Healthy Families-Thriving Communities

Practice Standards Manual

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I. Introduction

Purpose of the Manual

The purpose of the Healthy Families-Thriving Communities Practice Standards Manual (PSM) is to set a baseline standard of practice for the HFTC Collaboratives by establishing protocols for the major areas of Collaborative practice. Each protocol contains a purpose and objectives, the skills and competencies needed by the Collaborative worker and action steps required to achieve the objectives. The protocols should be used to guide practice, to structure training and to set performance measures for self-evaluation and supervision. The manual is also intended to be the place where workers go to find the essential tools for practice; therefore, we have included Collaborative policies and standard tools and forms as well. Finally, the manual establishes the framework for quality assurance and is a tool to monitor the service delivery system of the entire Collaborative network.

The primary audience for the PSM is the frontline worker and his/her supervisor – people who are "doing the practice." However, the manual should be used by all staff to ensure quality delivery of services. Additional audiences may include partners, funders, regulators and evaluators.

History of the Healthy Families-Thriving Communities Collaboratives

The history of the Healthy Families-Thriving Communities Collaboratives in the District of Columbia began in 1993 when the US Congress enacted the Family Preservation and Family Support Act (FPFS). The purpose of the Act was to provide incentives to develop broader alternatives to the foster care system including the prevention of unnecessary separation of children from their families; to expand the array of services and supports that empower and strengthen families; and to ensure permanency for children through reunification, adoption or other permanent living arrangements. With the assistance of new planning funds provided under the Act, DC's Commission on Social Services established a broad-based public/private partnership to design a multi-year family preservation and support plan. The Commission chose the theme "Healthy Families-Thriving Communities" to frame the planning efforts and selected a steering committee to guide the development work.

The goal of HFTC was not only to help families avert crises, but also to give families the tools they needed to provide safe and nurturing homes for their children. In addition, realizing that families cannot be expected to succeed in

unsupportive environments, the steering committee developed community-building strategies that would lead to thriving communities. The committee proposed a series of neighborhood-based Collaboratives to guide the new initiative that would build on the assets of each neighborhood and assure that new programs were responsive to the unique needs of each community.

At the same time the Family Preservation and Family Support planning efforts were under way in the District, the City's child welfare system – like many systems in major urban settings through the country – was in crisis. A court order called for far-reaching reforms to the Child and Family Services Agency (CFSA), including a requirement for the development of "decentralized community-based services to assure the needs of families are met within their own neighborhoods." In 1995, the court determined that the District government failed to make substantial progress in improving the child welfare system and placed the system under a General Receiver.

The recommendations of the FPFS plan became the centerpiece of the General Receiver's effort to reform CFSA, and planning grants were awarded to the first four Collaboratives in 1996. The Collaboratives were charged with developing an organizational and service delivery proposal by which they would partner with CFSA to serve families in their respective neighborhoods. The framework for this partnership was unique when viewed in the national context. Other public child welfare systems were being reformed by decentralizing service delivery; the Collaboratives were designed to change the way services were planned and delivered. Child welfare systems traditionally became involved with families only at points of crisis; the Collaboratives would build networks of support that would be accessible to families before crisis.

The key differences between the traditional system and the Collaborative model are demonstrated in the following table.

Traditional System	Collaborative Model
Workers and services are centralized and physically distant from clients.	Workers and services are located where at-risk families live.
Families receive help only after finding abuse and neglect.	Families receive voluntary service as soon as problems arise, reducing the need for formal intervention.
Agency responds narrowly to family needs with limited help or removal of child.	Neighborhood-based support system activates informal supports to prevent removal of child.
Services are defined in categorical terms; services are limited by categories of care.	Family and child needs are defined comprehensively; services and supports are flexible to meet needs of families and neighborhoods.

Workers operate solely within traditional professional disciplines.	Services are provided by interdisciplinary teams of social workers and family support workers from the community.
Communities mistrust services and providers.	Communities become partners in services system.
Services system is dominated by public funds and agency staff.	Community agencies are primary service providers in collaboration with informal support and public and private partners.
Services system is insensitive to cultural and ethnic diversity.	Workers respect diversity; services are tailored to family and neighborhood composition.
No common agreement exists on success standards.	Communities agree to outcomes that measure success.
No one is accountable for positive results for families and children.	Communities hold themselves and all other providers accountable for results.
Decisions on funding and programs are made by centralized bureaucracies.	Decisions are made by Collaborative workers and staff.

The Collaborative model was enhanced by the adoption of the Family Development Training and Credentialing Program (FDC) in 2003 as a core strategy. The FDC is a training program for frontline workers that is designed to reorient human service practice to the family support approach. Workers learn to develop respectful partnerships with their clients, providing the foundation for strengthening and empowering families to become self-reliant and able to handle future challenges.

Recognizing that a more coordinated and comprehensive approach was needed to address the complexity of family issues, in 2006 CFSA and the Collaboratives began creating a new model to improve outcomes for children and families called the Partnership for Community-Based Services. In 2008, ten CFSA "in-home units" – supervisors and social workers who work with families whose children are still in the home – were strategically placed in Collaborative offices. This "co-location" created a stronger partnership between CFSA and the Collaboratives that improved services to families and children because their workers were able to plan and conduct interventions as a team.

