Multi-Agency Collaboration/Single Team-Single Plan

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Introduction

The Multi-Agency Collaboration/Single Team-Single Plan approach to practice began in 2014 as a prevention model to serve Tennessee's most vulnerable population. Initially, this approach was created targeting babies diagnosed with Neo-Natal Abstinence Syndrome as a response to the opioid crisis. The model has since expanded the criteria for those who qualify to participate, reaching more families with children at risk for entering foster care who need services from multiple state agencies. Department of Children's Services provides oversight and continued implementation of the Multi-Agency Collaboration/Single Team-Single Plan approach to practice, however, the approach belongs collectively to the following state agencies represented in the Steering Committee; Department of Intellectual and Developmental Disabilities, Department of Health, Department of Education, Department of Mental Health and Substance Abuse, Department of Workforce Development, Department of Human Services, and Department of Health Care Finance and Administration. Representatives from each of these agencies, various community partners, and a contracted care coordinator participate in Child and Family Team Meetings (CFTM) to contribute in creating plans for families that outline services that each agency can provide, embracing the idea that we are better together. Coordination of those services and support is ongoing.

Qualifications

- All families are engaged with the Department of Children's Services;
- Families have needs that could be met or serviced by at least two (2) state agencies or community partners;
- Families whose children are at high risk of entering custody;
- Families choose to participate and sign the consent form indicating their agreement;
- Local teams can create additional qualifications based on the needs in the area, however there are no outlined targeted populations based on age or safety allegation for this approach;
- Although this is a prevention model, with supervisory approval, the approach can be used to serve families with children in foster care to reduce their length of stay, on a case by case basis.

Care Coordination

Each family is assigned a Care Coordinator. The Care Coordinator holds a unique role within the Multi-Agency Collaboration/Single Team-Single Plan approach to practice with two primary functions:

1. Serve as a direct support to the family and assists them with implementing and participating in services identified through the CFTM;
2. Serve as the hub for communication, keeping team members well-informed of the family's progress.

Throughout the course of a family's participation, the Care Coordinator may work with the family up to twenty (20) hours per month to meet the family's needs. In addition to tasks outlined in the Implementation Process, tasks the Care Coordinator could perform include as part of their role include, but are not limited to:

- In-home visits

- Therapeutic services
- Scheduling appointments
- Transportation
- Attending medical appointments
- Requesting records
- Arranging needed services such as substance abuse treatment or medical care
- Coordinating with community partners to maintain continuity of care

Care Coordinator Assignment

Once the family agrees to participate, the DCS worker enters a case service request into TFACTS. This should be entered as Family Support Services and the narrative should indicate this case is a Multi-Agency Collaboration/ Single Team-Single Plan case for fiscal staff to approve the appropriate number of hours. Initial requests can be made for a three (3) month time frame. The DCS staff will then contact the Care Coordinator to begin the process of working together on this case.

NOTE: The Care Coordinator providers are the same providers who hold the DCS Family Preservation Contracts in each region.

Getting Started

Step 1: Referral

DCS Child Abuse Hotline receives a referral alleging abuse and/or neglect. The referral is assigned to a DCS worker to respond.

Step 2: Family Identification/Selection

As DCS staff respond to referrals, they assess the family to determine if the Single Team- Single Plan approach to practice is appropriate. If the DCS worker is unsure if the family would be appropriate for the approach, they will consult with the county or regional point person or supervisor in making the decision to offer the approach to the family.

Step 3: Invitation to Family to Participate

If the family is appropriate for the Single Team-Single Plan approach, the assigned DCS worker will discuss the approach to practice with the family and invite them to participate. It is important to remember that presentation is critical when detailing this approach to practice with families, and relaying the correct information can make a difference when attempting to gain buy-in from families, since participation is voluntary.

