COMMUNITY RESPONSE TEAMS

Best Practice Recommendations & Implementation Guide

Updated September, 2026

Strengthening Care for Pregnant and Postpartum Individuals Affected by Substance Use: *A framework for building coordinated, compassionate, community-based support systems*

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VCHIP
VERMONT CHILD HEALTH IMPROVEMENT PROGRAM

PERINATAL QUALITY COLLABORATIVE VERMONT

KidSafe Collaborative

VERMONT
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DEDICATION

This document is dedicated to Sally Borden, a visionary leader whose pioneering work through the Children and Recovering Mothers (CHARM) Team helped shape how the field thinks and approaches perinatal substance use care and families affected by substance use.

Through her unwavering commitment to improving outcomes for pregnant and parenting individuals affected by substance use disorders and their children, Sally created a more compassionate, patient-centered, and collaborative approach to care. Sally's belief in the power of bringing professionals and systems together influenced countless professionals and strengthened systems of care for families across Vermont and beyond. Sally's leadership, expertise, and dedication have inspired generations of professionals, regardless of the system they work in, to meet individuals and families with dignity, respect, and hope. The recommendations in this document reflect the values Sally championed throughout her career: collaboration, shared responsibility, continuity of care, and a steadfast belief in the potential for recovery and healthy family outcomes for all.

We gratefully acknowledge Sally's lasting contributions to the field and dedicate this work to her legacy of service, innovation, and tireless commitment to improving the lives of children, youth, and families.

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INTRODUCTION

This guidebook was created to ensure that every Vermont community has the tools to build and sustain a strong Community Response Team (CRT). The vision is that it will support regions without an active CRT, assist active teams seeking to strengthen their existing work, and serve as a resource for statewide evaluation and system-building.

It is important to note that CRTs vary by region in their structure, membership, and meeting format, reflecting the resources and needs of the communities they serve. The recommendations in this guide draw from the collective experience of CRTs across Vermont and are intended as best practices to provide a shared foundation that promotes collaboration, equity, and consistent access to services for families impacted by substance use.

It will help you:

- Understand perinatal substance use in Vermont
- Learn about the value of CRTs
- Evaluate community readiness
- Define best practices
- Prepare to start a CRT or implement best practices in an existing CRT in your region
- Identify widely applicable concepts and lessons from the CRT model

BACKGROUND

Perinatal Substance Use in Vermont

Maternal Mortality Review Panel

The Maternal Mortality Review Panel (MMRP) was established in 2011 to conduct comprehensive, multidisciplinary reviews of maternal deaths for the purpose of identifying factors associated with these deaths and creating recommendations for system changes for improving the health care and social services for individuals living in Vermont. The review includes considerations of health disparities and social determinants of health, including race and ethnicity.

To date, the MMRP has reviewed and analyzed more than a decade of maternal mortality cases from 2012 through 2024. Because the number of cases each year is small, combining thirteen years of data is necessary to identify meaningful patterns and disparities that would not be visible when looking at individual cases alone.

Maternal Mortality Review Panel 2026 Report to the Legislature

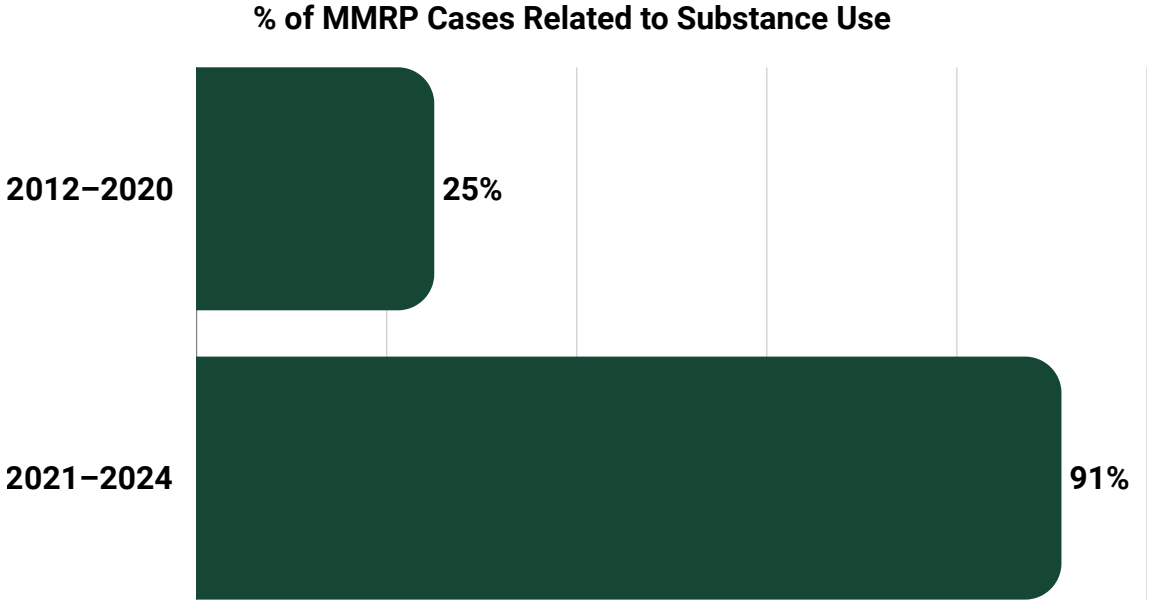
Key Decisions in MMRP Case Review

There are six key decisions the MMRP makes for each death reviewed:

1. **Was the death pregnancy-related?**
2. **What was the cause of death?**
3. **Was the death preventable?**
4. **What factors contributed to the death?**
5. **What are the recommendations to address those contributors?**
6. **What is the anticipated impact of those actions if implemented?**

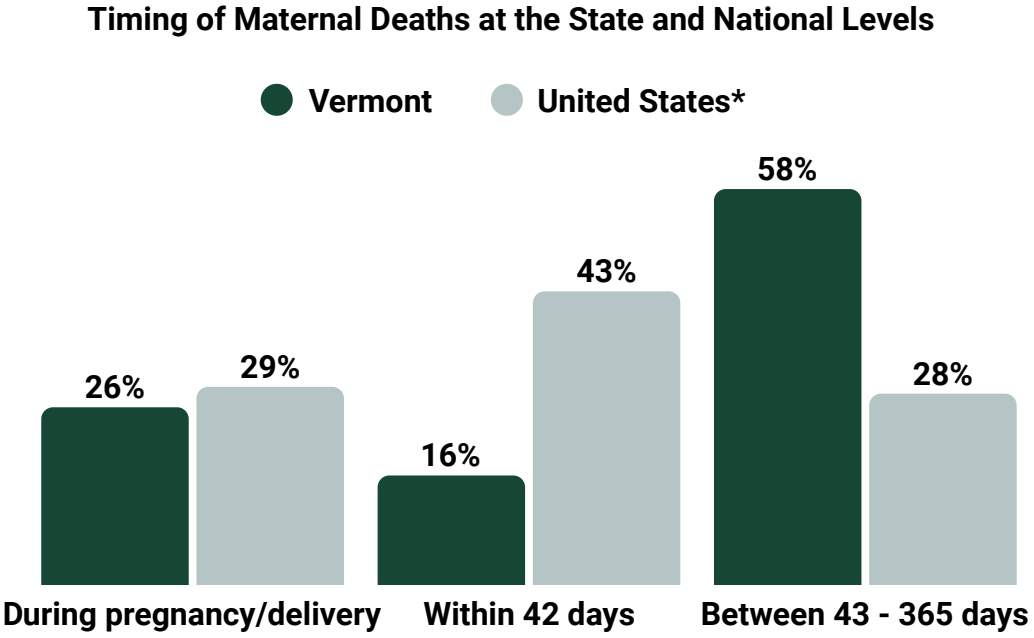
A Snapshot of Key MMRP Findings in 2026:

- **Substance Use**: Since the MMRP started reviewing cases, the causes of death have shifted to become primarily substance use related:



Source: Maternal Mortality Review Panel, 2026

- **Timing of Maternal Deaths**: Since 2012, most perinatal deaths in Vermont have taken place during the postpartum period (74% of all cases). Of those postpartum deaths, the majority happened between 43 days and one year after the end of pregnancy. The MMRP has highlighted this extended postpartum window as a particularly vulnerable time for perinatal people in Vermont.



*At the time of data collection, 46 states were reporting maternal deaths.

Sources: U.S. Centers for Disease Control and Prevention, 2017-2021. Vermont Vital Statistics, 2012-2024.

MMRP Data into Action

In 2026, blended CDC Overdose Data to Action and Perinatal Quality Collaborative grant funding is supporting continued efforts to strengthen coordinated care for perinatal people with substance use disorder. This funding specifically focuses on supporting and implementing Community Response Teams across Vermont, enhancing cross-cutting collaboration and coordinating care for perinatal people who use substances.

This toolkit was created as part of that effort. It serves as a practical guide for communities interested in adopting or strengthening the Community Response Team approach to support perinatal people affected by substance use. The materials in this document booklet are designed to help local teams build consistent, compassionate, and coordinated systems of care. By offering adaptable tools and shared language, the toolkit aims to support communities in launching, sustaining, and continuously improving their CRT model in ways that reflect local strengths and needs.

"In 2025, the panel reviewed three deaths, one death occurred in 2022 and two occurred in 2024. The cases reviewed this year by the MMRP included two deaths by accidental overdose and one from suicide. All were in the postpartum period in or near the home, involved polysubstance use and included mental health issues. Intimate partner violence and involvement with the child welfare system were also indicated in two of the reviews." -Maternal Mortality Review Panel Report to the Legislature 2026

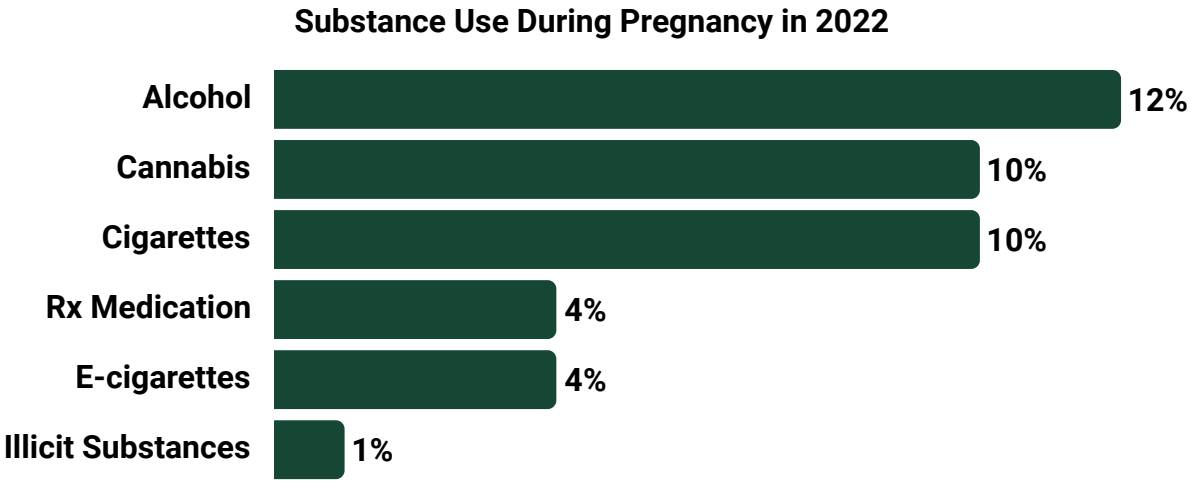
Pregnancy Risk Assessment Monitoring Program (PRAMS)

The Pregnancy Risk Assessment Monitoring System (PRAMS) is a survey of women who recently gave birth that asks about their experiences, behaviors, and healthcare utilization before, during and shortly after their pregnancy.

2020 Pregnancy Risk Assessment Monitoring System (PRAMS) Highlights

Key PRAMS Findings:

- **Substance Use**: Vermont has some of the nation's highest rates of substance use among pregnant individuals and caregivers, including tobacco, alcohol, cannabis, and other substances.
- **Age**: Individuals 35 and older were more likely to drink alcohol while pregnant, while those under 25 were more likely to use cannabis during pregnancy.
- **Medication Assisted Treatment (MAT)**: The percent of pregnant people with substance use disorder (SUD) who are enrolled in MAT is decreasing.



Source: Pregnancy Risk Assessment Monitoring System, 2022

The CRT Model

Community Response Teams (CRTs) have developed across Vermont as a way to bring together diverse partners in coordinated support of families impacted by substance use, with particular attention to pregnant individuals, infants, and young children. While CRTs intentionally reflect the unique needs and resources of their geographical regions, they are united by a common commitment to serving the same core population and by a shared philosophy of the importance of structured, multidisciplinary collaboration.

At the core of the CRT model is the intentional collaboration of medical providers, substance use treatment and recovery supports, and child welfare representatives, alongside other essential government and community organizations. By design, CRTs bring together systems that are often viewed as incompatible, in conflict, or separated by significant barriers to cross-system collaboration and information sharing. Through structured partnership, CRTs create a forum where these organizations can coordinate services, share knowledge, and collectively problem-solve on behalf of families they mutually serve.

The CRT model provides space for case consultation, systems navigation, and timely connection to services. By convening health care providers, social service organizations, and community-based entities, CRTs help reduce duplication of effort, address systemic barriers, and create more seamless pathways of care.

In addition to supporting individual families, CRTs also strengthen relationships among partner organizations. Through regular communication, shared learning, and relationship-building, CRTs enhance the community's overall capacity to respond effectively to the needs of families affected by substance use. The model emphasizes family-centered, trauma-informed, and equity-driven approaches that prioritize dignity, respect, and responsiveness to the needs of each family.

Overview of Existing CRTs in Vermont

In-Depth Technical Assistance Work

In April 2023, Vermont was selected to receive In-Depth Technical Assistance (IDTA) from the National Center on Substance Abuse and Child Welfare (NCSACW). The goal of IDTA was to increase the State's capacity to improve the safety, health, permanency, and well-being of infants and families affected by prenatal substance exposure. IDTA concluded in March 2025.