The Collaboratives

There are currently seven Collaboratives operating in the District of Columbia. Each Collaborative is an independent 501c3 led by a community-based board of directors. The Collaboratives are:

- **Columbia Heights/Shaw Family Support Collaborative** – primarily serves Ward 1 and 2 residents. Contact information: 1816 12th Street NW, Suite 201, Washington, DC 20009 / (202) 518-6737 / www.chsfsc.org

- **East River Family Strengthening Collaborative** -- primarily serves Ward 7 residents. Contact information: 3732 Minnesota Avenue NE, Washington, DC 20019 / (202) 397-3700 / www.erfsc.org

- **Edgewood/Brookland Family Support Collaborative** – primarily serves Ward 5 and 6 residents. Contact information: 1345 Saratoga Avenue NE, Suite #2, Washington, DC 20018 / (202) 832-9400 / www.ebfsc.org

- **Far Southeast Family Strengthening Collaborative** – primarily serves Ward 8 residents. Contact information: 2041 MLK Jr. Avenue SE, Washington, DC 20020 / (202) 889-1425 / www.fsfsc.org

- **Georgia Avenue/Rock Creek East Family Support Collaborative** – primarily serves residents of Ward 4. Contact information: 1104 Allison Street NW, Washington, DC 20011 / (202) 722-1815 / www.garcec.org

- **North Capitol Collaborative, Inc.** – primarily serves Ward 1, 2, 5 and 6. Contact information: 200 K Street NW, Suite 3, Washington, DC 20001 / (202) 588-1800 / www.north-cap.org

- **South Washington/West of the River Family Strengthening Collaborative** – primarily serves residents of Ward 6. Contact information: 1501 Half Street SW, Suite 31, Washington, DC 20024 / (202) 488-7997 / www.swwr.org

Each Collaborative draws on the unique capabilities and services found within its network of service providers to assist at-risk children and families; however, there is a set of core neighborhood-based prevention services that each Collaborative provides.

- **Primary Prevention Services (Prevention)** – services designed to strengthen families and prevent child abuse and neglect before signs of abuse and neglect are present

- **Secondary Prevention Services (Preservation)** – services for at-risk families who have one or more risk factors associated with child maltreatment that are designed to improve family functioning and keep children safe in their homes

- **Tertiary Prevention Services (Stabilization)** – services for families formally involved with the child welfare system that are designed to provide family support and reduce the recurrence of child abuse and neglect

The HFTC Collaborative Council

As the Collaboratives began to sign service contracts with CFSA, stakeholders in the process identified the need for a policy-making body that could coordinate crosscutting issues relating to the Collaboratives. In response, the Healthy Families-Thriving Communities Collaborative Council ("the Council") was established in 1997.

The mission of the Council is to provide leadership and direction regarding the development and implementation of a city-wide neighborhood-based family support system. The Council enhances each Collaborative and the neighborhood it serves by uniting all partners into a cooperative effort dedicated to improving the quality of life for the residents of the District of Columbia.

The Council's core functions include documentation, quality assurance and evaluation; governance and internal coordination; service enhancement and resource development; and technical assistance and training.

The Collaboratives' Shared Vision and Principles

The Collaboratives' vision is to develop and sustain a seamless network of community partners throughout the District of Columbia that work to build strong families and supportive communities in which children, youth and adults can safely and productively reside and thrive. The Collaboratives base their work with children and families on the shared principles listed below.

Commitment to children – The Collaboratives are committed to the safety of children, to their right to be free from abuse and neglect and to their right to achieve their full potential as members of our community.

Respect for families – The Collaboratives believe that despite the challenges they often face, families are innately resilient and possess strengths which provide the foundation for change. When their strengths are recognized and affirmed, families can be full partners as they work to develop new skills and capacities.

Community partnership – The Collaboratives honor the strengths of the communities in which they work. The Collaboratives' goal is to involve community residents in the design, development and oversight of services to families and to build on the capacity of partner agencies to better serve families and children.

High quality, flexible and responsive services -- The Collaboratives are committed to high quality services that produce positive outcomes. Frontline workers have access to flexible resources that can be responsive to the unique needs of each family.

Accountability – The Collaboratives are committed to defining the results expected from their services and to be accountable for those outcomes. All Collaborative operations should be transparent to their partners and to the community.

A Framework for Practice

Practice entails the use of interpersonal relationships and other interventions to influence or change human behavior, to improve family functioning and to develop a safe and permanent environment for children. In the Collaborative model, practice goes even further -- strengthening and empowering families so they can reach their long term goals, and developing the community resources to support and sustain these family outcomes.

The following beliefs are the foundation of Collaborative practice:

- children have a right to permanence and stability in their lives;
- children have a right to live with their families except when they cannot be protected from abuse or neglect;
- children who are temporarily unable to live safely with their families should be placed with siblings if possible and in close enough proximity to their families so frequent visits may occur when appropriate;
- services should be developed to meet the needs and goals identified by the family;
- services should be strength-based and solution-focused;

- services should be provided in the least restrictive home or community-based environment consistent with the needs and safety of the child; and
- interagency collaboration and information and referral should build community capacities and the ability of families to meet their own needs by accessing community resources.

Evaluation of Collaborative Services Using ETO

The Collaboratives use an internet-based case management database called Efforts to Outcomes, or ETO, to monitor and improve programs and services. Created by case managers, ETO enables workers and staff to link their interactions with families directly to measurable program outcomes. Data that are captured with the ETO software include intake demographics, assessment data, referral data, case notes and client history. Additionally, the Collaboratives use ETO for service planning, tracking improvement of family functioning and monitoring of the overall impact and quality of programs and services.