Step 4: Enrollment in the Approach

If the family agrees to participate, the DCS worker asks the family to complete the official consent to participate and authorization to release information. A copy of this document will then need to be uploaded into the appropriate section of the family's electronic case file. The family is also given the Bridge to Family

Stability/Family Needs Survey to review, complete, and to bring with them to the first CFTM. This tool is an excellent ice breaker during the CFTM and should be completed with the help of the assigned Care Coordinator.

Step 5: DCS Case Management Invites Care Coordinator

The DCS worker submits a Case Service Request for Family Support Services to begin care coordination services. The DCS worker should contact the provider to let them know a request has been submitted so they can be included in the initial CFTM. After a family has enrolled in the approach, the care coordinator role can evolve as we learn what the family's priorities and needs are, but ultimately, should be utilized to coordinate the team and services and to serve as the lead of the team.

Step 6: Notice of New Enrollment and CFTM

The DCS worker ensures invitations to the initial CFTM are sent to all state agency representatives, community partners, and informal supports suggested by the family, using the template located on the DCS intranet. All members of the local team should be invited to the initial meeting to discuss the full range of service options available to the family. The DCS worker may also invite other partners who can provide specific services needed by the family. County specific contact lists are provided to all participating staff, to assist in building the invitation; all contacts on the list receive an invitation. Team members should understand that they may have to attend a meeting on short notice depending on the safety risk to the child.

Step 7: Initial Single Team-Single Plan Approach CFTM Preparation

The Care Coordinator will meet the family prior to the initial CFTM. This meeting is to begin establishing rapport, prepare the family for the meeting, and help them complete the Bridge to Family Stability Survey. This also allows the family to feel supported as they enter the meeting. The Care Coordinator will ensure all team members have a copy of the assessment at the beginning of the meeting.

Step 8: Initial CFTM and Single Plan Development

During the meeting, the Single Plan document is completed, in conjunction with the non-custodial permanency plan. These plans should mirror each other in regard to strengths, needs and services. The care coordinator acts as scribe and fills out the Single Plan Document based upon the team discussion about family priorities, goals, and action steps. The family should be considered the expert regarding their family and should drive the conversation around needs and priorities. The Single Plan should include the services identified for the family in the order of priority, and responsible parties to engage those services, members of the team and their contact information, and the family's vision and priorities.

During the CFTM, the group will determine which team members should remain a part of this family's team based on the family's needs. If a particular service or partner is not needed or not relevant to the family's situation, that partner can step away from the active services team and does not need to attend follow-up CFTMs for that family, unless they are specifically asked to help.

At the end of the meeting, all team members will be given a copy of the Single Plan document.

At the end of the initial CFTM, the family is asked to complete the Your Voice Matters Survey which is an electronic survey that should be administered with the help of DCS or Care Coordination staff. The survey can be found at the following link:

https://stateoftennessee.formstack.com/forms/your_voice_matters

The team and the Single Plan will remain flexible to accommodate the changing needs of the family.

Step 9: Service Implementation

The team begins implementing services with the highest priority services identified at the CFTM. Individual providers can often start their specific services by discussing the Single Plan document and explaining how their service fits with the identified family-specific goals. Services and providers contribute their expertise to support the family, ensure safety, and help the family reach their goals. The care coordinator will continue to be the hub of communication, checking in with service providers to track and adjust as needed.

Step 10: Ongoing Communication

Communication between team meetings is critical. There is a common set of communication expectations used in this approach to practice. A secure email group for each family can be used to share updates and information between meetings. The care coordinator and all team members are responsible for alerting the entire team about successes/milestones and challenges that arise. Team members are empowered to notify the team if there is a concern about safety or well-being of any member of the family or if a service needs to be adjusted.

Care coordination staff will schedule a monthly staffing call to review the status of all families enrolled in the Single Team/Single Plan Approach. This professionals meeting allows the team members an opportunity to update each other about progress and/or concerns.

