CORE ELEMENT:
CARE COORDINATION & COLLABORATION

Care Coordination and Collaboration engages family members, treatment providers, community resources, and natural supports as a cohesive group with shared goals for working with a youth and family. Care coordination includes forming and meeting face-to-face with a treatment team, developing teamwork among participants, sharing relevant information on a regular basis, planning together, measuring treatment progress together, and working collaboratively to add, change, or end services. Care coordination and collaboration follows the same process whether IHT is the hub or the youth also has Intensive Care Coordination; in the former case, the IHT team takes the lead role for care coordination; in the latter, the ICC team leads the process with IHT as an active participant.

CONTRIBUTION TO THE OUTCOME: The foundation for child-centered, family-driven treatment is a team that *always* includes family. Collaborative care strives to join all stakeholders in a youth's life to ensure effective work across domains. Different perspectives on a team create opportunities to find and use strengths. Consistent collaboration between the IHT team and the range of natural supports and service providers working with the family results in cohesive efforts to achieve desired outcomes, foster the family's community connectedness, and promote sustainability of treatment gains. Ideal communication takes a variety of forms that are organized, timely, culturally responsive, and inclusive.

NOTE: All practices below are expected of IHT. When IHT is the hub, the IHT team takes the lead role in care coordination. When youth has ICC, the IHT team joins and supports the ICC process. These differences are noted in the appropriate rows.

REMINDER: Review all Elements. See especially: Collaborative Intervention Planning, Intensive Therapeutic Intervention, and Preparing to Exit. Each matrix describes the work of IHT as a practice shared between a clinician and a Therapeutic Training and Support (TT&S) staff member. Unless specifically noted as the province of the clinician only, the practices expect teamwork and refer to either or both staff members, as fits each family situation.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
Context for intervention plan		
• Discusses with family the importance of developing an ecological perspective of youth's needs and possible locations of intervention in context of family, school, and community. • Reviews with family the purposes of care coordination, role of IHT in coordinating care, and option for Intensive Care Coordination (ICC). • As needed, refers for ICC and functions as interim hub until ICC begins. • Plans transition to ICC with maximum continuity and fewest repeat experiences possible; holds joint meeting with ICC, IHT, and family. • Communicates any change in hub to referral source.	• Provides unclear or overwhelming explanation of ICC or IHT care coordination. • Refers for ICC, but does not facilitate smooth transition. • Neglects care coordination while ICC referral is in process. • Does not notify referral source about referral for ICC.	• Does not offer or explain ICC. • Does not explain IHT role in care coordination as hub. • Declines to make referral, or discourages use of ICC, even when family requests it.
• <u>When youth has ICC:</u> Assesses with family/ referral source whether IHT is the best option for care coordination. • Discusses with family the purposes of care coordination and role of IHT as part of the Care Plan Team (CPT).	• Provides unclear or overwhelming explanation of ICC or IHT care coordination. • Explains roles as silos without discussing how they will coordinate.	• No explanation of care coordination. Non-existent or negative communication about ICC.
Forming a team		
• Explores with family members the idea of a larger "Team" of stakeholders to work together with IHT. • Ensures that youth and family know that Team membership can change over time. • Explores with family members whom to include on Team and whether there are important "missing" members (medication prescriber,	• Discusses idea of Team but gives up if family is disinclined. • Sets rigid standards for developing Team (who should be on it, how often it should meet) rather than individualizing for family. • Focuses on relationship titles (Guidance Counselor, Aunt) rather than stakeholder's function in youth's and family's life.	• Decides unilaterally on Team members. • No consideration of natural supports. • Does not consider Team meetings to be part of IHT. • Accepts family preferences without question, even when important stakeholders are left out. • Expects family to configure Team and keep

