such as those using legal or prescribed substances. Others treat every POSC notification as a maltreatment report, generating high volumes of child welfare referrals in cases where no safety concerns exist and drawing families into government intervention they do not need. At the same time, some families who could benefit from a POSC go unidentified, forfeiting the chance to engage them in supportive services early.

Subjective decision-making compounds the problem. Where testing is left to individual clinician judgment, Black patients are tested at higher rates than White patients despite not having a higher rate of positive results (Jarlenski et al., 2023), and Black and Indigenous infants are investigated at disproportionate rates following medical professional reports (Edwards et al., 2023). Best practice therefore calls for clear, consistent clinical and social screening protocols paired with objective, science-based criteria for identifying the need for a POSC or a maltreatment report. One hospital, by narrowing its approved screening indications (eliminating factors with low predictive value or no impact on clinical care at delivery admission) and adding clinician decision support, eliminated the racial gap in both testing and child welfare referrals without reducing detection of clinically relevant substance use (Azimi et al., 2025).

Use of POSCs as static documents with limited follow-up for families not involved with child welfare, rather than as ongoing, coordinated service plans. Birth parent interviews point to limited follow through on their POSC after discharge from the hospital. While consolidated resource information was helpful, many parents still did not know how to access services and wanted more coordination to support engagement after discharge (He et al., 2024). It stands to reason that birthing people, especially those experiencing the risks associated with receiving a POSC, may require proactive assistance to access support and services in the days and weeks following birth.

Inconsistent data collection and reporting practices. States vary in their data collection and reporting practices, which limits their ability to track POSCs and prenatal substance exposure across systems as required under CAPTA. Indeed, while states receiving CAPTA grants report POSC data annually, many states' submissions are incomplete. Recent federal and state resources note several barriers. Relevant data are often housed in disparate systems, with some key elements unavailable or inconsistently collected, and states may still be modifying data systems and collection protocols for CAPTA reporting. Privacy, confidentiality, and governance requirements can slow cross-agency data sharing (National Center on Substance Abuse and Child Welfare, 2024). The federal reporting requirement leaves key definitions to states, which contributes to measurement inconsistencies. The annual data report counts infants identified, POSCs developed, and referrals made. CAPTA separately requires states to monitor whether local entities are providing referrals to and delivery of appropriate services, but states carry out that monitoring differently, some at the systems level, some at the case level, and some both. As a result, there is no comparable picture across states of what families actually receive after a POSC is written, or of how they fare afterward, including subsequent child welfare involvement.

Absence of dedicated funding to support POSC implementation. Lack of dedicated funding to support POSC implementation compounds these challenges, limiting investment in POSC-related practice, workforce development, and infrastructure. Although POSC implementation is federally required under CAPTA, CAPTA funding remains small relative to the scope of coordination and service delivery envisioned. Moreover, CAPTA funding is one of the few dedicated child welfare funding streams that is flexible, and states often use it across a wide range of allowable programs and activities, with POSCs representing just one of many competing demands. The result is that POSCs require workforce, policy, and infrastructure investments that exceed what the available funding supports..

Unclear roles, responsibilities, and accountability structures. POSC require coordination across multiple systems, including child welfare, public health, behavioral health, substance use, and early childhood. This coordination can be challenging when roles and responsibilities are unclear. For example, healthcare providers identify the need for most POSCs, child welfare is responsible for capturing and reporting Plan data, and the services and supports families receive through their POSCs are often provided under behavioral health, child welfare, and substance use agencies. Interviews with state and county administrators have found wide variation in who is responsible for implementing and monitoring POSCs. With no dedicated funding and a lack of clear structure, it is uncertain who is accountable for designing, developing, overseeing, and resourcing the work. As a result, attempts at improvement often require multiple agencies to be ready at the same time to prioritize this issue in partnership with one another as a multi-system strategy.

COMMUNITY PATHWAY OPPORTUNITY

Despite these challenges, some jurisdictions have begun to develop Plans of Safe Care models that function as robust, supportive community pathways with real results for families—demonstrating that it is possible to design models that are voluntary, supportive to families, protective for infants, and operate largely outside of child welfare systems (Deutsch et al., 2022).

Based on Chapin Hall's review of emerging approaches, well-designed Plan of Safe Care community pathways share several common features:

- Separating POSCs from maltreatment reports, so families are served outside of child welfare whenever possible
- Standard criteria for a Plan that incorporate clinical and social risk factors, operationalized through a structured decision-making process
- Training for mandated reporters in supportive, nonpunitive engagement
- Connection to services with follow-up support for families.
- Streamlined and standardized processes through a unified workflow or portal
- Cross-system governance and accountability

Design: Building Blocks of a Robust Plan of Safe Care Community Pathway

A Plan of Safe Care is only as strong as the pathway behind it. When voluntary, well-resourced, and coordinated across systems, it can be the connection that keeps a family together.