The Vermont IDTA (VT-IDTA) workplan included the following goals:

Goal 1: Map existing clinical and community-based services and support across the state that work with pregnant individuals and families experiencing substance use and identify barriers and gaps in care.

Goal 2: Ensure integration among existing (and new) clinical and community-based services/supports.

Goal 3: Apply a health equity approach to the issue of substance use in pregnancy and in families, including a review of policy and structural factors that contribute to health disparities.

Goal 4: Improve data collection as a strategy to apply quality improvement methods in clinical and community care toward the goal of increased care coordination and systems integration.

Goal 5: Address gaps and concerns related to the current process of developing and notifying plans of safe care.

Community Response Team Regional Status Assessment

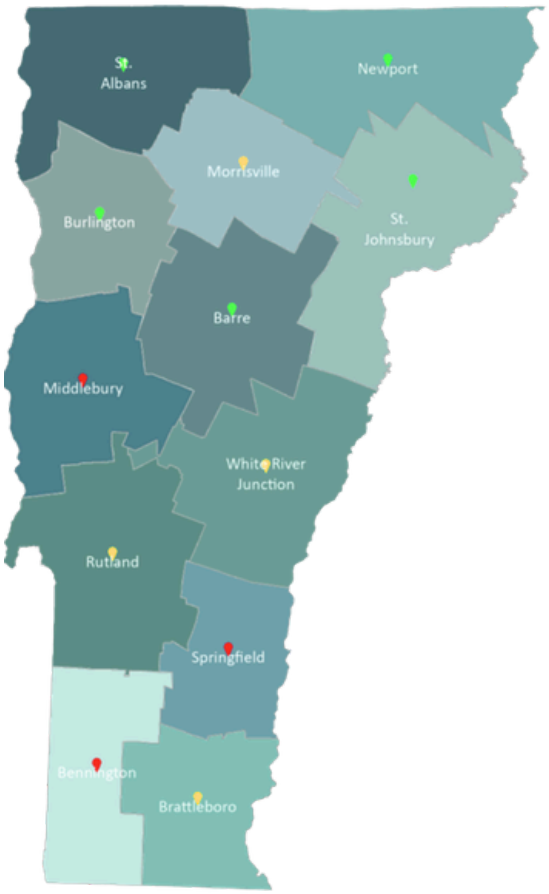
In January 2024, the Vermont In-Depth Technical Assistance (IDTA) team produced a briefing report on the status of CRTs in Vermont. To create the report, the Vermont Department of Health Division of Family and Child Health developed a survey tool to identify and map all functioning CRTs. The survey was administered to the 12 Family and Child Health Coordinators working in each Agency of Human Services (AHS) District. Members of the VT-IDTA team also completed follow-up calls with individuals involved in CRTs across the state.

Snapshot of the 2024 Findings:

5 Active Teams:
Barre
Burlington
St. Albans
St. Johnsbury
Newport

4 Inactive Teams:
Brattleboro
Rutland
Morrisville
White River Junction

3 Regions with no CRT Team:
Springfield
Middlebury
Bennington



Summary of Community Response Team (CRT) leadership Structure:

- Leadership varies by region.
- There is no designated leadership entity to oversee the CRTs.
- The leadership role is voluntary and can be taken by anyone on the team.
- CRT leaders and members are not paid for facilitation and participating in the meeting, therefore the time taken to participate in the CRT meetings is voluntary.
- When CRT members leave their roles, especially the leads, these transitions can derail the CRT work.
- None of the CRT teams currently have a person with lived experience in the specific role of peer support on the team.
- Sustainability plan and recommended best roles in a community to lead these teams is lacking. Best practice guidelines have not been updated since 2016.
- There is no uniform data collection system or monitoring activities to track the CRT work.
- Currently, there is no formal state system structure supporting CRT work in the region. Therefore, engagement varies widely.

Source: Vermont In-Depth Technical Assistance, 2024

Community Response Team Best Practices Workgroup

In continuation of the findings in the status assessment and as part of the workplan toward Goal 2 from the IDTA work, the Community Response Team Best Practices Workgroup was launched.

The workgroup is comprised of several members of the VT-IDTA core team, representatives from CRTs across the state, and other stakeholders. Workgroup membership was rolling and open to any interested person.

The recommendations issued from this workgroup were generated through collaborative discussion and a consensus decision making model.

SPOTLIGHT ON VERMONT CHARM TEAMS

SAMHSA Resource for Collaborative Model Approach (2016)

A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders

This manual provides guidance for states, tribes, and local communities on collaborative, evidence-informed approaches to treating pregnant women with opioid use disorders, including best practices and considerations for coordinated care.*

SAMHSA CASE STUDY (2026)

Healthy Starts: Postpartum OUD Care Transitions for Mother and Infant

This publication describes evidence-based strategies for supporting pregnant and postpartum patients with OUD to promote healthy outcomes for families. It highlights current research, features a case study of the Vermont CHARM Team approach, and provides recommendations for clinicians and care teams working across the perinatal continuum.

BEST PRACTICE RECOMMENDATIONS

Recommendations

1. Team Makeup
2. Information Sharing
3. Team Logistics and Administrative Support
4. Operations
5. Collaboration & Coalition Building

Recommendation 1: Team Makeup

Community Response Teams should be comprised of a core team of representatives. These core team members should participate on every community response team regardless of geographic location. In addition, each CRT also can include location-specific representatives who are supports/services specific to that region. Each CRT member holds equal participation value regardless of their status as a core or location-specific member.

Teams are encouraged to consider which position/s within the listed organizations are best suited to collaborate on the CRT. Factors to consider include staffing, capacity, interactions with identified patients, and other region-specific factors. Organizations are also encouraged to consider the unique needs of the family unit, adult, and child when selecting team representatives.

Recommended Core Team Members

1. Children's Integrated Services Coordinator or program staff
2. Department for Children and Families – Economic Services Division, Reach Up
3. Department for Children and Families – Family Services Division*
4. OB/Gyn office who see patients eligible for inclusion for discussion at the CRT
5. Pediatric offices or family care offices who see patients eligible for inclusion for discussion at the CRT
6. Regional Designated Agency
7. Regional Home Health agency
8. Regional medication for opioid Use disorder (MOUD) hub and/or spoke
9. Recovery center or other peer support
10. Vermont Department of Health – Regional District Family and Child Health Coordinator

Location-Specific Members for consideration. This is not an exhaustive list.

1. Head Start Program
2. Outpatient treatment offices
3. Parent Child Center
4. Regional delivery hospital, particularly labor and delivery or recovery units**
5. Residential treatment providers
6. RPP Clinician
7. VT Department of Health - Division of Substance Use Programs

**Inclusion of DCF Family Services*

Many active CRTs across Vermont already include representatives from the Department for Children and Families - Family Services Division (FSD). The workgroup agrees that regions considering establishing a CRT should give thoughtful consideration to the benefits and challenges of including FSD on their teams.