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school personnel, youth peer support, Department of Children and Families social worker, non-custodial parent, caregiver therapist, natural supports). • Explores possible "virtual" Team members (not able to attend in person), including technology for virtual meetings, written or recorded contributions by absent members, etc. • Fully explores with family the decision to leave out a particular stakeholder, including consequences of decision. • Reconsiders Team membership regularly and changes as needed.	• Assesses membership at start but does not revisit over time. • Limits participants to formal supports. • Explores only superficially, without probing for valuable relationships or natural supports. • Accepts a family's decision about exclusion of a particular person without discussing consequences.	IHT updated. • Considers Team to be family and IHT only.
• **When youth has ICC:** Supports ICC in exploring with family members whether there are any new participants to invite to the CPT and in revisiting CPT membership regularly.	• Accepts CPT membership without exploring options to include or exclude members.	• Decides unilaterally on inviting CPT members. • Does not consider CPT membership discussions to be part of IHT. • Fails to collaborate with ICC.
Initial meeting for care coordination		
• Plans with family members to meet face-to-face with proposed Team at least once near start of IHT to develop clear, shared understanding of communication plan, priority needs, and proposed intervention. • Invites Team members to meet, per plan made with family, to discuss complexity and the need for coordination; documents Team formation efforts. • Prepares Team participants for meeting format and topics to discuss.	• Plans superficially or too concretely without clearly developing the purpose. • Invites only subset of proposed members. • Minimal or no follow-up to encourage attendance. • Does not adequately prepare Team for participation.	• No evidence of Team planning. • No preparation of family for Team meeting. • No preparation of Team members. • Allows difficult topics to come up as "surprises" to family.
• **When youth has ICC:** Joins existing Care Plan Team at the first meeting after IHT starts, attends all meetings, and collaborates per expectations of the CPT.	• Inconsistent attendance or participation.	• Does not attend CPT meetings or attends but does not share. • Fails to collaborate with ICC.
Coordination with medication prescriber		
• Attends specifically and persistently to including medication prescriber in care coordination, including prescriber at 24-hour level of care (LOC) placements. • Makes diligent outreach efforts (email, tele-	• Makes attempts to contact prescriber but without persistence. • Checks in with prescriber for initial assessment but neglects further communication. • Leaves contacting prescribers up to caregivers	• No contact with prescriber. • No effective communication at assessment and/or throughout intervention. • Misinformation about medications. • No discussion with family about medication

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phone, in person) to contact prescriber during both initial assessment and intervention planning, to include prescriber perspective in written documents, and to provide prescriber with information relevant to role of medication in context of intervention. • Invites prescriber to all face-to-face Team meetings. • Includes prescriber in regular Team updates between meetings. • Establishes a communication plan (preferably written) with prescriber to monitor medication (benefits, compliance, side effects, changes). • Gathers input from prescriber at minimum before each Team meeting and intervention plan update. • Accesses consulting psychiatrist for second opinion as needed.	without discussing the importance of integrating medication into the overall intervention. • No invitation to Team meetings; assumes that prescriber won't attend meetings. • Insufficient attention to medication benefits and concerns. • Fails to obtain second opinion on medication questions.	as part of intervention. • Medication monitoring not considered part of Team discussion.
Team participation		
• Facilitates Team discussion to establish shared understanding of intervention and to maintain strengths-based, solution-focused stance. • At initial Team meeting, collaborates with family members to share family vision, strengths and needs, initial treatment plan, proposed roles of each Team participant, and current safety plan. • Invites input from Team members at each step. • Actively facilitates inclusive participation among Team members. • Addresses and resolves conflicts among Team members, both in the moment and with any needed follow-up.	• Uneven facilitation skills (too rigid, too lenient, off-topic, not everyone is heard). • Recognizes conflict on Team but does not resolve. • Ends meeting without a time frame for future meetings. • Allows Team to dwell on problems only. • Elicits input from only a subset of Team.	• Holds meeting without family. • Allows some Team members to dominate so not everyone is heard. • No agenda. • Avoids conflict, or discusses only later with other Team members. • Speaks for the family. • "Tells" the Team rather than discussing mutually.
• **When youth has ICC:** Collaborates with family members to share proposed IHT intervention plan and invite input from CPT.	• Reports IHT intervention plan without allowing CPT input.	• Presents IHT plan at CPT without preparing family for discussion. • Fails to collaborate with ICC.
Ongoing coordination with Team		
• Explores with family how they prefer to communicate (frequency, medium) with IHT between sessions and with other Team	• Communicates according to pattern set by IHT without individualizing. • Agrees on verbal plan but no written	• No discussion or plan for communication. • Minimal or no communication. • Overcommunication, more than "need to know"