II. The Protocols

The protocols that follow are designed to set a baseline standard for Collaborative practice with families.*

Each protocol is comprised of six sections.

1. Purpose – a general statement of the goal of the area of practice
2. Objectives – a specific statement of what needs to be accomplished to meet the goal of the area of practice
3. Competencies and Skills -- the baseline knowledge and implementation skills that the worker must possess and utilize related to the area of practice
4. Action Steps – the sequential activities that the worker must engage in to achieve the objectives of the protocol
5. Role of the Supervisor – a list of the major requirements for supervision and support in the area of practice
6. Tools and Forms – a list of standardized and sample forms included in the appendix that support the area of practice

The protocols are general in nature and are intended to provide the framework for Collaborative orientation, training and supervision. Collaborative workers are encouraged to become very familiar with the contents of each protocol and to use the protocols to guide their daily practice. Workers will also find the protocols helpful in providing the structure for self-evaluation.

*Note: The use of the term "family" is intended to be inclusive of individuals.

ENGAGING FAMILIES

PURPOSE

Engagement -- the gateway to Collaborative work -- provides the basis for all other activities necessary to serve and support the family. Engagement is the ongoing process of building a positive and effective working relationship between the family and the Collaborative worker that begins with the initial contact with the family. Building rapport is the most essential component of the engagement process because it provides the foundation for a family's receptivity to Collaborative services. The overall goal of improving long-term family functioning cannot be achieved without the engagement of the family.

OBJECTIVES

- To develop a healthy working relationship between the family and the Collaborative worker that includes good communication
- To empower the family
- To ensure that the family feels supported

COMPETENCIES AND SKILLS

The competencies and skills listed below are needed by the Collaborative worker to achieve the Engaging Families objectives. They must be utilized in the worker's initial and ongoing contacts with the family.

1. Baseline knowledge

   - Core principles of family development
   - Techniques for building rapport
   - Open-ended questioning and solution-focused interviewing
   - Family dynamics

2. Implementation skills, including the ability to

   - Help the family to recognize its resilience, strengths and successes
   - Assist the family in identifying its needs and goals by actively involving the family in the planning process
   - Demonstrate empathy and support by using basic counseling skills such as active listening

ROLE OF THE SUPERVISOR

- To provide the worker with guidance and support throughout the engagement process
- To provide clinical consultation as needed

TOOLS AND FORMS

- Core Principles of Family Development

CLIENT CONTACT

PURPOSE

Client contact is the process of engaging families for the purpose of ongoing assessment, planning and monitoring of safety and progress. Direct contact may occur in the client's home, in the Collaborative office, at a school or in other community settings. Indirect contact may occur via telephone or mail.

OBJECTIVES

- To support the family in identifying and achieving its goals
- To create and maintain a strong, working partnership between the family and Collaborative staff
- To assess safety and reduce risk
- To support and coach family members on parenting, home maintenance, budgeting, personal development or other critical skills
- To obtain accurate information about the family

COMPETENCIES AND SKILLS

The competencies and skills listed below are needed by the Collaborative worker to achieve the Client Contact objectives.

1. Baseline knowledge

    - Family dynamics, such as parent-child interaction
    - Standard case note formats

2. Implementation skills, including the ability to

    - Empathize with families in distress
    - Utilize good problem-solving skills
    - Utilize solution-focused interviewing skills
    - Demonstrate cultural competency and sensitivity
    - Assess family functioning
    - Demonstrate basic writing ability
    - Manage a schedule and prioritize
    - Ensure personal and environmental safety
    - Maintain appropriate boundaries at all times

- Maintain confidentiality

ACTION STEPS FOR SCHEDULED HOME VISITS

The home visit is an important component of Collaborative work with families because it provides an opportunity for the worker to

- observe the family in its most natural setting which leads to a better understanding of family needs, issues and dynamics;
- assess family functioning and risk; and
- develop and monitor the Family Development Plan.

The following chart summarizes the recommended frequency of home visits based on assessed risk level. At a minimum, the worker must conduct 3 home visits to a family prior to the completion of the appropriate assessments (see Assessment protocol).

Frequency of Home Visits Based on Assessed Risk Level (Table 1)

Risk Score	Risk Level	Minimum Number of Home Visits Per Month
55.5 – 99.5	High Risk = 1	4
30.5 – 55	Moderate Risk = 2	2
0 – 30	Low Risk = 3	1

1. Prepare in advance for the scheduled home visit.

A complete checklist to assist workers in preparing for scheduled home visits can be found in the Home Visit Guidelines in the appendix of this manual; however, the most important things to remember are listed below.

- Review the family's case file before the visit.
- Develop goals and an agenda for the visit. The primary driver of the home visit should be the Family Development Plan.
- Identify and gather the information, resources and tools needed to conduct the visit.

- Take steps to ensure safety during the home visit. In particular, provide a designated Collaborative staff member with the worker's cell phone number, the home visit itinerary and client contact information for all clients on the itinerary.

2. Review and utilize the Home Visit Guidelines which include suggestions for entering a family's home respectfully and safety precautions.

3. Use the home visit to engage in relationship building with the family.

4. Observe the degree of risk and safety in the family, household, and community and use these observations to complete case notes and the Family Assessment Form (FAF) at a later time.