"Red Flag" Communications: In these "red flag" situations, team members should immediately send an email to the family services team and call the DCS worker assigned to that family. Red flag situations include but are not limited to:

- Any positive drug screens or relapses
- Any missed appointments, if disruptive to client progress or child health/safety
- Change of residency or homelessness
- Any domestic violence issues
- Any noncompliance/nonparticipation with the program
- Any law enforcement issues
- Any marks seen on the child
- Any hospitalizations (emergency room visits, inpatient services, etc.)
- Lack of services such as food, diapers, proper formula, clothing, electricity, or housing
- Not using safe sleep
- Unable to contact the family, after multiple attempts

- School absences or truancy, thee (3) or more consecutive days or chronic absenteeism
- Other situations that raise concerns about the safety of the child or family

As required by Tenn. Code. Ann. § 37-1-403, all persons have a responsibility to report suspected child abuse or neglect to the Child Abuse Hotline, 877-237-0004.

Step 11: Family Interaction

DCS staff and service providers interact with the family, according to their regular program expectations. The Single Plan document lists the team members and their contact information so families can call the lead coordinator or a direct service provider at any time with questions or concerns. All service providers are representing the team when they visit a family. Team members should be transparent when working with families and partner with families to build a trusting helping relationship.

Step 12: Cultivate Informal Supports

Many programs already emphasize the development of informal supports. Each formal service provider engaged with the family should assist the family in gaining informal supports and help them identify opportunities for positive peer support such as a support group, neighbor or friend. Informal supports should be discussed in each CFTM with the family.

Step 13: Reconvene CFTMs

CFTMs will be convened every three months to review the status of the case and to revise the plan to reprioritize goals and services. CFTMs will also be reconvened as policy requires if more frequent and at transitional points in the case. Any member can call a CFTM if needed. Progress CFTMs allow the family and the team to celebrate progress and identify the next priority area of need. The care coordinator will ask the family to complete the Bridge to Family Stability/Family Needs Survey prior to each CFTM so the team can assess progress and needs. The care coordinator will also encourage the family to complete the Your Voice Matters, Family Satisfaction Survey following the meeting to collect honest customer feedback.

CFTMs will be reconvened according to DCS policy, including transitional points in the case. If it appears that a family needs something different than what is happening under the plan or if concerns arise, the DCS worker or any other team member may ask to reconvene the full CFTM services team to see what other options are available. MAC/STSP services team members may rotate to a higher or lower priority role based upon the needs of the family. The team and the Single Plan will remain flexible to accommodate the changing needs of the family.

Step 14: Family Transition

When safety risks have been reduced, and DCS is ready to close the case, a closing CFTM will be held. A family may choose to continue working with other partner service providers based upon their ongoing needs and relationships. If the family would like continued support from other agencies, the team members will use that CFTM to:

- Clarify which service providers will remain active with the family.
- Establish who will take the lead, depending upon which partner agency has the greatest involvement with the family.
- Set the next quarterly family team meeting before the meeting ends.

This ongoing support can continue until the family is no longer engaged with multiple service providers or no longer wants to meet with the care team. At any time, if an issue arises, the team members can be called upon to address questions or participate in the team meetings.

Ongoing Collaboration

After implementing Single Team-Single Plan, DCS Central Office will facilitate check-ins with all partners, to hear about progress, successes, and to strategize around barriers. DCS Central Office staff will also use the check-in as an opportunity to update the CFTM contact list and provide that updated list to the team in that area. During check-ins it is important to be open, honest, and forthcoming with all things pertaining to the approach because the team is strengthened through feedback. Topics that are typically discussed during check in meetings are enrollment, presentation of the approach to families, the CFTM process, Your Voice Matters Survey, use of technology for meetings, providers perspective, community partner perspective, DCS perspective, invitation and change in team members, and technical support.

Front line staff and supervisors from all participating agencies and partnerships are asked to provide feedback through a satisfaction survey which is distributed two (2) times yearly. The data is aggregated and shared with the Steering Committee.

External customer feedback is collected through the Your Voice Matters Survey. Families are asked to complete the survey each time they participate in a CFTM. The data is aggregated and shared with the Steering Committee and to each region regarding their individual feedback. This helps inform practice and make any adjustments specifically related to each area of the state.