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stakeholders between face-to-face meetings. • Communicates weekly with all Team members based on family preferences. • Agrees on communication plan with Team, including both meetings and ongoing contact. • Models effective, collaborative communication between IHT clinician and TT&S practitioner. • Communicates all urgent developments promptly (preferably within 24 hours) to relevant Team members.	communication plan. • Communicates inconsistently, infrequently, or with only a subset of Team. • Tries to maintain communication but gives up when no response to first attempts. • TT&S and clinician communicate partially, inconsistently, or superficially. • Waits for regularly scheduled communication to update, even in urgent matters. • Leaves communication about crisis up to MCI rather than contacting Team.	• Non-existent or negative communication between TT&S practitioner and IHT clinician.
• **<u>When youth has ICC:</u>** Maintains regular communication with all Team members according to communication plan made with family and CPT. • Communicates all urgent developments between meetings promptly to relevant CPT members.	• Communicates inconsistently, infrequently, or with only a subset of CPT. • Waits for regularly scheduled CPT to update, even in urgent matters.	• No communication between scheduled meetings. • Leaves all communication up to ICC. • Fails to collaborate with ICC.
• Engages Team members (including family) in reporting on progress toward measurable treatment goals at 90-day intervals, and when significant changes occur. • Ensures that progress towards building strengths is part of each discussion. • Considers other service options/ transitions in consultation with Team members.	• Inconsistent progress reports, or only with subset of Team. • Not enough measurable progress indicators. • No balance of discussion between strengths and needs. • Does not reconcile different perspectives. • Lack of organization, haphazardness in communications.	• Allows other Team members to overpower family voices. • Allows Team members to dictate next steps. • No measurable objectives.
• **<u>When youth has ICC:</u>** Joins CPT members in reporting on progress toward measurable treatment goals at 90-day intervals, and when significant changes occur.	• Inconsistent progress reports, or only with subset of CPT.	• No participation in CPT progress discussions. • Fails to collaborate with ICC.
Mobile Crisis and other emergency care coordination		
• Communicates proactively with Mobile Crisis Intervention (MCI) provider whenever youth is at risk of needing emergency intervention. • Shares Safety Plan and Advanced Communication. Follows up with MCI after intervention. • Communicates immediately with any 24-hour LOC where youth is placed in crisis and	• Shares intervention information at start but does not update MCI regarding possible crises. Communicates with MCI only after crisis. • Talks with MCI but does not include other Team members. • No discussion with Team about potential use of MCI and when to call. • Responds to crisis without sufficient urgency	• No prior communication or follow-up to crisis. • No discussion of MCI with Team. • No additional communication or actions following out-of-home placement.

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continues with daily communication during stay. • Attends discharge meeting from 24-hour LOC.	regarding timeliness, additional family time, communication with Team.	
Team meetings to assess changes		
• Meets face-to-face with the Team to evaluate efficacy of services at approximately 90-day intervals to ensure effective collaboration and resolution of differences. • Convenes Team meeting when IHT clinician or TT&S changes. • Convenes additional meetings when family circumstances change significantly (including emergency placement out of home), when intervention is "stuck," or when providers change. • Re-evaluates need for ICC when youth and family situation changes (new state agency involvement, Special Education change, added treatment providers).	• Waits too long to meet with Team. • Holds meetings but with superficial discussion of intervention. • Ineffective facilitation hampers consensus about adjusting to changes. • Relies primarily on phone or email; minimal face-to-face meetings. • Considers ICC only at beginning of service. • Not sure of different roles of ICC and IHT. • No mention that Family Support and Training (FS&T) can continue when either IHT or ICC ends.	• No face-to-face meetings. • Minimizes/ignores when intervention is "stuck" or blames on others. • Closes IHT when "stuck" without consulting Team. • No transition meeting when providers change. • Dictates level of care coordination needed. • Makes referral to ICC without telling family. • No mention of FS&T role with either service.
• **When youth has ICC:** Participates in all CPT meetings. Requests additional CPT meetings when family circumstances change significantly.	• Rushes discharge without full CPT agreement. • Superficial plan for next steps without considering options with CPT. • Plans next steps with subset of CPT only.	• Rushes discharge based on conflict with CPT. • No plan for supports after transition. • Does not attend CPT meeting for end of services.
• Holds face-to-face meeting as end of IHT approaches to review intervention and decide collaboratively with family members on next steps. • Meets (at least virtually) even if family terminates abruptly. • When family ends treatment in unplanned manner, debrief with all team members to discuss reason(s) and what can be learned from the experience. • Assembles relevant Team members for "warm hand-off" to new providers at close of IHT service, as needed/ according to family wishes.	• Rushes discharge without full Team agreement. • Discusses discharge only at end of service, not throughout. • Superficial planning for next steps without considering full range of options. • Plans next steps with subset only. • Develops transition plan but shares only with subset of Team. • Holds only virtual meeting at end of service. • Superficial discussion of unplanned ending without focusing on learning opportunity.	• Rushes discharge based on false claims of limits on services. • Does not request additional authorization even when warranted. • No plan for supports after discharge. • No transition meeting. • No discharge planning. • No plan for hub-dependent services when hub ends. • No discussion of unplanned ending.
• **When youth has ICC:** Joins CPT discussions as end of IHT intervention approaches to review progress and decide collaboratively with CPT on next steps, continuity of care, and service transitions, if any. • Assures space at CPT for "warm hand-off" to new providers at close of IHT service, as needed and according to family wishes.	• Rushes discharge without full CPT agreement. • Superficial plan for next steps without considering options with CPT. • Plans next steps with subset of CPT only.	• Rushes discharge based on conflict with CPT. • No plan for supports after transition. • Does not attend CPT meeting for end of services.