Roundtable Discussion Questions – 3 Priority Areas

- Cultivating a Collaborative and Coordinated Service Delivery System
    1. When you have a client engaged in multiple systems, how do you coordinate their care?

        o Through the intake process – question what other services they are receiving/involved in
        o Most times don't know that they are involved until later in relationship building; HIPAA hinders contact with other providers once finding out about their involvement
        o During conversations with the client/family, start to peel away layers and part of their story, go deeper as relationship builds (if not a single point of contact)
        o Problem is accuracy of client and which systems they are involved in – they aren't always sure, and it would be based on what they feel comfortable telling (with stigmas, would they feel comfortable with telling they go to Methadone Clinic or are involved in OCY)
        o Sometimes families are involved in so many points of contact/systems that they cannot remember who is coming from where
        o Reasons why client would not say where they are receiving other services: fear, judgment, stigma, alliance/relationship has not been made yet = little trust, scared to be labeled or receive poor care because of stigma associated with their "label"; fear of agencies talking to each other; fear of losing children; have so much going on in their lives (daily crises, survival mode, trouble with basic needs)
        o Organizations and systems are in siloes especially related to HIPAA/confidentiality
        o Might know who else is involved if the other service/system makes the referral
        o Email conversations
        o "Reaching back & forth" and keeping referral source in the loop
        o "Working: the phones- Care Coordinators
        o Behavioral Health Einstein may not have a strong connection. However, their Senior leadership has recognition of the need.
        o *Difficult to find a child psychiatrist, many people agreed
        o  "Warm hard off"
        o Find somebody that you know in the system
        o Effective coordination is provider relationship based
        o Keeping an awareness of other services
        o Staying connected to other services
        o Reach out & find community service – ex. Early Head Start

    2. Do you have a 'working' or 'helpful' referral system?  How do you follow up on client referrals?

        o CVCA – regulations of family-based services require 2 points of contact for interagency coordination
        o Hospitals have a short/limited time frame to build relationship; no time to follow up and are unsure if RN Care Coordinators follow up with referrals made
        o AAP – pediatric providers do not know who to follow up with, patient is poor historian, pediatricians do not know what services are available
        o Follow up can be hard because of silos within the continuum of care, confidentiality, limited contact with client, no direct access to records
        o NFP and MCH programs – provide referral sources with a letter of disposition whether a client enrolls or does not enroll in the services the provider referred the client to
        o Don't have time to follow up; don't know where to follow up
        o Check with client, but some clients are poor historians, or don't know what services/providers they have, or feel stigmatized and have fear of telling what services they have
        o Need for point person contacts – never know who to call, staff turnover issues

- Yes, we follow up on referral
- No, we don't have time to do that
- Sometimes other community partners can give us an update
- *Checking with the client
- *Taking notes on a quality point of contact and reaching back to them
- Asking the client to call back if they don't get assistance with the referral
- Point person contacts are valuable

3. What other collaboratives/coalitions/initiatives are you a part of that strengthen your provision of care for families?
   - Fathers Matter
   - TCN, ICN, Bucks-Mont Collaborative – these are more broadly focused though, not necessarily on coordination of care for home visiting/family support services
   - There are many other collaborative groups, but discussing referrals w
   - Confidentiality limits coordination of care, especially with Drug and Alcohol, HIV, Office of Children and Youth
   - There is Communities That Care, but this is
   - No direct access to clients' records, which would coordinate care better and strengthen continuum of care
   - Fathers Matter
   - Tri County Consortium
   - Interagency Council of Norristown
   - Coatesville area resource network
   - Phoenixville area Network
   - Pottstown trauma informed community
   - Montgomery County Trauma Informed Initiative
   - Bucks Mont Collaborative
   - Men of Excellence
   - Netzer-Pottstown
   - Children's Ministries Health
   - Communities That Care
   - Teen Parent Task Force
   - Suicide Prevention
   - Montgomery County Health Alliance
   - Dept. of Aging and Adult Services
   - Round Table
   - HUB Police Task force
   - Weed & Seed

- Building Partnerships with Families

  - Building Partnerships with Families is time consuming
  - System of Early Intervention
  - Uses support of other organizations
  - Pattan resource
  - Reflective Supervision is used in Pottstown Family Center
  - PA keys is a resource
  - We need a culture shift in how we build partnerships with families
  - A support from senior leadership driven by collected data identifying priorities - Einstein
  - There is a recognition of need to "get better" at client services
  - Connecting to all family members is important
  - Having access to patients 'literally" to be with them

- Opportunity and time to be with and a willingness to share time with other providers
- Recognizing vicarious trauma

1. What kind of on the job support do you receive that helps you reflect upon your practice in an ongoing manner?
   - Reflective supervision – part of program models for several home visiting models: reflective process between supervisor and supervisee about what is going on in the field (good and bad), figure out the next steps for client situation or employee situation, explore what additional support is needed, identify professional goals and issues – ensures that the supervisee has a safe place to be heard and has a listening ear; ability for the supervisee to vent their frustrations and get it out of their system to be able to focus on moving forward either with a client situation or a professional situation
   - Professional development trainings and opportunities
   - Comments from hospital systems who thought reflective supervision would be a great addition to their employment – don't have anything like this in the hospital, a lot of burn out occurs, apathy towards clients can become present
   - Support from other departments and organizations, resources from them to help families