Separate Plans of Safe Care from maltreatment reports. Caregiver substance use can occur alongside conditions that endanger an infant, but exposure by itself does not establish that those conditions are present. Determining whether a POSC is needed and determining whether a maltreatment report is required are, therefore, different decisions, and states should treat them separately. The first is an eligibility determination under the state's definition of an affected infant. The second applies the state's mandatory reporting standard, informed by evidence about what does and does not indicate risk of maltreatment to an infant.

CAPTA requires states to have policies and procedures addressing the needs of infants born with and affected by substance abuse, withdrawal symptoms resulting from prenatal exposure, or a FASD, but does not define those terms. States should establish clear definitions of these terms that identify the infants who need a POSC, and separate criteria establishing when a CPS report is required. This separation helps to ensure that POSCs connect families to services without exposing them to a CPS investigation when the state's reporting standard is not met, while reserving child welfare involvement for situations where it is. The distinction matters: policies that define prenatal substance use as child abuse or that require reporting it to CPS are associated with lower rates of adequate prenatal and postpartum care among people who use substances during pregnancy, and with fewer provider referrals to treatment (Austin et al., 2022).

Articulate standard criteria for a POSC, incorporating clinical and social risk factors, and use a structured decision-making process to operationalize them. Identifying which infants and families need a POSC should rely on clear, consistent clinical and social screening protocols. Then, a structured decision-making process should ensure that providers apply those criteria consistently, reducing subjectivity, bias, and the potential for misunderstanding. This process can include universal verbal screening so that bias does not inform who is identified for a POSC; clear criteria for when a CPS report is required, reflecting the state's mandatory reporting standard; step-by-step guidance through key questions and thresholds; and ready access for providers responsible for identifying families for POSCs, for example as a desk aid or a prompt within an IT system they already use.

Where a provider is uncertain whether the reporting threshold is met, a multidisciplinary case discussion that weighs family strengths, challenges, and unmitigated or potential risks can support a more consistent judgment, as can a clinical consultation line to confer with other providers offers a further safeguard where team-based discussion is not available.

Train mandated reporters for supportive, nonpunitive engagement. Training for professionals who develop POSCs, such as nurses, social workers, physicians, substance use disorder providers, and child welfare staff, can clarify the difference between CPS reporting and POSC notification, explain when each is required, and emphasize stigma-free, trauma-informed, and culturally responsive communication. This will reinforce that substance use disorder is a treatable health condition rather than a moral failing. Training addresses the challenge of judgmental encounters and supports the broader goal of engaging families voluntarily.

Connect families to services and provide follow up support. POSCs are more meaningful when they integrate supports and services across systems, beyond those available from child welfare, to create a larger network of support for families navigating substance use disorder needs. Ensuring families receive the services a POSC identifies, rather than leaving the POSC solely on paper, is what turns a referral into a meaningful benefit for children and families. The following five strategies can strengthen the service referral.

1. *Refer broadly across agencies and community-based organizations.* A POSC should reach beyond a single provider or system to include substance use disorder treatment programs, maternal and infant health services, home visiting programs, mental health providers, and community-based organizations that families already know and trust.

2. *Include economic and concrete supports.* Connections to economic and concrete supports, including unconditional cash payments, housing services, transportation, and child care, are particularly beneficial for caregivers and infants and are associated with decreased risk of child welfare involvement. Transportation and child care also increase the likelihood that parents will attend, engage with, and complete substance use disorder treatment (Marsh et al., 2000; Dore & Doris, 1998). Pairing economic and concrete supports with evidence-based services can further increase families' uptake, retention, and completion (Cusick & Anderson, 2024).

3. *Use navigation, particularly peer navigation and relational supports*. Research on community-based navigators, peer specialists, and peer recovery coaches serving substance use populations before, during, and after childbirth suggests they can improve treatment engagement while lowering the risk of substance exposure at birth (Ryan et al., 2008). Recent studies on the role of doulas throughout the perinatal period have also shown promising evidence in their ability to provide maternal health, substance recovery, and social support to both pregnant and recently postpartum individuals with substance use disorders (Gannon et al., 2024; Haerizadeh-Yazdi et al., 2023). Navigators can explain the POSC in accessible language, help families understand their options, and support engagement with treatment, maternal mental health care, parenting programs, and home visiting. They can problem-solve challenges such as transportation, child care, or housing; maintain regular contact through the high-risk postpartum period; and coordinate updates to the Plan. In doing so, they help families turn referrals into real connections and sustain engagement over time, strengthening the stability and protective factors child welfare systems look for when assessing infant safety and family functioning.