Family Services plays a critical role in the safety, care, and protection of children and may be actively involved with families impacted by parental substance use. Their participation can offer valuable insight, education, and consultation to CRTs even in cases where they are not directly involved with an individual family. Excluding Family Services from a CRT may limit or prevent opportunities for comprehensive, coordinated support for families. Exclusion of FSD may also limit the options available for information sharing; see Recommendation 2: Information Sharing.

At the same time, the presence of DCF Family Services may introduce fear or hesitancy among families, potentially limiting their voluntary participation in the CRT. There may also be barriers and concerns to address regarding information sharing by team members.Regions are encouraged to weigh these considerations carefully and work collaboratively to determine involvement of FSD.

It is recommended for groups to consider their regional needs, including the frequency of FSD involvement in cases, opportunities for consultation and training, the impact on positive cross-sector relationship building, and the potential impact on family engagement. Different case review models may support flexible involvement, such as engaging Family Services only in cases with active FSD involvement or structuring participation around team education and systems consultation rather than individual case discussion.

It is also important to note that all CRT members are considered mandated reporters and are required to act according to Vermont law. Each member has a professional and legal obligation to make a report to FSD if they suspect child abuse or neglect. CRT meetings and case reviews are not intended to serve as forums for determining whether a member should make a report. Including FSD on a CRT does not change an individual member's responsibility to report and is unlikely to increase the rate of reporting or influence whether a member chooses to file a report in a specific case.

***Involvement of Regional Delivery Hospitals*

Regional delivery hospitals are included in the list of location-specific members due to the important role they play in caring for pregnant individuals and newborns who may be eligible for discussion within a CRT. Hospital-based providers, particularly those working in labor and delivery, postpartum, or recovery units, may offer valuable clinical insight, care coordination, and opportunities for timely connection to supports.

However, the availability of birthing hospitals across Vermont has declined in recent years, contributing to the emergence of "maternity care deserts" in some regions. As a result, many delivery hospitals now serve patients from broader geographic areas and may fall within the service regions of multiple Community Response Teams. While participation in more than one CRT may be ideal from a care coordination perspective, the capacity of hospital staff to attend multiple regional meetings may be limited.

CRTs are encouraged to include representatives from regional delivery hospitals whenever possible, while also recognizing the operational constraints that may affect participation. Teams should plan proactively for collaborative engagement with delivery hospitals, which may take different forms depending on regional needs and capacity. Examples may include participation when a hospital's patient is included on the case list, establishing regular communication outside of CRT meetings when appropriate, identifying a regional care coordinator role, or developing other creative coordination strategies that support timely information sharing and continuity of care.

Recommendation 2: Information Sharing

Successful Community Response Teams rely on effective communication and collaboration between partner organizations. Sharing client information in a timely, transparent, and appropriate manner is essential for coordinated care. At the same time, CRTs must navigate legal, ethical, and trust-based considerations when sharing sensitive, highly confidential information.

All teams must ensure that their information sharing practices comply with applicable federal and state laws, including HIPAA, 42 CFR Part 2, and FERPA, where relevant. Teams are encouraged to develop clear protocols for information sharing that are grounded in informed consent, confidentiality, and respect for family autonomy.

Whenever possible, CRTs should obtain written, voluntary consent from individuals whose cases are being discussed. Consent forms should be easy to understand, outline the purpose and scope of information sharing, and clearly state which organizations will have access to the shared information. Team members should be prepared to explain the CRT process to families and answer any questions to support truly informed consent.

In addition to individual consent, teams are encouraged to establish a Memorandum of Agreement (MOA) or Understanding (MOU) among participating organizations. MOA/MOUs are legally binding agreements and must be established and signed following individual organization policies for these types of agreements. Despite the administrative burden of establishing them, they are a valuable tool to clarify shared goals, expectations, and responsibilities. They also provide a framework for information sharing, participation, and confidentiality for highly protected personal health information.

All teams should become an empaneled Child Protection Teamthrough the Vermont Department for Children and Families. Empanelment offers legal protections for team-based case review and allows for a broader scope of information sharing particularly for child safety. Becoming an empaneled child protection team can strengthen the legal foundation of the CRT and help promote transparent, coordinated care while maintaining compliance with confidentiality requirements. However, it is important to recognize that empanelment creates additional administrative work and responsibilities. Teams should plan proactively for this administrative workload as part of CRT development and maintenance. Further details and planning considerations for empanelment are outlined in Section 3.

In cases where individual consent is not provided, teams must adhere strictly to the minimum necessary standard and legal restrictions around information disclosure. The scope of information shared under empanelment is specific, and some agencies or organizations may provide additional guidance on what their team members are permitted to share. Regardless of these stricter guidelines, empanelment ensures that DCF Family Services Division (FSD) can provide general consultation, share relevant information, and offer guidance and input from the perspective of child protection. Teams may choose to structure their meetings to allow for general education, systems-level consultation, resource sharing, or pattern identification even when individual case discussion is not possible.

Regions are encouraged to seek legal and compliance support as needed and to provide regular training for CRT members on relevant privacy regulations and best practices in client-centered information sharing. Examples include, but are not limited to VCHIP ICoNS conferences, PQC-VT trainings, AIM bundles and information, consultation and presentation with subject matter experts, and more.

Recommendation 3: Administrative Support

Strong logistical and administrative structures are foundational to a successful Community Response Team. Dedicated support allows the team to function smoothly, maintain consistent participation, and focus on collaborative problem-solving for families.

Core administrative responsibilities for a well-functioning team include, but are not limited to:

- Facilitating the meeting and conversations
- Member onboarding and support
- Agenda development and meeting reminders
- Documentation, including meeting notes, case summaries, data collection, and support for continuous quality improvement efforts
- Consent form management, including clear and secure record-keeping practices that maintain compliance with privacy standards
- Meeting logistics such as virtual meeting links or room reservations
- Overseeing the process of empanelment as a Child Protection Team, including submitting the initial request, managing the required annual renewal process, and coordinating any case-by-case temporary empanelment when needed.

Whether these tasks, and others identified by each team, are held by one primary coordinator or distributed across multiple members, each task must be explicitly identified, defined, and understood. Cross-training and shared responsibility can strengthen team stability, but only when accompanied by clarity about who is responsible for each function. Teams should also establish an alternate plan for administrative duties when the designated individual is unavailable due to illness, vacation, or other scheduling conflicts.

In evaluating how to structure administrative support, teams should consider not only the skills required for each task but also the short- and long-term capacity of the individuals or entities carrying them out. Experience has shown that CRT operations can be disrupted or cease when administrative responsibilities rest with a single individual who leaves their position. Selecting an entity or role with stability and ongoing responsibility for these tasks is essential to the long-term functioning and success of the team.

It is also recommended that teams carefully determine who will facilitate the meeting discussion. Effective facilitation requires a high degree of skill to help the team navigate complex conversations where disagreements or differing viewpoints may arise, ensuring that discussions remain respectful, focused on shared goals, and remain client and family centered. A strong facilitator must also be willing and able to speak about and address bias and stigma. This is especially important given the population CRTs serve. The facilitator carries a primary role in ensuring that they, and other CRT members, do not perpetuate these issues.