5. Assess the family's progress toward meeting the goals in their Family Development Plan and use the assessment to revise the plan as needed, or every 90 days.

6. Encourage positive parenting skills and healthy parent-child interaction.

7. Help caregivers develop an understanding of child development stages and suggest activities that promote healthy child development.

8. Ensure that the family has health insurance and prenatal care (if needed) and is up-to-date with medical and dental check-ups and immunizations.

9. Promote healthy inter-dependence, empowerment and stability for parents.

10. Encourage and facilitate the family's active participation in identifying additional family resources that could be enlisted for support.

11. Document all client contact efforts made/attempted in ETO.

ACTION STEPS FOR UNSCHEDULED HOME VISITS

Unscheduled or unannounced visits may be made when the worker is unable to reach the family by telephone or by mail or when the family has not been available for scheduled home visits. The approach with a family who is expecting a visit might be quite different from that for an unannounced one. Without prior arrangements, some families are reluctant to allow a stranger into their home, or even answer the door unless they are expecting a visitor.

1. Follow the action steps for scheduled home visits, as appropriate.

2. Discuss previous attempts to contact the family with the supervisor; obtain the supervisor's approval before conducting the visit.

3. Take appropriate safety precautions including having another staff member join the home visit.

4. When someone answers the door, introduce oneself and explain the purpose of the visit and how long it will take.

5. Offer to allow the family member to verify worker employment with the Collaborative before entering the home.

ACTION STEPS FOR CLIENT MEETINGS IN THE COLLABORATIVE OFFICE, A SCHOOL OR OTHER COMMUNITY SETTING

Follow the action steps for scheduled home visits, as appropriate.

ACTION STEPS FOR TELEPHONE CONTACT

1. Ensure that a signed Consent for Release of Confidential Information Form is on file at the Collaborative prior to making any contacts on behalf of the family.

2. State name, title, organization and the purpose for the call.

3. Confirm that the client contact information in the client's file is correct and complete; seek additional information if necessary.

4. Follow the proper telephone etiquette guidelines in the manual appendix.

ROLE OF THE SUPERVISOR

- To assist workers in planning their visits or telephone contacts to address priority issues and advance the Family Development Plan
- To accompany supervisees for coaching purposes or to assess or intervene as needed
- To ensure clients are contacted regularly and home visit timelines are adhered to

- To ensure case notes are accurately completed within the recommended timeframe
- To discuss and address concerns that arise in supervision
- To coach staff on proper client contact etiquette
- To ensure that the principles of confidentiality are adhered to

TOOLS AND FORMS

- Case Note Format – Samples
- Consent for Release of Confidential Information Form
- Family Assessment Form (FAF)
- Field Itinerary
- Home Visit Form
- Home Visit Guidelines

INTAKE

PURPOSE

The purpose of the intake process is to determine a referred family's eligibility for Collaborative programs and services and to ascertain the family's presenting service needs and immediate level of risk and safety.

OBJECTIVES

- To process and track referrals from all sources
- To collect basic identifying information on all families who seek Collaborative services
- To ensure the family understands what the Collaborative does
- To ensure that family members understand their rights and responsibilities
- To assess the family's presenting service needs
- To determine the family's immediate level of risk and safety
- To determine eligibility for Collaborative services
- To provide information and referral to alternate services if necessary and track the status of each referral
- To determine the appropriate case disposition and assignment for each family

COMPETENCIES AND SKILLS

The competencies and skills listed below are needed by the Collaborative worker to achieve the Intake objectives.

1. Baseline knowledge

    - Collaborative services and community resources
    - The referral process
    - Collaborative and program specific eligibility requirements
    - ETO intake guidelines

2. Implementation skills, including the ability to

    - Perform an assessment of the family's immediate level of risk and safety
    - Utilize the engagement skills outlined in the Engaging Families protocol

GENERAL INTAKE ACTION STEPS

An intake form must be completed for all cases except clients who seek information and referral services only. In addition, an assessment of the family's service needs and immediate level of risk and safety must be conducted for all cases during intake.

The intake worker will determine the family's immediate level of risk and safety by interviewing the family and by clinical observation -- in consultation with the supervisor, if necessary. In making the determination of immediate level of risk and safety, the worker should consider the balance between a family's risk factors and protective factors.

Imminent safety concerns must be addressed at all times, including during intake. Emergency services may be rendered during intake to address unsafe conditions, to prevent harm to children/family members, to prevent eviction or cut-off of utilities and/or to deal with an immediate and critical need for food, transportation, clothing and/or emergency funds. Before emergency services are provided, the worker must complete the intake form, determine the family's immediate level of risk and safety and secure supervisory approval.

The intake process must be completed within 21 days of receipt of all required documents from CFSA or, in the case of a community referral, within 21 days of the initial client contact.

The documents that must be collected from the client during intake are:

- picture identification of the caregiver soliciting services;
- a birth certificate for all minor children;
- proof of income; and
- proof of residency in the Collaborative area.

Additional documents may be required depending on the family's presenting need.

During intake, the worker will classify each case according to case type/program areas. These include: Community General, Short Term Crisis Support, Community Diversion, Supportive and Youth Aftercare. Once a family has been placed into one of these case types/program areas, the family should remain in that program area until case closure.