4. *Use warm handoffs rather than referral information alone.* In a warm handoff, the referring provider makes an active connection to the receiving service through direct interaction rather than simply passing along contact information. Warm handoffs increase receipt of services compared with standard referral approaches, with the strongest effects on initial linkage (Taylor & Minkovitz, 2021). Navigation shows similar effects: In a randomized trial with 2-1-1 callers, adding a navigator increased the likelihood that caregivers contacted a referred service compared to providing only a verbal referral (Kreuter et al., 2012), and a systematic review focused on perinatal substance use found patient navigation was associated with increased receipt of services and improved maternal and neonatal health (Wouk et al., 2024).

5. *Develop the POSC prenatally so services are in place before or at birth.* Although CAPTA does not require it, ideally a service provider, such as a substance use treatment agency or prenatal care provider, would develop the POSC during pregnancy. Doing so connects families to services earlier and reduces the likelihood of child welfare involvement after birth.

Streamline Plan of Safe Care processes through a unified workflow or portal. A single standardized workflow can support and drive the full process—from identification and eligibility determination through POSC development, referrals, and any required child welfare notification. This can take the form of:

- a technology platform or portal that supports data entry, decision logic, and referral routing, or
- a standardized manual workflow with uniform tools and forms used across hospitals and providers.

Several states have developed centralized online notification portals and structured data collection systems for Plans of Safe Care. Technical assistance and implementation guidance emphasize the importance of standardizing data elements, forms, and reporting procedures across hospitals to support consistent implementation and federal reporting requirements.

Build cross-system governance and accountability. A leadership body that spans health, child welfare, behavioral health, substance use, and early childhood systems, with inclusion of partners with lived experience, should oversee design, implementation, and monitoring of POSCs to support collaboration. A cross-system governance group can set shared definitions, priorities, and performance measures; align policies and protocols across agencies to minimize conflicting guidance; review data on identification, POSC completion, service linkages, and disparities; and guide continuous improvement efforts while addressing implementation barriers. This structure directly responds to the challenges of fragmented data, inconsistent practices, and limited accountability and is well-positioned to design and oversee implementation of Plan of Safe Care community pathways. When POSC criteria, roles, and processes are developed through cross-system collaboration, implementation is more likely to be coordinated and consistent (National Center on Substance Abuse and Child Welfare, 2020a; 2020b). Where counties administer child welfare, this governance may span two levels: a state body setting shared definitions, standards, financing, and performance measures, and county or regional bodies overseeing local implementation and connecting families to local services.

Financing: Resources to Bring the Plan of Safe Care Community Pathway to Life

Building and sustaining a strong Plan of Safe Care community pathway requires stable funding for navigation, services, information systems, training, administration, and governance. Sources of sustainable financing for the Plan community pathway include the following:

Title IV-E Prevention. Plans of Safe Care and the Title IV-E Prevention Program, which provides optional federal support for certain evidence-based mental health, substance use, and in-home parent skill-based services to help children remain safely with their families, naturally align on their preventive intent. It should be noted that a 2026 amendment to the Child Welfare Policy Manual clarifies that expectant parents may also receive Title IV-E–funded services to prevent the child from entering foster care at birth, thus enabling more pregnant people to access services under a POSC prenatally. Several mechanisms exist for leveraging Title IV-E for Plan activities:

- By incorporating the use of **Motivational Interviewing (MI),** a well-supported evidence-based practice on the Title IV-E Clearinghouse, into the service delivery of providers throughout the POSC process, eligible portions of providers' time become Title IV-E reimbursable as a service and under the rules of Title IV-E administration. MI provides a framework to reach, engage, and empower families and may be particularly well suited for Plan navigators who follow-up to help with referrals and offer support. In this case, the jurisdiction could align its criteria for candidacy for foster care (the finding that a child is at imminent risk of entering foster care) with its eligibility criteria for Plans of Safe Care and the POSC itself could inform or even constitute the child-specific prevention plan required by the Title IV-E Prevention Program (U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau, 2024).

