ENGAGING COMMUNITIES IN FAMILY CARE PLANS

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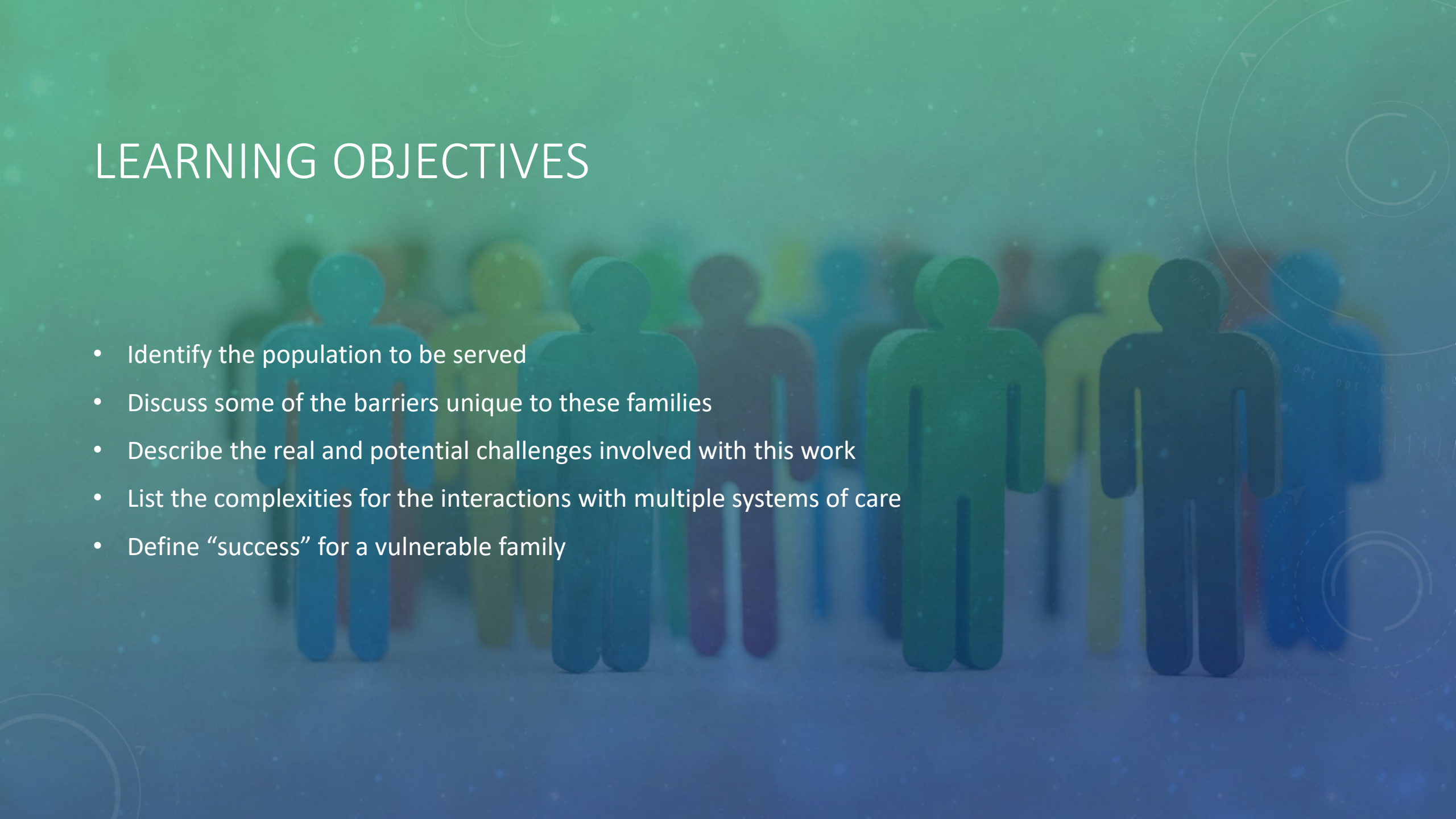
PARKVIEW HEALTH

LEARNING OBJECTIVES



- Identify the population to be served
- Discuss some of the barriers unique to these families
- Describe the real and potential challenges involved with this work
- List the complexities for the interactions with multiple systems of care
- Define “success” for a vulnerable family

WHAT ARE WE TRYING TO DO?

WHAT IS A PLAN OF SAFE CARE OR FAMILY CARE PLAN?