ACTION STEPS: CFSA Referral Process

1. Receive referral from CFSA via fax in most cases.

2. Review referral to determine the case type and appropriateness of the service request.

   - See matrix of case types in the appendix.

3. Determine eligibility for services based on whether the client

   - resides in one of the Collaborative target areas/wards;
   - has a child under the age of 18 living in the home or plans reunification within six months; and
   - is available to participate in case management (minimum of one parent or caretaker).

4. Review documents from CFSA to ensure the inclusion of

   - a referral form;
   - a consent form;
   - the case plan (for Supportive Cases only); and
   - the SDM (CFSA Structured Decision Making Tool).

   <u>Note: If these documents are not received from CFSA within 3 business days of the initial CFSA request, close the case and refer back to CFSA. Notify the CFSA referring worker of this action by telephone and send a follow-up e-mail.</u>

5. Acknowledge receipt of the referral via e-mail within one business day.

   - Send acknowledgement to all involved parties including the liaison office, the referring social worker and the referring social worker's immediate supervisor.
   - Return referrals sent to an incorrect Collaborative to CFSA and maintain a record of all related correspondence.

6. Enroll in the ETO intake program within one business day of receipt of the referral.

7. Determine the family's immediate level of risk and safety by interviewing the family, clinical observation and consulting the supervisor.

- Note: A complete risk assessment will be performed later. (See Assessment protocol.)

8. Initiate contact with all relevant parties (client and referring social worker or agency) within two business days of receiving the referral. (Note: The level of risk may dictate an immediate response, and the worker should respond appropriately.)

    - Utilize the following methods for making initial contacts. (See Client Contact protocol for more information.)
        - Telephone call
        - Follow-up phone call
        - Home visit
        - Certified letter to client's address
        - Joint home visit or conference call that involves CFSA and client when necessary or possible
    - Discuss requested services and actual services required.
    - Determine the client's willingness to participate in services.
    - Obtain additional information from CFSA if necessary.
    - Complete the Intake Information Form.
    - Track all contact attempts in ETO.

9. Obtain the client's signature on the following forms when the client agrees to accept services:

    - Confidentiality and Consent to Receive Services Form;
    - Consent for the Release of Confidential Information Form;
    - Client Grievance Form; and
    - Intake Information Form.

10. Update the current status of the referral to the referring social worker and his/her supervisor via e-mail within 15 days of receipt of each referral. The referral status possibilities are listed below.

    - **Received** when the Collaborative has acknowledged receipt of the referral
    - **Not Accepted** when the family is ineligible for services or when the wrong Collaborative received the case
    - **Family Declined Services** when the family decides to refuse services
    - **Closed** when the worker has made three unsuccessful attempts during the intake process to contact the client (one of which must be a home visit) and a certified letter has been sent to the client informing him/her of the intent to close the case based on non-response. The worker must

notify CFSA that the referral is being rejected due to inability to contact the client.
- **Open** when the client has signed the necessary documentation and accepted services

Note: A client's status will change throughout the intake process.

11. Determine the final status of a referral within 21 days of enrollment in intake.

12. Assign the case to a worker.

    - Complete the Notice of Case Action Form.
    - Secure supervisory approval of case assignment.
    - Deliver to assigned case worker.

13. Dismiss from ETO intake and enroll in an ETO program.

14. Create a case file.

ACTION STEPS: Community Referral Process

1. Receive referral or contact from a community source. Referral sources include:

    - self-referral;
    - relative, neighbor or other concerned citizen such as a property manager or resident council officer;
    - school or recreation center;
    - church; and
    - other public or private agencies/organizations.

2. Acknowledge referring party, if appropriate.

3. Attempt to engage the client by utilizing the following methods:

    - telephone call;
    - follow-up phone call;
    - home visit; and/or
    - a certified letter to client's address.

4. Conduct an intake interview and determine eligibility for services.

- Determine eligibility for services based on whether the client
  - resides in one of the Collaborative target areas / wards;
  - has a child under the age of 18 living in the home or plans reunification within six months; and
  - is willing to participate in case management (minimum of one parent or caretaker).
- Orient the client to the Collaborative process, explaining the roles and responsibilities of client, worker and Collaborative.
- Determine the client's willingness to participate in services.
- Obtain the client's signature on the following forms when the client agrees to accept services:
  - Confidentiality and Consent to Receive Services Form;
  - Consent for the Release of Confidential Information Form;
  - Client Grievance Form; and
  - Intake Information Form.
- Provide Information and Referral, if necessary.

5. Enroll in the ETO intake program within one business day of receipt of the referral.

6. Determine the case type and appropriateness of the service request.

   - See matrix of case types in the appendix.

7. Determine the family's immediate level of risk and safety by interviewing the family, clinical observation and consulting the supervisor.

   - Note: A complete risk assessment will be performed later. (See Assessment protocol.)

8. Assign the case to a worker.

   - Complete the Notice of Case Action Form.
   - Secure supervisory approval of case assignment.
   - Deliver to assigned case worker.