- **Title IV-E administration (child-specific)** could be claimed for time spent by POSC navigators on referring and connecting families to Title IV-E prevention services. Additionally, federal guidance clarifies that administrative claiming also extends to navigation activities that reduce barriers to engagement, including assistance with child care, transportation, or similar supports that help families participate in Title IV-E prevention services. This claiming strategy would likely be worthwhile when referrals to Title IV-E services occur relatively often as part of the POSC pathway—such as through consistent referrals to statewide evidence-based home visiting programs or common substance use interventions. If referrals to Title IV-E prevention services are relatively infrequent, then the administrative burden of establishing processes to capture staff time and expenditures should be weighed against the potential revenue.
- **Title IV-E administration (general)** could be claimed to cover eligible initial and ongoing administrative costs associated with the POSC pathway on a cost-allocated basis—that is, to the extent the expenses support the "proper and efficient administration" of the Title IV-E prevention program. Eligible expenditures include both infrastructure and staff time—such as spending on technology, training, policy development, program development and management, data collection, reporting, and CQI. Importantly, it could be used to cover expenses for development and maintenance of a POSC technology platform.
- **Title IV-E Prevention Services.** Title IV-E prevention services include a range of mental health, substance use, and parenting interventions that could be appropriate for families receiving POSC. Knowing that a POSC is only as good as the services families can access through it, jurisdictions may wish to expand offerings for Title IV-E prevention services that are likely to align well with the needs of families receiving POSCs. In particular, Title IV-E could be claimed for the direct provision of home visiting services delivered through the Plan pathway when the service is allowable under the Title IV-E Prevention Program, the child meets candidacy requirements, and the service is included in the child's prevention plan. In this scenario, the POSC community pathway can function as a referral and engagement route into Title IV-E reimbursable home visiting services. In addition, jurisdictions may consider leveraging Title IV-E funds for evidence-based substance use services such as Sobriety Treatment and Recovery Teams , peer support models, and contingency management models.

Medicaid. Medicaid reimbursement is available for peer support specialists for mental health and substance use services. Peer support services must be integrated into comprehensive, individualized plans for care for the parent, which aligns with the Plan of Safe Care context. Peer support specialists must also be supervised by a mental health professional and must complete required training and certification (Centers for Medicare & Medicaid Services [CMS], 2007).

Federal Grants. Some federal grants can support Plan of Safe Care costs, including CAPTA and Temporary Assistance for Needy Families. These grants cover 100% of applicable expenses without state participation but are finite, unlike Title IV-E and Medicaid, which are uncapped. Moreover, because they can be used flexibly, these funds tend to be in demand for many purposes.

TOP 3 ACTIONS FOR STATE AND COUNTY LEADERS

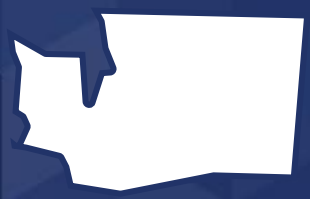
The following actions support the development of Plan of Safe Care community pathways as prevention-oriented approaches operating largely outside of child welfare. They emphasize clarifying who will lead, who is at the table, and how the work connects to existing strategies before moving into more detailed design decisions.

1. **Clarify leadership for the Plan of Safe Care community pathway.** An early step is to look systematically at existing statutes, current practice, political context and leadership capacity related to perinatal substance use and Plans of Safe Care. This type of review can help identify where there is genuine support for a community pathway and which senior leader or agency is best positioned to sponsor the work. Clarifying who is expected to hold overall responsibility for convening partners and advancing decisions provides a clear point of reference as the POSC community pathway is designed.

2. **Establish a cross-system core team with the necessary expertise.** Once sponsorship is clearer, state and county leaders can establish a small core team that brings together child welfare, public health, behavioral health, Medicaid, hospital and birthing providers, early childhood partners, and people with lived experience. As the team is formed, it is useful to consider the expertise and authority needed to inform the Plan of Safe Care community pathway decisions. These decisions include legal and privacy issues, information systems and data, Medicaid and financing, clinical practice for perinatal and substance use disorder, peer support, equity, and evaluation. Teams should invite additional members or ask for technical assistance where gaps appear. This core team offers a practical forum for describing the intended role of the Plan of Safe Care community pathway and for working through early implementation questions.

3. **Align existing strategies to define early implementation priorities**. With leadership and a core team in place, states can review how a Plan of Safe Care community pathway intersects with existing strategies related to perinatal substance use disorder, maternal and infant health, prevention, and child welfare. Looking across these efforts can clarify which problems the pathway is intended to address, which populations and settings are most important to include initially, and how the work can reinforce, rather than duplicate, current initiatives. This alignment helps define a small set of near-term implementation priorities that are grounded in existing commitments and provides a clearer foundation for subsequent decisions about practice, data, and financing.

Taken together, these steps provide a foundation for designing and building a Plan of Safe Care that functions as intended: a robust, voluntary, supportive pathway that keeps families safely connected to care outside of child welfare.