Teams may consider a variety of options to fulfill the administrative role of their CRT, and this may vary by region. Both government and non-government entities may be appropriate, depending on local context and resources. Examples include a non-profit organization, a representative from the hospital or medical system, or a Vermont Department of Health (VDH) Division of Substance Use (DSU) prevention consultant. In the absence of a clear choice, teams should strongly consider utilizing their regional district VDH Family and Child Health Coordinator, as this role is consistent and present statewide.



Recommendation 4: Operations

The effectiveness of a Community Response Team depends not only on its membership but also on the consistency and quality of its operations. Predictable, structured, and sustainable practices help maintain momentum, strengthen relationships, and ensure continuity of support for families.

Meeting Structure and Schedule

Teams should establish a predictable meeting schedule that is both consistent and responsive to the needs of the population served. While this guide does not prescribe a specific schedule, meeting at least monthly is recommended as best practice. This frequency balances staffing and preparation demands with the evolving needs of families, particularly prenatal patients, for whom long gaps between meetings may have significant impacts. Meeting less frequently risks losing continuity, momentum, and timely responsiveness. Offering hybrid or virtual participation options can further increase accessibility and sustain engagement across diverse organizations and geographic areas.

Onboarding and Member Preparation

CRTs are advised to develop clear protocols for onboarding new members. Orientation materials should outline the CRT's purpose, structure, confidentiality expectations, and operational procedures. Thorough onboarding ensures that new members are prepared to participate effectively and uphold shared standards from the outset.

Team Sustainability and Succession Planning

Sustainability must be a central consideration for CRT operations. Member turnover is inevitable and not inherently problematic; however, without intentional planning it can disrupt team functioning. Teams should maintain processes to identify replacement members or alternates, particularly for core members, and organizations are encouraged to train additional internal staff so that knowledge and capacity are not lost when a single individual departs or is unavailable.

Succession strategies for those that hold administrative tasks, including back-up plans and cross-training, are equally important. Shared responsibility, clear documentation of procedures, and well-defined expectations all support long-term stability and continuity.

In-Kind Staff Participation and Financial Considerations

CRT operations rely on consistent in-kind staff participation as the foundational resource. For many regions, in-kind participation alone may be sufficient to support regular meetings and essential administrative tasks. Some entities, however, may determine that additional financial support is necessary to sustain staff involvement, such as grant funding to offset staff time dedicated to coordination or facilitation.

Teams may also identify needs or priorities that require financial resources beyond staffing. Examples include funds for family engagement (e.g., gift cards), stipends for education or professional development, or materials for team outreach. The type and level of financial support needed will vary by region depending on organizational structure, community resources, and local priorities.

To support long-term stability, teams should plan early for the sustainability of in-kind staff participation. Sustaining in-kind involvement over time may require organizational leadership support, intentional workload planning, and periodic reassessment of capacity. Regular review of staffing needs and support structures can strengthen the CRT's ability to function effectively over time.

Relationship Building and Team Cohesion

The operational success of a CRT depends heavily on the strength of relationships among its members. Trust, open communication, and mutual respect are essential to effective collaboration and information sharing. Teams should invest in building and maintaining these relationships through inclusive decision-making, coalition-building opportunities, and intentional activities that support shared learning. Ongoing training can reinforce a culture of trust and accountability, helping the CRT remain cohesive and resilient even as individual members or organizational representatives change.

Recommendation 5: Collaboration & Coalition Building

Collaboration is at the heart of an effective CRT. Beyond the mechanics of case review, CRTs thrive when members build trust, understand one another's roles, and share a commitment to collective problem-solving. Intentional time and strategies for coalition building are essential to strengthening both individual relationships and the overall system of care.

CRTs should include regular time for team-building activities. This can be accomplished through structured opportunities for information sharing, system updates, and broader discussions beyond individual cases. While the case review process is often the central focus, dedicating space for open dialogue helps members better understand the perspectives of other disciplines, strengthens collaboration, and builds the foundation of trust necessary for addressing challenging situations.

Additional Recommendations for Strengthening Collaboration:

- Shared Learning and Training: Teams are encouraged to engage in joint training opportunities to build a common foundation of knowledge and skills. Shared training on topics such as substance use, trauma-informed care, and health equity can create shared language and strengthen collective capacity.

- Role Clarification and Cross-Education: Members should have opportunities to explain their organizational role, constraints, and decision-making authority to the team. This cross-education supports mutual understanding and reduces misunderstandings that can otherwise undermine collaboration.

- Celebration of Successes: Taking time to highlight positive outcomes. Whether for families, system improvements, or member contributions, shared positive outcomes reinforces a sense of shared purpose, fosters motivation, reduces stigma of clients, and helps to reduce burnout.

- Conflict Resolution Practices: Because CRTs bring together diverse organizations and viewpoints, disagreements are inevitable. Teams should establish respectful, structured methods for addressing conflict to ensure it strengthens rather than weakens collaboration.

- Equity and Inclusion Practices: Collaboration is enhanced when all voices at the table are valued and heard. Teams should be attentive to power dynamics and actively promote equitable participation from all members.

- Together, these practices help ensure that CRTs operate not only as functional case review teams but as strong, resilient coalitions capable of driving systems change and improving outcomes for families across Vermont.

Closing

Building and sustaining strong Community Response Teams is both a challenge and an opportunity. It requires trust, resources, and persistence, but it also yields the reward of stronger families, healthier communities, and a more connected system of care. This guide is intended to serve as a foundation for action, whether to launch a new team, strengthen an existing one, or evaluate progress toward equity and access. Additional information and support can be found in the CRT Toolkit (name TBD) at insert webpage. By implementing these recommendations, regions can help ensure that CRTs remain a cornerstone of coordinated, equitable, and family-centered support for Vermonters impacted by substance use.

REFERENCES

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3. Vermont Vital Statistics. (2012-2024). Vermont Department of Health Vital Statistics System.
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5. Vermont In-Depth Technical Assistance (VT-IDTA). (2024). *Briefing Report: Regional Status Assessment of Community Response Teams*. Vermont Department of Health.

Appendix A: Acknowledgments

The Community Response Team Best Practices Workgroup thanks the partner organizations across Vermont whose representatives contributed their time, expertise, and insights to the development of this guide. Their collective experience reflects the shared commitment to strengthening systems of care and improving outcomes for families impacted by substance use.

- Central Vermont Medical Center, UVM Health
- Department for Children and Families, Family Services Division
- Department for Children and Families, Children's Integrated Services
- KidSafe Collaborative
- Kingdom Recovery Center
- Vermont Child Health Improvement Program
- Vermont Department of Health, Burlington Office
- Vermont Department of Health, Division of Family and Child Health
- Vermont Department of Health, Division of Substance of Substance Use

The Community Response Team Best Practices Workgroup gratefully acknowledges the contributions of the following individuals. Their expertise, dedication, and collaboration were central to the development of these recommendations.