9. Dismiss from ETO intake and enroll in an ETO program.

10. Create a case file.

ROLE OF THE SUPERVISOR

- To oversee the intake process and ensure adherence to agency policies
- To approve emergency services during intake if warranted to reduce immediate risk and safety concerns
- To provide clinical consultation in determining case status and/or final case disposition when needed
- To monitor and review correspondence and documents related to the intake process
- To ensure the completion of the necessary documents
- To identify training needs to enhance the knowledge, skills and competency levels necessary to perform intake duties

TOOLS AND FORMS

- Client Grievance Form
- Community Support Agreement
- Confidentiality and Consent to Receive Services Form
- Consent for the Release of Confidential Information Form
- Family Assessment Form (FAF)
- Family Responsibility Form
- Information and Referral Form
- Intake Information Form
- Notice of Case Action Form
- Privacy Statement
- Program Rules

ASSESSMENT

PURPOSE

The family assessment evaluates and identifies the current level of family functioning, the current risk to the children of abuse and/or neglect and the family's strengths, assets, resources and service needs. Families are empowered through their direct participation in the assessment process, which begins with the initial point of contact and continues throughout the life of the case.

OBJECTIVES

- To determine the degree of safety for children and families
- To assess areas of risk to children and families
- To identify family strengths, assets, resources and service needs

COMPETENCIES AND SKILLS

The competencies and skills listed below are needed by the Collaborative worker to achieve Assessment objectives.

1. Baseline knowledge

    - Safety and risk factors
    - Evaluation tools including the Family Assessment Form (FAF), the Family Basic Needs Assessment and Risk Assessments
    - ETO assessment guidelines
    - Collaborative partner agencies
    - Community services and resources
    - High risk behaviors that may lead to abuse and neglect
    - Protective factors that prevent abuse and neglect

2. Implementation skills, including the ability to

    - Use engagement skills to gather information on the family
    - Use client records, reports, evaluations and other pertinent information to inform the assessment

- Assist the family in recognizing its own strengths and accomplishments and in identifying its natural supports
- Utilize approved evaluation tools such as the FAF, Risk Assessments, genograms, ecomaps and Family Group Decision Making meetings
- Recognize and address the concrete needs of the family and imminent safety issues
- Assess family functioning and safety and risk factors from initial contact to case closure

ACTION STEPS

Assessment Schedule (Table 2)

Days from Program Enrollment*	Type of Assessment
Within 5 days	Pre-Family Basic Needs Assessment
Within 30 days	Pre-FAF (includes initial Risk Assessment)
Closure <90 days	Post-Family Basic Needs Assessment, Closing Risk Assessment and Closing Summary
At 90 days	Post-Family Basic Needs Assessment and Risk Assessment 2
At 180 days	Risk Assessment 3
At 270 days	Risk Assessment 4
Every 90 days thereafter	Risk Assessment 5, 6, 7 …..
Closure >90 days	Post-FAF (includes Closing Risk Assessment and Closing Summary)
At 365 days	1-Year FAF

*Note: Program enrollment is defined as the family being enrolled in any of the case management service areas. **Program enrollment does not include the intake program.**

Note: This assessment schedule is applicable for most but not all Collaborative case types. Those included are Community General, Diverted, and System Transformation Initiative (STI.) A matrix of case types and assessment tools can be found in the appendix of this manual.

1. Collect family assessment information using the following methods, as appropriate:

   - interview family members individually and/or together;
   - engage families in activities such as drawing genograms and ecomaps;
   - observe family members (including children) interacting at home or in the community;
   - examine written materials such as case records and school reports;
   - make contact with other agencies or individuals involved with the family; and
   - refer family members for an evaluation by a qualified professional.

   Note: Families must sign the Consent for the Release of Confidential Information Form before the worker can contact other sources or request copies of records/documentation concerning any member of the family.

2. Complete the Pre-Family Basic Needs Assessment within 5 days of program enrollment.

3. Complete the Pre-FAF Assessment within 30 days of program enrollment in accordance with FAF training and protocol guidelines and enter into ETO.

   - Obtain a family functioning score and an initial risk assessment score from the Pre-FAF.
   - Use assessment information to create the Family Development Plan and future work with the family. (See the Family Development Planning protocol.)

4. Assess and collect information continuously throughout the life of the case.

   - Utilize the collection methods outlined in Step 1.
   - Engage the family using methods outlined in the Engaging Families protocol.

5. Monitor the risk and safety levels of participating families by completing the subsequent Risk Assessments according the assessment schedule (Table 2) on the previous page. Enter the Risk Assessments into ETO.

6. Complete the Post-Family Risk Assessment, the Closing Risk Assessment or Post-FAF and the Closing Summary at case closure. Enter the case closure assessments and the Closing Summary into ETO.

   - Complete the Family Basic Needs Assessment, the Closing Risk Assessment and the Closing summary if the case closes within 90 days of program enrollment.
   - Complete the Post-FAF and the Closing Summary if the case closes after 90 days. (Note: The Post-FAF includes a Closing Risk Assessment score as well as a Closing Family Functioning score.)
   - Information from either the Closing Risk Assessment or the Post-FAF should inform the Closing Summary and lead to recommendations of linkages to other community resources if needed.

ROLE OF THE SUPERVISOR

- To provide guidance/coaching/mentoring of the assessment process including the collection of information and completion of the actual assessment forms
- To ensure that all assessments are completed in accordance with the action steps described above
- To review all assessments and ensure the results are linked to the creation of the Family Development Plan and discussed in the case review process
- To ensure that a Consent to Release of Confidential Information Form is completed for every source prior to requesting information regarding the family

TOOLS AND FORMS

- Closing Summary
- Consent for Release of Confidential Information Form
- Family Assessment Form (FAF) including the Pre-FAF, 1-Year FAF and the Post-FAF
- Family Basic Needs Assessment
- Risk Assessments

FAMILY DEVELOPMENT PLANNING

PURPOSE

Family development planning is a dynamic process that is based on shared power between family and worker and should result in a service plan that addresses the family's goals as well as any risk and safety issues discovered through assessment. The family developing planning strategy is a central component of the Family Development Training and Credentialing Program (FDC), originating from Cornell University, in which all Collaborative case managers are credentialed.