LANDSCAPE ACROSS THE COUNTRY

- New Hampshire
  - Mandatory reporters are required by legislation to include a POSC
- Delaware
  - Aiden's Law legislated a coordinated effort for family care plans
- Colorado
  - Task Force to pilot and implement this model with engaged hospital systems
- Kentucky
  - Partnerships with NAS work groups to pilot this and inform policy
- Connecticut, California, Illinois, Tennessee, New York, Arizona also engaged in implementation across systems of care

BEING A "PILOT SITE"

- Sub-committee provided templates and a vision
- This is a well-established process in other systems of care
- New to any healthcare provider
- More questions than answers
- What? Why? How? When? Who?

THE VISION

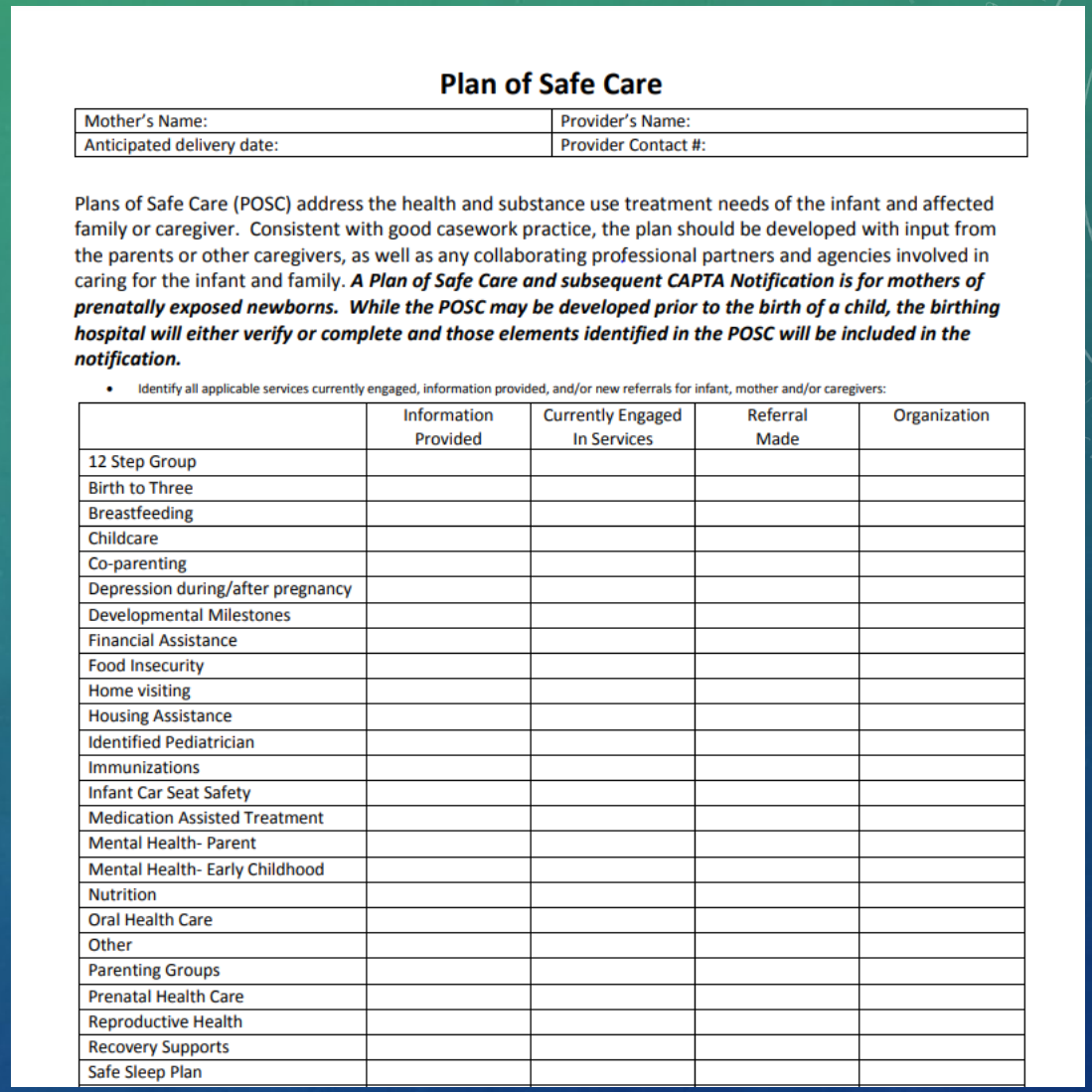
Initiate a conversation and plans for families early in prenatal care to identify the support network around the family, and link those supports together to enhance and strengthen it. We want to identify the “village” that each family has with a non-punitive approach and multi-disciplinary support team.