- Jennifer Auletta
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- Meghan Masterson
- Mariah Ogden
- Adrianna Tomasi
- Maria White
- Krysta Zabriskie

Appendix B: Regional Resource Identification Checklist

1. Recommended Core Team Members

☐ CIS Coordinator or program staff

Name: _____

Contact Details: _____

☐ DCF - Economic Services Division

Name: _____

Contact Details: _____

☐ DCF - Family Services Division

Name: _____

Contact Details: _____

☐ OB/GYN Practice(s)

Name: _____

Contact Details: _____

Name: _____

Contact Details: _____

☐ Pediatric/Family Care Practice(s)

Name: _____

Contact Details: _____

Name: _____

Contact Details: _____

☐ Designated Agency

Name: _____

Contact Details: _____

☐ Home Health Agency

Name: _____

Contact Details: _____

☐ MOUD hub and/or spokes

Name: _____

Contact Details: _____

Name: _____

Contact Details: _____

☐ Recovery Center(s) or other peer supports

Name: _____

Contact Details: _____

Name: _____

Contact Details: _____

☐ Vermont Department of Health - Regional District Family and Child Health Coordinator

Name: _____

Contact Details: _____

2. Location-Specific Members for Consideration

☐ Head Start Program

Name(s): _____

Contact Details: _____

☐ Parent Child Center

Name: _____

Contact Details: _____

☐ Regional Delivery Hospital

Name: _____

Contact Details: _____

☐ Outpatient Treatment Practice(s)

Name: _____

Contact Details: _____

Name: _____

Contact Details: _____

☐ Residental Treatment Provider(s)

Name: _____

Contact Details: _____

Name: _____

Contact Details: _____

☐ Lund Regional Partnership Program Staff

Name(s): _____

Contact Details: _____

☐ VT Department of Health - Division of Substance Use Programs

Name(s): _____

Contact Details: _____

☐ Other: _____

Name(s): _____

Contact Details: _____

Appendix C: Understanding Your Impact and Telling the Story

A Community Response Team creates meaningful change in a region, and capturing that story helps teams understand what's working, where families are benefiting, and how collaboration is strengthening local systems. Tracking some simple markers can help teams see their impact over time and celebrate progress. Potential measures to track the impact and tell the story include:

Quantitative

- Family Connections — number of unique families supported; number of children supported
- Partner Engagement — number of representatives, number of partnering organizations, participation rate (percent of key organizations attending)
- Cases — number of case reviews conducted

Qualitative

- Barriers Identified — challenges families face
- Success Highlights — stories or examples that show how coordinated support made a difference
- Process Improvements — changes made to workflows, communication, or coordination as a result of team meetings
- Training or Resource Requests — identified areas where additional support is needed
- Team Reflections — insights about what's helping the team function well and what could strengthen collaboration

Additional Considerations:

- Frequency: Monthly/Quarterly/Annually
- Who will document
- How documentation will be saved/shared
- Measures for ensuring confidentiality/privacy

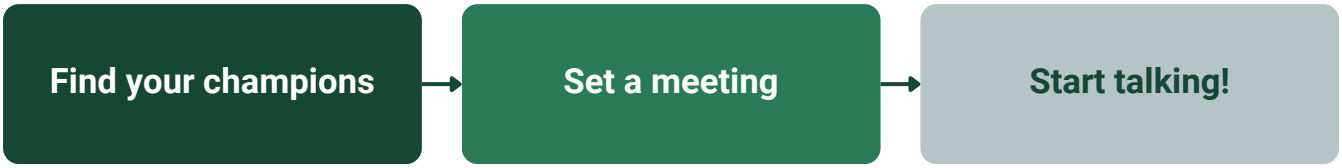
Keep in Mind...

If your CRT secures grant funding or other financial support, be aware that additional, more specific performance measures may be required. These funder-driven metrics often extend beyond the core measures listed here and may include detailed reporting on activities, outcomes, or population-level impacts.

Appendix D: Starting the Conversation in Your Community

This appendix provides a set of core messages and framing tools to help you introduce the Community Response Team approach to potential partners and early stakeholders. These points are designed to support you in building interest, establishing shared purpose, and creating momentum as you begin forming your team.

Use these key messages and talking points when connecting with partners and potential team members. They can be woven into slide decks, shared in email outreach, or incorporated into one-on-one conversations. Use whatever approach feels most natural and effective for your community and potential partners.



Key Messages

- **The CRT is flexible and community-driven.** Each region can tailor its structure, membership, and priorities to local priorities and strengths.
- **Starting a CRT is NOT all or nothing**. This guide provides recommended best practices but there are smaller steps that can be taken to build towards this. Start by focusing on priority tasks with established or invested key partners.
- **There is a strong foundation and precedent for this work.** CRTs already operate successfully across Vermont, offering proven examples, shared learning, and guidance to support new communities as they launch and grow their teams.
- **Communities already have many strengths and resources.** The CRT helps align them, reduce duplication, and identify gaps.
- **Cross-sector collaboration leads to better outcomes** for families, including improved engagement, smoother care transitions, and stronger support networks.
- **The CRT model strengthens local coordination and reduces workload** by bringing together partners who support perinatal individuals affected by substance use.
- **This approach centers the needs and experiences of pregnant and parenting people** who use substances, ensuring they receive compassionate, connected, and non-stigmatizing care.
- **This work reduces stigma and promotes dignity** by shifting conversations toward support, safety, and family well-being.

FAQs

What is the purpose of a Community Response Team?
A CRT's purpose is to bring partners together to coordinate care for perinatal individuals and families affected by substance use. It creates a structured space for shared problem-solving and communication across systems, helping reduce barriers and ensure families receive timely, connected, and compassionate support.

Who should be part of the team?
Membership will vary by region and depends on local resources, strengths, and priorities. CRTs often include clinical providers, social service agencies, early childhood partners, recovery organizations, public health professionals, and people with lived experience. See Best Practice Recommendation #1 for a comprehensive list of partners to consider.

How much time or commitment is expected?
Teams typically meet at least once a month. Roles can be flexible, and participation can evolve as the team grows. Hybrid or virtual participation options can increase accessibility and sustain engagement.

Does our community need to have everything figured out before starting?
No! The CRT model is designed to grow over time. Early meetings often focus on relationship-building, mapping existing resources, and identifying shared priorities. Start by focusing on priority tasks with established or invested key partners.

Do all partners need to be empaneled before we get started?
Not necessarily. In the early stages or in the pilot phase, individual consents for each organization could be utilized.

What if we already have related initiatives underway?
The CRT can complement and strengthen existing efforts by creating a shared table for coordination and reducing duplication. Existing groups or coalitions with established relationships are a great place to start, inviting other partners to join as the work progresses.

Will we need to track data or measures?
Basic measures are recommended for all teams. This will allow If your community receives future grant funding, additional or more specific metrics may be required by funders. See Appendix C for more details.

First Steps to Build Momentum

- Identify a small group of early champions who can help shape the first meetings and outreach.
- Schedule an initial gathering to introduce the CRT concept, share any applicable data, and begin mapping existing resources.
- Clarify the team's early purpose—such as improving communication between organizations, supporting care transitions, or increasing utilization of available resources. Consider the regional priorities and strengths to help define initial areas of focus.
- Develop a simple outreach plan to engage additional partners, including those not traditionally involved in perinatal substance use work.
- Create a shared list of immediate priorities to guide the first few months of meetings.
- Revisit and refine the team structure as membership grows and community strengths, needs, and priorities become more evident.