OBJECTIVES

- To develop individualized plans that focus on developing skills to increase the safety of children and the stability of families
- To develop plans that reflect the family's assessment of their situation as well as the assessment of the Collaborative worker
- To develop and sustain a strong working relationship among team* members
- To define roles, tasks and responsibilities for all team members
- To improve accountability among team members through the monitoring and updating of the family plan

*Note: The "team" includes the family, Collaborative worker and community partners.

COMPETENCIES AND SKILLS

The competencies and skills listed below are needed by the Collaborative worker to achieve the Family Development Planning objectives.

1. Baseline knowledge

    - The Family Development Training and Credentialing Program curriculum
    - High risk behaviors that may lead to abuse and neglect
    - Protective factors that prevent abuse and neglect

2. Implementation skills, including the ability to

- Communicate with the family using positive, everyday language
- Interview families in a way that elicits strengths, acknowledges past successes and identifies underlying issues
- Assist the family in recognizing patterns that contribute to stress/crisis
- Identify and reinforce individual, family and community protective factors that keep children safe and the family stable

ACTION STEPS

The Family Development Plan is a tool for guiding all of the work with the family and should be developed within 30 days of case assignment. The components of the Family Development Plan are:

- family data;
- the family's goals;
- steps the family will take to reach its goals;
- steps the worker will take to help the family reach its goals;
- the family's list of its strengths and resources;
- the worker's list of the family's strengths and resources;
- a list of client concerns; and
- a list of worker concerns.

Using the following steps, Collaborative staff will work with the family to develop, implement and monitor their comprehensive family plan.

1. Create relevant and appropriate goals with the family based on family and worker assessments, particularly the FAF. (See Assessment protocol.)

2. Assist the family in identifying small steps to achieving their goals.

3. Help the family prioritize their most immediate goals.

4. Determine who will be responsible for which tasks.

5. Determine when the tasks will be performed and/or completed.

6. Determine how the team will measure the accomplishment of objectives and goals.

7. Complete the written plan based on steps 1-6.

8. Develop a safety plan to address any known high-risk behaviors; include a long-term plan for family stability and relapse prevention.

9. Review the plan with the appropriate supervisor.

10. Obtain the family's signatures on the final version of their plan.

11. Enter the plan goals into ETO so that services can be tracked.

12. Monitor the effectiveness of the plan and the family's progress toward goal achievement during home visitation and every 90 days.

13. Revise the written plan as necessary; enter revisions into ETO.

14. Offer the family the opportunity to participate in a Family Group Decision Making (FGDM) conference throughout the life of the case.

ROLE OF THE SUPERVISOR

- To review with the worker the strengths and concerns identified in the assessment in preparation for developing the plan
- To support the worker in developing strategies that build on the family's strengths and address concerns
- To review the plan with the worker upon completion and to coach the worker on any outstanding issues that may need to be included in the plan
- To track the family's progress in follow-up supervisory sessions
- To approve all plan revisions – at 90 days, when the assessment is repeated, and thereafter

TOOLS AND FORMS

- ETO Service Plan
- Family Assessment Form (FAF)
- Family Development Plan
- Risk Assessments

DOCUMENTATION

PURPOSE

Accurate and timely documentation of all interactions with or on behalf of a family is essential to Collaborative best practices and to achieving the objectives of case management. Case notes are an integral component of documentation and provide the foundation for determining the future course of action with a family. The Documentation protocol specifies how and when information must be documented.

OBJECTIVES

- To provide a record of client progress
- To provide a record of work performed by Collaborative staff
- To provide a record of interactions between a supervisor and a supervised worker that relate to a case

COMPETENCIES AND SKILLS

The competencies and skills listed below are needed to achieve the Documentation objectives.

1. Baseline knowledge

   - The case note format
   - Collaborative privacy and confidentiality policies

2. Implementation skills, including the ability to

   - Write in a clear and concise manner
   - Capture observations and insights in writing
   - Use ETO to document work and capture efforts
   - Demonstrate basic computer literacy skills

ACTION STEPS

Case Notes

Collaborative staff must document any and all contact with and/or about families to whom services are being provided. This includes visits, phone calls, e-mails and collateral or community contacts.

Note: All interactions with or about a client must be documented as case notes using a standard case note format. Samples of case note formats can be found in the appendix of this manual.

1. Write case notes immediately after a contact with a family, or after a community or collateral contact concerning a family, using the designated case note format. At a minimum, the case notes should address all of the following:

   - purpose of the contact;
   - when the contact occurred;
   - where the meeting or home visit took place;
   - who was present for the meeting or home visit;
   - the worker's observations and informal assessment;
   - the family's level of motivation;
   - the content of the meeting or home visit relative to the family's development goals and plan;
   - any unusual incidents as identified in an Unusual Incident Report (see policy on filing such reports in the policy section of the manual);
   - agreed-upon next steps as they relate to the Family Development Plan goals or an emergency situation; and
   - the date of the next home visit or scheduled meeting.