2. How do you define and measure your success with families?
   - There have been changes to the reimbursements received from insurance companies to hospitals based on the patient experience at the hospital – pay for performance – CMS takes a percentage of reimbursement from the hospital, then only gives it back based on the patient experience/satisfaction data, which is collected by a third party. Some things that bring a patient's satisfaction down include: delayed discharge, pain management, keeping the patient informed on their care/condition, friendliness, care of the patient from staff, respectfulness of staff towards patient; negative feedback = money does not come back that CMS takes from hospital
   - Data from CMS has shown that the patient is more forgiving of more acute medical treatment if they are treated better, are happier, more satisfied
     i. Out of this work groups are being developed by AMH, such as a patient advisory council; Behavioral Specialists at AMH for the OB/Gyn clinic to identify mental health and Drug and Alcohol issues in a patient

   - Client satisfaction - surveys
   - Retention of clients through duration of program – do they stay until graduation
   - Continuous quality improvement plans to identify areas needing improvement and come up with plans to improve those areas

3. What are your challenges to a) engagement and b) achieving success with families?
   - Challenges to engagement:
     i. Culture shift in how we work with families and build relationships/partnerships
     ii. Making connections stick with families
     iii. Finding out the real reasons why clients do not stay with services or come back to providers – let the clients tell their story
     iv. Language barriers
     v. What are we doing or not doing as providers that put responsibility back on the client
     vi. Asking about D&A use with families in a non-judgmental way that will connect with the client to not feel stigmatized or fear others knowing
     vii. Support from leadership within organizations
     viii. Trauma-informed care and how trauma effects clients

ix. Culture shift in providers' offices – all the way to the receptionist – anyone who has contact with a client and may affect their feeling of being respected or heard, may drive the client away from services

x. Data collection driven – takes time away from building relationship with clients to ask all of the questions/assessments that drive data for funders

xi. Cold call approaches don't work

xii. Not being in person to build relationships – short contact period/limited contact

xiii. Language Barriers

xiv. Perceptions and stigmas

xv. Shame, fear, trust

xvi. Bias

xvii. Important to think that everybody has a disability

xviii. Person centered care (doesn't exist)

xix. Changing culture shift is also difficult for clients

xx. Important for professionals to challenge themselves and reflect upon their own bias

- Challenges to achieving success with families:
    i. Engagement issues – see above challenges – if we cannot engage with a family, there won't be success with the family, if they leave the program early
    ii. Data collection drives "success"
    iii. We have to shift our mindset around data collection
    iv. HIPAA and confidentiality – cannot access or coordinate care with other providers that may be more beneficial in a wrap-around model
    v. Having professionals in house that can work with clients and families then and there versus referring out with no follow-up
    vi. Getting accurate information from families who may not want to disclose certain things because of fear, stigma, being alienated based on the question or their answer
        - May not disclose substance use because of stigma or fear of not receiving quality care, end up with poor maternal health, poor birth outcomes, issues with being reported to OCY after birth, versus preventative approach before birth
        - Asking questions in a sensitive, competent and empathic way versus judgmental – to make better informed treatment approaches

- Mitigating Maternal Substance Use effects on Infants and Young Children
    1. What challenges are you experiencing in your setting?
        - Increased number of substance using pregnant women and increased number of infants born affected – hospitals
        - Increased number of NAS births
        - Stigma of providers around substance using pregnant women; complaints from clients around how they are treated at other providers (OB, hospital settings)
        - Access to D&A services is not easy for providers let alone clients who may not identify that they are using
        - Lack of services for pregnant women –
        - Unregulated treatment for pregnant women (Methadone – Gold Standard vs Subutex – unregulated, prescribed by PCP who does not monitor nearly as closely as Methadone (weekly or monthly monitoring), which is not good for withdrawal possibilities)
        - Knowing how to get accurate information from clients due to their fear of stigma, poor treatment, etc.
        - No coordinated care, little continuum of care – HIPAA and confidentiality barriers
        - Access to service is not easy
        - Lack of services
        - Connection to services around substance use. Pathway is unclear

- o Our own views around addiction uncomfortable about discussing make it difficult to discuss

2. What is your method for identifying/screening substance use with your clients?
   - o Data collection forms used in programs, intake forms
   - o Asking clients, but may not get accurate information
3. Once identified, what is your protocol for getting services?
   - o Many do not have protocols for getting services, beyond possibly reporting to OCY at birth of baby
   - o For home visiting services, help link the client to treatment (if they want it) by connecting with Office of D&A, helping with calls to providers, insurance, etc.
4. What do you notice about your 'successes' and 'barriers' to engaging families in further services/treatment?
   - o Sometimes our own issues make it difficult to talk with clients about addiction, especially when the client is pregnant, but we have to address our own biases and be more aware of our approach being strengths-based and person-centered.
   - o Sometimes there is an ethical dilemma when working with a client who has an addiction and is pregnant or has young children; we don't want to alienate families from our service by reporting to OCY or ask questions that make client or provider uncomfortable

Priority areas:
Reflective supervision
Not knowing how to talk with clients about substance use/addiction
Opportunities for collaboration
Need for professional training: cultural competence, drug and alcohol, trauma training
Organizations need to change their approach around working with clients
OBs are needed around the table
We need to expand our look at the population
More staff support is needed by leadership
Need to understand the resources available
Collaboration is key – there needs to be a culture shift around engagement
More access to services – coordination of care needed
Mental Health Services lack of Spanish speaking
More access to services
More Spanish speaking staff in general more paperwork handouts
Early Head Start has a large Spanish speaking
Sustaining relationships
Reaching the population with higher infant mortality rate