An annual report is completed by Central Office each year to share with the associated state agencies and community partners the status of the Single Team Single Plan approach to practice in Tennessee.

Tasks & Tools: Checklist/Timeline

A DCS Worker's Single Team Single Plan Task List

Enrollment

- ☐ Invite the family to participate. Explain the program and note that it is a voluntary program.
- ☐ Have the family sign the official Consent to Participate/Release of Information form.
- ☐ Enter a Case Service Request (CSR/PSG) for the Care Coordinator Services. Contact the Care Coordinator to let them know you have a new case.
- ☐ DCS oversight staff record the enrollment information on the Tracking Spreadsheet
- ☐ DCS will secure a location and a facilitator for the CFTM
- ☐ DCS worker uses the CFTM Invitation Template to create the invitation for the first CFTM and the CFTM Contact List to invite all cross departmental representatives and informal supports suggested by the family to the CFTM. The DCS worker will also invite other partners with specific expertise or services needed by the family. In most areas the DCS point person sends out the invitation for the first meeting so the most up to date contact list is used.
- ☐ DCS worker/Care Coordinator will provide the family with the Bridge to Family Stability/ Family Needs Survey prior to the CFTM to review and complete to use at the meeting. DCS/ Care Coordinator may assist the family in filling this out if there is a need. The design is for the Care Coordinator to do this with the family so that they have someone with them and have an established relationship when the meeting begins but DCS can do this in the Care Coordinator's absence.
- ☐ DCS will bring all completed assessments so that they can be discussed in the meeting.
- ☐ DCS will assist in making copies of the Bridge to Family Stability Survey and will distribute those at the CFTM.
- ☐ DCS will prep the family for the CFTM.

The First CFTM

- ☐ DCS will convene the CFTM, preferably at a location other than the DCS office.
- ☐ The family talks about their vision and goals for the meeting and why they feel this meeting is occurring.
- ☐ The team will review together the results of the Bridge to Family Stability Survey.
- ☐ Single Plan Document is fully completed discussing every section during the CFTM and distributed to the family, team members, and any other team members that could not be present or gatekeepers of identified agencies if applicable. The Care Coordinator serves as the scribe for this form.
- ☐ Following the CFTM the family completes the Your Voice Matters Survey from a Formstack link using the Care Coordinator or DCS's equipment.
- ☐ The Care Coordinator for the family will send out a family email to those members who are staying on the team so that the group email is established.
- ☐ Care Coordinator begins work with the family to meet their vision, goals and action steps and updates the team regularly.

Monthly

- ☐ Care Coordination staff will schedule a monthly staffing call to review the status of all cases that are using the Single Team/Single Plan Approach.

Days after Enrollment

- ☐ The Care Coordinator will schedule a CFTM with all of the members of the team that are established and any new members who might be helpful to meet the family's vision.
- ☐ The Care Coordinator works with the family prior to the CFTM to complete an updated Bridge to Family Stability/Family Needs Survey and provides the updated assessment to the team to review the progress in the CFTM.
- ☐ The CFTM will reconvene following the DCS CFTM schedule (every three months) including transitional points in the case or when a member of the team feels a meeting should be called to discuss an immediate need. The Single Plan is updated based upon activities and progress.
- ☐ Care Coordinator/ DCS staff engages the family to complete the Your Voice Matters Survey every three months following the CFTM through the same Formstack link.

Case Closure

- ☐ When the safety risk is reduced to the point where DCS is ready to close their case, a CFTM will be convened.
- ☐ At the closing CFTM, the team will clarify which service providers will remain active with the family, who will take the lead for the team, and set up the next quarterly meeting for the team.
- ☐ The team will continue to meet quarterly, update the assessments, and the single plan until the family is ready to discontinue to quarterly meetings. This ongoing support is designed to help the family have support even after their DCS case is closed for as long as they need it.