COMMUNITY READINESS ASSESSMENT TOOL

Indicator / Practice	Readiness	Priority	Notes -What is going well? -What else do you need to do? -Who do you need to connect with?
Partnerships & Collaboration			
Key partners identified *See Checklist			
Existing relationships between partners are active and functional.			
Shared understanding of the purpose and goals of a community response team among key partners.			
Commitment from leadership across partner organizations to participate.			
Community Need & Context			
Regional information available on perinatal substance use, overdose risk, and service gaps.			
Understanding of lived experience through engagement with individuals and families.			
Awareness of cultural, geographic, and socioeconomic factors shaping access to care.			
Clear rationale for why a response team is needed now.			
Readiness for Implementation			
Shared goals and early priorities identified by partners.			
Willingness to pilot and refine the model as the team learns.			
Openness to continuous improvement and feedback.			
General agreement that the community is ready to move forward.			

Resources, Capacity & Sustainability			
Designated coordinator or lead organization willing to convene the team.			
Capacity for key partners to attend meetings, follow up on action items, and participate in case review or system-level discussions.			
Basic operational supports (plan for meeting platform, scheduling, documentation, etc.).			
Long-term vision for sustaining the team beyond initial launch.			
Policies, Protocols & Safety			
Shared agreements on confidentiality, information-sharing, and consent.			
Trauma-informed and stigma-free practices understood and embraced by partners.			
Clear referral pathways for perinatal individuals who use substances.			
Awareness of legal and ethical considerations related to substance use in pregnancy.			
Stigma, Bias & Equity			
Commitment to equity in design and implementation.			
Partners commit to regular learning around stigma, bias, and the systemic factors shaping perinatal substance use.			
Accessibility considerations (language, literacy, transportation, technology, etc.).			

Appendix F: Sample Memorandum of Agreement (MOA)

The following pages include a sample MOA currently used by the CHARM Team to outline roles, responsibilities, and collaborative expectations among partners engaged in coordinated perinatal substance use response. This sample is provided for illustrative purposes only. Regions developing their own MOA should consult appropriate organizational, legal, and compliance entities to ensure the document aligns with local needs, structures, and requirements.

The CHARM Team's MOA is specifically tailored to work with individuals affected by opioid use disorder, reflecting the team's focus and the partners involved. Community Response Teams may choose to adopt a broader scope depending on the populations they serve and the goals of their collaborative model. The example included here can serve as a starting point for thinking through cross-sector agreements, but each region should adapt content to fit its own context, partners, and priorities.

Key Elements of a Memorandum of Agreement

- Purpose of the CRT
- Structure of the Collaboration
- Information Sharing Framework
- Privacy and Confidentiality Requirements
- Mandatory Reporting
- Client Consents
- Client Rights
- Consent Duration

MEMORANDUM OF AGREEMENT REGARDING

CHILDREN AND RECOVERING MOTHERS (CHARM)

Whereas, the Children and Recovering Mothers Program [hereinafter "CHARM" or the "Program"] is a coalition of service providers serving women with chemical dependency and their children. It is not a separate legal entity.

Whereas, the purposes of CHARM are to coordinate services to meet the needs of pregnant and birthing parents with chemical dependency and their children, improve the delivery of services to these birthing parents and their children, and identify gaps in services that need to be addressed.

Whereas, an individual participating in CHARM [hereinafter "client participant"] may be provided direct services by any or all of the Parties, in which case that individual becomes a client of each Party that provides such a service.

Whereas, the Parties desire to set forth their understandings with respect to the way in which they will comply with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 [hereinafter "HIPAA"], federal confidentiality provisions governing substance abuse treatment, and State confidentiality provisions.

Now Therefore, the Parties, acting by and through the undersigned duly authorized agents, hereby agree as follows:

(1) In order to facilitate the internal case coordination, referral and assessment needs of client participants, each such participant in the Program will be requested to sign

a Client Consent for release and sharing of information among the Parties in the form attached to this Agreement as Attachment B (hereinafter the "Client Consent"). The Client Consent, when signed by the client participant, is intended solely for the uses described in it and is not intended to serve as a consent for release of information with respect to any other matter, including, without limitation, treatment, payment, or health care operations, or for disclosure of confidential information to any third party, except as expressly so authorized by that Client Consent.

(2) With respect to all information related to client participants in the Program, each Party agrees to fully abide by the terms and conditions set out in the HIPAA Privacy Rule, 42 C.F.R. Part 2, 7 C.F.R. § 246.26, and State confidentiality provisions to the extent such rules and provisions apply to that Party.

(3) Each Party that is currently subject to HIPAA will continue its practice of being individually responsible for providing HIPAA Privacy Rule protections (including, without limitation, a Notice of Privacy Practices) and State privacy protections to each client participant to whom it provides direct services.

(4) Except as otherwise required by State or federal law, each Party specifically agrees to restrict access to and use of any and all information regarding client participants only to those client participant personnel who require access to such information for the purposes set forth in the Client Consent.

(5) The Parties further agree that, unless otherwise provided or allowed by law, any and all information regarding client participants shall not be used or disclosed for any purpose except those specified in the Client Consent.

(6) The Parties recognize that as mandated reporters of suspected child abuse and neglect under the provisions of 33 V.S.A. § 4913, they are required to report any and all incidences where there is reasonable cause to believe that a child has been abused or neglected or is at significant risk of harm to the Vermont Department for Children and Families.

(7) Nothing in this Agreement shall give rise to or be deemed to give rise to any third party beneficiary rights to any third party, and in particular, but without limitation, this Agreement does not give rise to any third party rights to any client participant.

This agreement is effective immediately following obtainment of the final signature of the parties listed on Attachment A [hereinafter referred to collectively as the "Parties," or for any one of the Parties, as a "Party"], and replaces the Memorandum of Understanding Regarding the Children And Recovering Mothers Program signed November, 2012.

So entered into By,

[INSERT SIGNATURE PAGES]

CHILDREN AND RECOVERING MOTHERS (CHARM) PROGRAM

CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT AND SOCIAL SERVICES

(VERSION.05022024)

INTRODUCTION:

Children and Recovering Mothers ("CHARM") is a cross-agency collaborative team whose goal is to improve the health and safety of babies born to birthing parents with a history of opioid use disorder by coordinating medical care, substance use disorder treatment, child welfare, and social service supports.

The CHARM coalition of service providers works together to provide a collaborative approach to supporting birthing parents and their infants prenatally and post-partum to one+ year(s).

GENERAL PROVISIONS CONCERNING YOUR CONSENT

I, _____, date of birth _____, authorize the use and disclosure of my health and treatment information and that of my child by and among each of the team members of the Children and Recovering Mothers (CHARM) Team, including any individual(s) involved in the direct service or service coordination within each organization.