WHAT IS THIS PLAN?

A checklist?

A care map?

A network of support



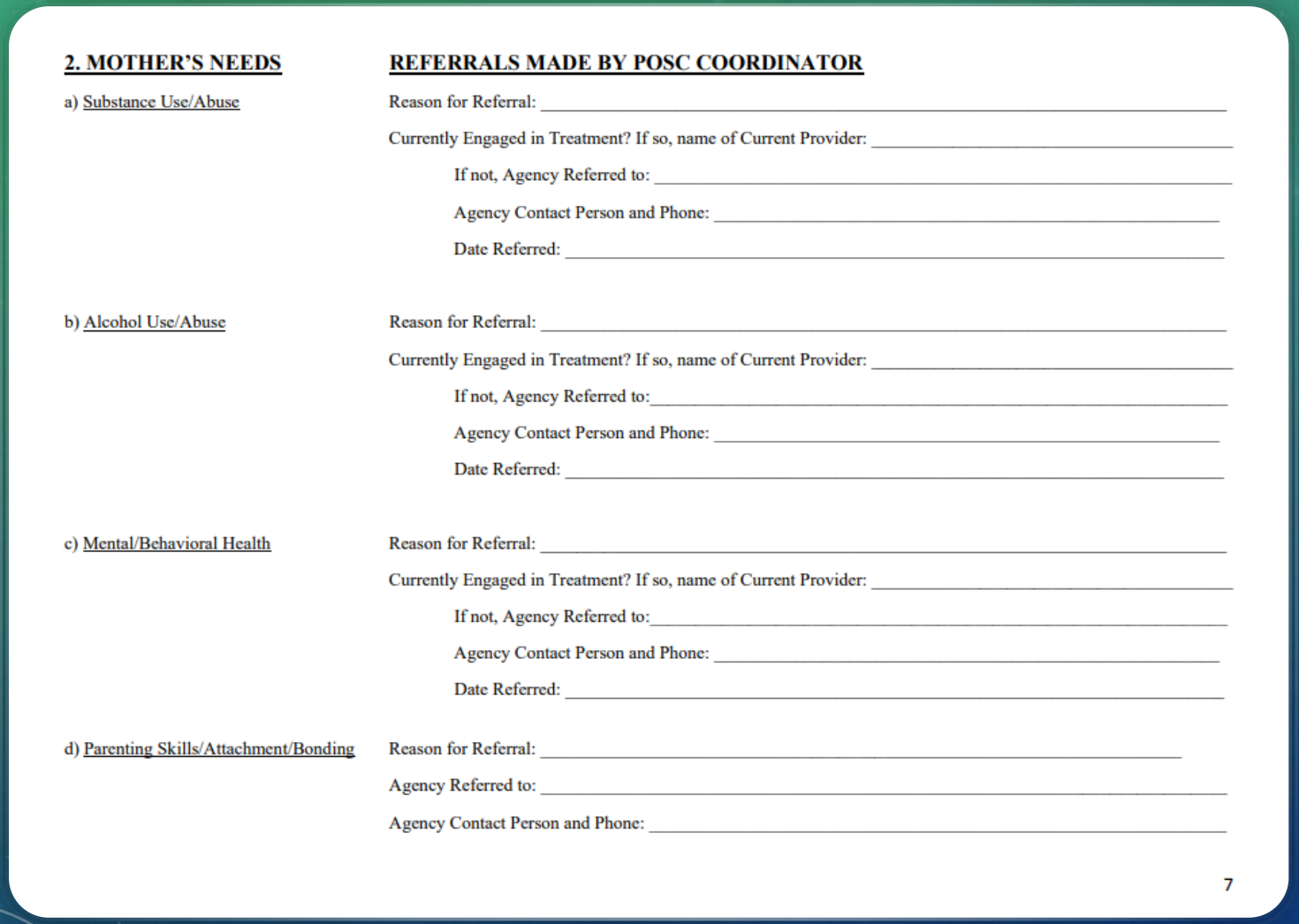
Plan of Safe Care

Mother's Name:	Provider's Name:
Anticipated delivery date:	Provider Contact #:

Plans of Safe Care (POSC) address the health and substance use treatment needs of the infant and affected family or caregiver. Consistent with good casework practice, the plan should be developed with input from the parents or other caregivers, as well as any collaborating professional partners and agencies involved in caring for the infant and family. ***A Plan of Safe Care and subsequent CAPTA Notification is for mothers of prenatally exposed newborns. While the POSC may be developed prior to the birth of a child, the birthing hospital will either verify or complete and those elements identified in the POSC will be included in the notification.***

- Identify all applicable services currently engaged, information provided, and/or new referrals for infant, mother and/or caregivers:

	Information Provided	Currently Engaged In Services	Referral Made	Organization
12 Step Group				
Birth to Three				
Breastfeeding				
Childcare				
Co-parenting				
Depression during/after pregnancy				
Developmental Milestones				
Financial Assistance				
Food Insecurity				
Home visiting				
Housing Assistance				
Identified Pediatrician				
Immunizations				
Infant Car Seat Safety				
Medication Assisted Treatment				
Mental Health- Parent				
Mental Health- Early Childhood				
Nutrition				
Oral Health Care				
Other				
Parenting Groups				
Prenatal Health Care				
Reproductive Health				
Recovery Supports				
Safe Sleep Plan				



2. MOTHER'S NEEDS | **REFERRALS MADE BY POSC COORDINATOR**

a) Substance Use/Abuse

Reason for Referral: _____

Currently Engaged in Treatment? If so, name of Current Provider: _____

If not, Agency Referred to: _____

Agency Contact Person and Phone: _____

Date Referred: _____

b) Alcohol Use/Abuse

Reason for Referral: _____

Currently Engaged in Treatment? If so, name of Current Provider: _____

If not, Agency Referred to: _____

Agency Contact Person and Phone: _____

Date Referred: _____

c) Mental/Behavioral Health

Reason for Referral: _____

Currently Engaged in Treatment? If so, name of Current Provider: _____

If not, Agency Referred to: _____

Agency Contact Person and Phone: _____

Date Referred: _____

d) Parenting Skills/Attachment/Bonding

Reason for Referral: _____

Agency Referred to: _____

Agency Contact Person and Phone: _____

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DELAWARE

- Robust plan
- 14 pages
- Includes mother, father and another caregiver
- Includes contacts for community agencies