WASHINGTON

Community Pathway Spotlight

WHAT MAKES WASHINGTON'S MODEL WORK

Washington's model illustrates how Plans of Safe Care can function as a true prevention tool when supported by infrastructure. Key elements include:

- clear referral rules and decision logic built into an electronic portal,
- rapid, proactive follow-up by trained navigators,
- connections to tailored services, including perinatal behavioral health, home visiting, and basic needs supports, integrated data systems that support equity monitoring without over-surveillance, and
- strong cross-system governance that includes lived experts.

Washington State has built a comprehensive Plan of Safe Care program that includes both an involuntary child welfare pathway and a voluntary community pathway using hospitals as the single-entry point and layering in strong navigation and governance. In Washington, the referral and decision pathway begins at delivery, when birthing hospital team members initiate Plan of Safe Care referrals by entering information into the SafeCare Portal. This is a secure state portal with built-in decision logic and an anti-bias checkpoint to guide providers through structured questions about safety concerns, caregiver needs, and consent. As part of this process, hospital team members identify prenatal substance exposure based on clinical assessment and information available in the medical record, including documented caregiver history and, when ordered as part of clinical care, maternal or newborn toxicology results. They then document both prenatal substance exposure and whether the infant meets Washington's definition of a substance-affected newborn. That definition includes infants with withdrawal symptoms or other clinical signs attributed to prenatal substance exposure as well as infants affected by Fetal Alcohol Spectrum Disorder. The delivery pathway is Washington's statewide approach and the first phase of the model. Washington is extending it earlier through a pregnancy pathway that would add referrals from prenatal providers and self-referrals. State guidance gives prenatal substance use disorder care teams a role in introducing families to the POSC before the birth.

CPS referrals are not automatic and are made when there are child protective concerns under Washington's mandatory reporting standard. As outlined in this referral flow visual, if the hospital information entered indicates immediate safety concerns, the portal prompts them to call CPS to make a report. If safety concerns are not present and a parent consents, the portal sends the referral directly to Help Me Grow Washington, the state's POSC navigation partner. Data sent to Help Me Grow and used for federal reporting are de-identified, including items such as zip code, race and ethnicity, age, and substance type, which allows the state to meet CAPTA reporting requirements without creating

unnecessary CPS records. For families accessing a POSC through the community-based pathway, the resource navigation and family support component is provided by Help Me Grow navigators, who contact families within 48 hours (excluding evenings and weekends) to explain the POSC process, review what information was shared, and describe what families can expect next. Navigators conduct a structured needs assessment to understand caregiver, infant, and family needs and then connect families to supports such as maternal mental health services, substance use assessment and treatment, housing resources, home visiting, recovery support, early childhood programs, food assistance, health insurance enrollment, child development supports, and baby supplies. All navigation occurs virtually. Navigators provide ongoing follow-up, confirm whether services were accessed, and update the POSC as needs evolve so it functions as a living plan rather than a one-time document. This navigation model is currently supported outside of Washington's Title IV-E Prevention Program, as Washington is not yet claiming Title IV-E for any component of its Plan of Safe Care model. The program is funded through CAPTA and philanthropic support.

At the system level, Washington's governance and shared leadership structure comprises lived and community experts alongside the Department of Children, Youth, and Families (DCYF), the Department of Health, the Health Care Authority, the Washington State Hospital Association, and Help Me Grow Washington (WithinReach). A regular implementation team made up of DCYF and Help Me Grow staff manages day-to-day operations and problem solving. A community of practice provides interagency oversight and direction, and brings hospital partners together to share lessons, refine workflows, and troubleshoot challenges. Additionally, in the early implementation phase, an ad hoc citizen review and advisory body that included individuals with lived experience reviewed policy and practice and elevated family perspectives.

Washington's approach to data and continuous improvement includes regular reporting from DCYF and Help Me Grow on referral volume, navigator activity, service connections, and geographic trends. De-identified data submitted through the referral portal supports federal CAPTA reporting and informs ongoing implementation decisions.

Statement of Independence and Integrity

Chapin Hall is an independent policy research center focused on providing public and private decision-makers with rigorous data analysis and achievable solutions to support them in improving the lives of children, families and communities.

Chapin Hall partners with policymakers, practitioners, and philanthropists at the forefront of research and policy development by applying a unique blend of scientific research, real-world experience, and policy expertise to construct actionable information, practical tools, and, ultimately, positive change for children and families.

Established in 1985, Chapin Hall's areas of research include child welfare systems, community capacity to support children and families, and youth homelessness. For more information about Chapin Hall, visit Chapinhall.org.

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