The Children and Recovering Mothers (CHARM) Team members participate from the following organizations:

- BAART Programs (Vermont)
- Community Health Centers
- Howard Center
- KidSafe Collaborative
- Lund
- Monarch Maples Pediatrics
- Northwestern Counseling and Support Services, Inc.
- Northwestern Medical Center
- Turning Point Center of Chittenden Co.
- Turning Point of Franklin Co.
- University of Vermont Health Network, Home Health & Hospice
- University of Vermont Medical Center/ University of Vermont Children's Hospital
- Vermont Agency of Human Services including Departments: Children and Families, Health, Health Access, Mental Health, Corrections
- VNA And Hospice of the Southwest Region

I understand that not all of the CHARM Team participating agencies are involved in my care or that of my child. I understand that the purposes of the CHARM Team are to evaluate the need for and facilitate the coordination of medical services, substance use disorder treatment services, and social support services in order to best provide for the health and safety of my child and to support my successful treatment during pregnancy and post-partum.

I authorize the use and disclosure of my health and treatment information and that of my child by and among the participating organizations of the Children and Recovering Mothers (CHARM) Team solely for these stated purposes. The means of this use of disclosure may be written, verbal or electronic.

The health and treatment information that will be shared may include the following:

- Name, date of birth
- Address, contact information
- Pregnancy and delivery
- Current living situation
- Psycho-social history
- Prenatal and post-partum medical care
- History and attendance at alcohol/drug treatment, including methadone and suboxone maintenance
- Mental health and/or drug and alcohol assessment, diagnosis, treatment, progress and discharge summary
- Department for Children and Families involvement
- Children's health and safety assessments and treatment
- WIC, Reach Up, Dept. of Corrections, VT AHS services

ADDITIONAL PROVISIONS CONCERNING YOUR CONSENT

I understand that my alcohol and/or drug treatment records are protected under federal statutes and regulations governing the *Confidentiality of Substance Use Disorder Patient Records*, including 42 C.F.R. Part 2, and my personal health information is protected by the Health Insurance Portability and Accountability Act of 1996 ["HIPAA"], 45 C.F.R. Pts. 160 & 164, and in some cases by 7 C.F.R. § 246.26, and such information cannot be disclosed without my written consent unless otherwise provided for in these provisions.

I also understand that my decision to use the services of the Children and Recovering Mothers (CHARM) Team is voluntary. My signature indicates that I understand the important information provided in this Consent. I may end CHARM Team services at any time.

I understand that if I want members of the CHARM Team to disclose information about me or my child to someone other than the members of the CHARM Team, I will need to sign a separate Consent or Authorization to release such health and treatment information for each party to whom such information is disclosed, except as specifically described below.

I further understand that if any of the members of the CHARM Team or the participating organizations want to use or disclose any information regarding me or my child for a purpose other than that described in this Consent form, except information required by law pertaining to the mandatory reporting of suspected child abuse or neglect, that member or participating organization must obtain my written permission, stating the purpose of the consent, prior to using or disclosing that information.

I also understand that I may request restrictions on the use or disclosure of treatment records. I understand that the CHARM Team will consider my request but is not bound to agree to it in which case I may decline to participate with the CHARM Team. However, my refusal to sign the CHARM Team Consent to Release Information will not affect my ability to receive services from the individual participating organizations.

I further understand that generally the participating organizations may not condition my treatment with them on whether I sign a consent form, but that in certain limited circumstances, I may be denied treatment with them if I do not sign such a form.

I may revoke this Consent at any time by notifying any member of the Children and Recovering Mothers (CHARM) Team, but revoking this Consent will not affect any actions that were taken by the CHARM Team or its participating organizations before I revoked it.

This Consent will remain in effect for the period while I receive services and for thirty (30) days after the termination of services by the last participating organization on the CHARM Team providing services to me, unless I choose to terminate it on the following date, or as a result of the following event or condition:

_____

I understand that the VT Department for Children and Families [DCF] may currently have opened, or in the future may open, a child-protection case that involves me or my child. If so, I specifically authorize the DCF representative on the CHARM Team to disclose and/or redisclose health and treatment information about me: (1) to other employees of DCF who have a need to know such

information; and (2) to the Vermont Family Division of Superior Court and any party to a juvenile proceeding which involves me or my child brought under Ch. 49-53 of Title 33 of the Vermont Statutes.

CHILDREN AND RECOVERING MOTHERS (CHARM) PROGRAM

CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT AND SOCIAL SERVICES

I have read all of the above information, and I understand its contents and consent to the disclosure and/or redisclosure of the confidential information identified above to the participating organizations and staff members of the CHARM Team for the purposes specified.

SIGNATURE(S):

_____

Name of Patient/Client (Please Print)

_____ _____

Signature of Patient/Client (18 and over or Emancipated Minor) or Signature of Parent/Guardian or Legal Representative — Date

_____

Witness: Print Name, Title, Organization

_____ _____

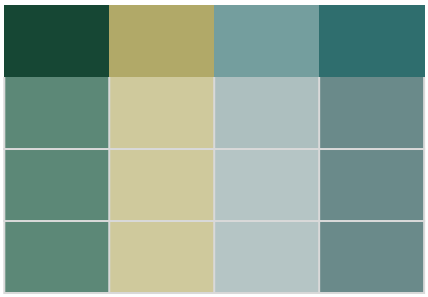
Witness: Signature — Date

This Consent to Release Information will be kept on file by KidSafe Collaborative Inc. or by another authorized organization on behalf of the CHARM team, unless revoked by the client or terminated as specified in this agreement.

Rev.: ☐
Date:

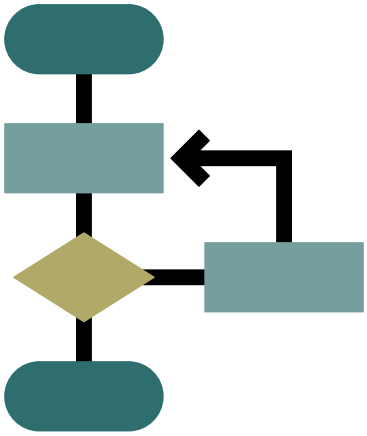
Appendix G: Foundational Tools

Foundational planning tools provide a structured approach to designing an effective CRT. Together, these tools can help stakeholders understand current challenges and resources, identify opportunities for improvement, clarify processes and roles, and develop a shared vision for the future.



A **Gap Analysis** evaluates current community resources and response capabilities to the desired future state. Questions answered:

- What services already exist?
- Where are people currently falling through the cracks?
- What specific gaps should the CRT address?



Workflow or Process Mapping outlines the sequence of activities, decision points, roles, and communication pathways involved in a process. Workflow mapping can help stakeholders understand how an individual, referral, or process moves through the system.

A **SOAR Analysis** is a strategic planning framework that focuses on positive potential and future goals.

- Strengths – What the region/group does well and its key advantages.
- Opportunities – External possibilities that can support growth and success.
- Aspirations – The vision, goals, and desired future state of the organization.
- Results – Measurable outcomes that indicate success and progress toward goals.

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The Community Response Team Best Practice Recommendations and Implementation Guide is supported by federal grants administered through Vermont's Department of Health Family and Child Health Division, as part of a comprehensive public health response to perinatal substance use.