INDIANA

DCS process

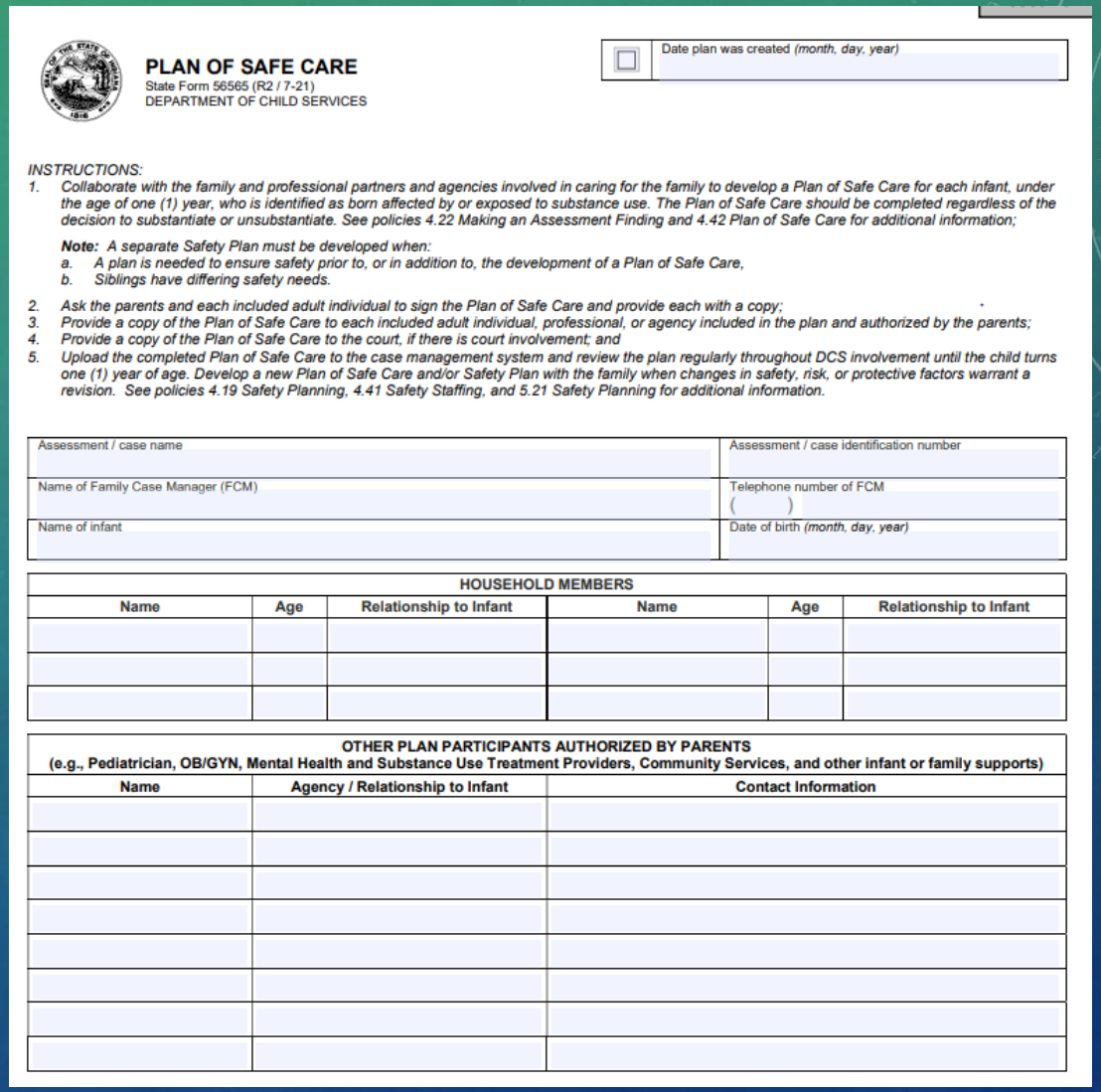
Includes risks and protective factors

Identifies needs for each family member

Lists out supportive agencies

Plan to be reviewed periodically

4 pages



PLAN OF SAFE CARE
State Form 56565 (R2 / 7-21)
DEPARTMENT OF CHILD SERVICES

☐ Date plan was created *(month, day, year)*

INSTRUCTIONS:

1. *Collaborate with the family and professional partners and agencies involved in caring for the family to develop a Plan of Safe Care for each infant, under the age of one (1) year, who is identified as born affected by or exposed to substance use. The Plan of Safe Care should be completed regardless of the decision to substantiate or unsubstantiate. See policies 4.22 Making an Assessment Finding and 4.42 Plan of Safe Care for additional information;*

   Note: *A separate Safety Plan must be developed when:*
   a. *A plan is needed to ensure safety prior to, or in addition to, the development of a Plan of Safe Care,*
   b. *Siblings have differing safety needs.*

2. *Ask the parents and each included adult individual to sign the Plan of Safe Care and provide each with a copy;*
3. *Provide a copy of the Plan of Safe Care to each included adult individual, professional, or agency included in the plan and authorized by the parents;*
4. *Provide a copy of the Plan of Safe Care to the court, if there is court involvement; and*
5. *Upload the completed Plan of Safe Care to the case management system and review the plan regularly throughout DCS involvement until the child turns one (1) year of age. Develop a new Plan of Safe Care and/or Safety Plan with the family when changes in safety, risk, or protective factors warrant a revision. See policies 4.19 Safety Planning, 4.41 Safety Staffing, and 5.21 Safety Planning for additional information.*

Assessment / case name	Assessment / case identification number
Name of Family Case Manager (FCM)	Telephone number of FCM ( )
Name of infant	Date of birth *(month, day, year)*

HOUSEHOLD MEMBERS

Name	Age	Relationship to Infant	Name	Age	Relationship to Infant

OTHER PLAN PARTICIPANTS AUTHORIZED BY PARENTS
(e.g., Pediatrician, OB/GYN, Mental Health and Substance Use Treatment Providers, Community Services, and other infant or family supports)

Name	Agency / Relationship to Infant	Contact Information

WHOSE PLAN IS IT ANYWAY?

TARGET AUDIENCES AND STAKEHOLDERS

STAKEHOLDERS

- Prenatal Care Providers
- Maternal Recovery Specialists – outpatient SW and peer supporters
- Nurse Navigators
- Community health workers
- Hospital units
  - Inpatient OB
  - NICU
  - Social Work
- Community home visiting agencies
- DCS
- Other community agencies and systems of care

GOALS FOR TEAM OF STAKEHOLDERS

- Parents have a plan for child's safety
- Parents have a plan for maternal safety
- Parents feel supported by the community agencies
- This plan is communicated to all supportive entities and the family
- Fosters communication between the supportive agencies
- This plan "moves" with the family to various supportive care agencies
- Process builds trust and remains family-centered

BARRIERS FOR HEALTHCARE PROVIDERS

This has never been "owned" by the prenatal team

- Is this the Family's plan? Is it the plan for baby?

Collaboration does not always happen

- Even on things we know we own

Trust

- Providers and patients don't trust each other

Participation in care

- The most vulnerable patients don't come in for care

Entities cannot easily communicate with each other

- If we build it, will anyone use it?
- Who will "own" the care plan?

TARGET AUDIENCE(S)

Stakeholders

- Need to align goals for best success
- Everyone has a role, but what's in it for me?
- Collaboration across complex systems
- Efficiency and effectiveness
- Scope of services
- Some stakeholders are not actively producing plan

Vulnerable Families

- Moms using substances
- Mothers with disabilities
- Mothers with other mental health challenges
- People who are already struggling

KNOWN BARRIERS FOR FAMILIES

Trust in the healthcare delivery system	Stigma – so much stigma	Trauma - how often the victims relive traumatic experiences or face new ones	Technology – access with limited financial means, or hesitancy to use	Chronic state of crisis
Readiness to change	Access, Insurance and cost of care	Employment- and all the challenges of having a job or not having one	Legal system – competes with building trust	Entities cannot / do not easily communicate with each other

VOICE OF THE CUSTOMER

- Survey findings
  - Digital is preferred
  - Collaborative – talking to each other
  - Inclusive
- Too much help?
  - Most families already have 4-5 supporting agencies
  - Confusing to families or redundant
  - Shifts burden of communication and collaboration to them

GOALS FOR FAMILIES

START WHERE YOU ARE

ANNA’S STORY

ANNA (NOT HER REAL NAME)

- Struggled with her own developmental delays and her own independence
- Referral from OB provider as she did not feel good about Anna's ability to parent
- Anna was very concerned that someone would take her baby
- Met with NN several times over several months
- Unstable housing, unemployed, does not drive
- Intermittently engaged with MANY supportive agencies
- Does not trust most of them and can't articulate what they are all doing for her

CARE PLANNING

- NN met with Anna Early 3rd Trimester and invited her aunt to come to appointment
- Referrals to agencies had been provided
- Patient did not identify any of the contacts as resources for support, just contacts
- Group meeting with NN, family, Anna, and other case managers, SW
- Plan grew over time, and all were “oriented” to the plan
- Anna took her baby home with help
- Some different contacts over time
- Continued for several months post delivery to assure that all are safe
- One contact keeps the baby for her sometimes and she visits

JAMIE'S STORY

- Jamie asked for help with methamphetamine addiction
- No MAT program for meth
- Home environment was a trigger, limited shelters for pregnant people
- Was told to stop using, detox at home, if she was clean for 7 days she could get into shelter
- Was not thrilled with IOP, not a candidate for residential treatment

CARE PLANNING

- Maternal Recovery Specialist talked to Jamie and providers
- Arranged for a short stay in the FBC to help manage anxiety and monitor patient
- Was able to get into IOP (Intensive outpatient program) for SUD and counseling
- Delivered and took baby home with her and moved into shelter
- Only a few months old but making it to her appointments and staying engaged with MRS

PEER RECOVERY TEAM

- Supporting women across 11 county area
- Referrals from nurse navigators, inpatient SW, cord tissue results
- Engaging clients as long as they will stay engaged
- Several have been connected to this support for over a year!

RECIPE FOR SUCCESS

WHAT WORKS

- Building a relationship
- Small doses add up
- Trust takes time to develop
- Inclusion
- Common goals
- Communication
- Collaboration
- Engagement

WHAT WE STILL NEED TO FIGURE OUT

- Communication platform
- Opportunities to be more efficient
- Ownership when DCS is not involved with the family
- How to measure success

CHALLENGES OF SYSTEMS

- Legal system
- Healthcare delivery system
- Psychiatric care
- Social services

- Different platforms
- Different “languages”
- Privacy and confidentiality
- Different goals

CHALLENGE OF METRICS

- Number of families with Care Plans – compared to Number of positive cords
- Counting referrals
- Quality of referrals
- Length of engagement
- Degree or intensity of engagement
- Some decline to participate but will remain sober
- Some decline to participate and will relapse
- Safety is goal for each family member- sometimes separation is needed

REFERENCES

- https://www.cffutures.org/report/plans-of-safe-care-learning-modules/
- IPQIC PSU toolkit