2. Input the case notes into ETO within 3 business days of the interaction or contact.

3. Print a copy of the case notes that were entered in ETO. Sign the copy and put in the client's case file.

Supervision Notes

1. Document immediately in ETO all interactions with a supervised worker concerning a case. At a minimum, the notes should include:

- the purpose of the supervisory session;
- when and where the session occurred;
- who was present in the session;
- the supervisor's observations and informal assessment;
- the content of the meeting;
- agreed-upon next steps; and
- the date of next scheduled session.

2. Supervisors input the supervisory notes into ETO within 3 business days of the supervisory session.

3. Print a copy of the notes that were entered in ETO. Sign the copy and put in the case file.

ROLE OF THE SUPERVISOR

- To oversee workers' case notes for accuracy, format and input into ETO on a timely basis
- To document all interactions with or concerning a supervised worker
- To ensure the documentation and management of all unusual incidents
- To ensure compliance with the legal and regulatory requirements of documentation

TOOLS AND FORMS

- Case Note Format - Samples
- Confidentiality and Privacy Policy
- Unusual Incident Report Form

CASE REVIEW

PURPOSE

Case review, in combination with regular case supervision, is a Collaborative's primary strategy for clinical and administrative oversight of service delivery to the families. All case-carrying staff and their supervisors are required to participate in weekly case review meetings which include case presentations and group discussion utilizing a collaborative, consultative problem-solving approach.

OBJECTIVES

- To assess and manage risk to persons served, the staff and the organization
- To supplement client assessment and review client progress in reviewed cases
- To promote staff knowledge and understanding of practice standards and case management techniques
- To provide a regular forum for information and resource-sharing among staff
- To identify critical issues and trends in family needs and service delivery across the organization
- To promote a service philosophy, a service model and practice standards

COMPETENCIES AND SKILLS

The competencies and skills listed below are needed by the Collaborative worker to achieve the Case Review objectives.

1. To ensure a productive case review meeting, all participants must have knowledge of:

   - community resources;
   - the Family Assessment Form (FAF);
   - safety and risk factors;
   - laws and procedures related to child abuse and neglect;
   - confidentiality requirements and procedures; and

- Collaborative practice standards.

2. The facilitator of the case review session must also have knowledge of:

   - group dynamics;
   - family dynamics;
   - various tools such as the genogram and ecomaps; and
   - ways to integrate the information provided by the Family Assessment Form.

3. Because case review is a consultative and a collaborative process, all participants are expected to participate fully in the case review meeting, demonstrating the following group process skills:

   - active listening;
   - ability to deliver constructive feedback; and
   - ability to accept constructive feedback and recommendations.

ACTION STEPS

The following chart presents the case review cycle which is based on the assessed risk level of the case.

Case Review Cycle (Table 3)

Risk Score	Risk Level	Normal Case Review Frequency
55.5 – 99.5	High Risk = 1	Every 30 days (includes new cases)
30.5 – 55	Moderate Risk = 2	31-60 days
0 – 30	Low Risk = 3	90 days

1. <u>All workers:</u> Complete case review forms before the meeting.

2. Designated staff member: Prepare a case review list based on the case review cycle and case risk level and distribute to all frontline staff and supervisors prior to the meeting.

3. Meeting facilitator: In addition to facilitating the case review meeting, ensure that thorough documentation of the meeting is kept including a list of those in attendance, cases reviewed and results.

4. Program assistant: Establish the next case review cycle at the end of the meeting.

5. All workers: Develop case notes and recommendations based on the case review; date and record in client case records.

ROLE OF THE SUPERVISOR

A Licensed Independent Clinical Social Worker (LICSW) must be present at all case review meetings, participating in the discussions and providing active guidance.

The role of the supervisor in the case review process is

- To monitor the case review process
- To ensure staff and organizational compliance with the policies and procedures for case review
- To provide initial training and ongoing feedback to staff to ensure that case reviews are effective and achieve the stated objectives

TOOLS AND FORMS

- Case Management Tools - Samples
- Case Review Form
- Family Assessment Form (FAF)
- Family Development Plan
- Family Group Conference Plan
- Risk Assessments

CASE CLOSURE

PURPOSE

Case closure is the process of planning, implementing and documenting the termination of a family's case management services. The primary reason a case is closed is that the family has achieved its goals and no longer requires Collaborative services.

OBJECTIVES

- To document the achievement of a family's goals, the reduction of risk and the improvement of family functioning
- To ensure the connection of the family to a support system and community-based services
- To engage the family in the case closure process

COMPETENCIES AND SKILLS

The competencies and skills listed below are needed by the Collaborative worker to achieve the Case Closure objectives.

1. Baseline knowledge

   - Community resources and other linkages that families can access upon case closure
   - The case closure process

2. Implementation skills, including the ability to

   - Actively involve the client/family in the termination planning process
   - Assist the family in recognizing its accomplishments
   - Help the family accept case closure with confidence in the their ability to handle future crises

ACTION STEPS

The designated family support worker will assume primary responsibility for the case closure activities listed below which are necessary for all families

receiving Collaborative services. The worker should seek the supervisor's guidance and assistance throughout the case closure process.

1. Meet with the family to assess jointly the family's progress and the possible timing of case closure.

2. Meet with the supervisor for consultation on the recommendation that the case should be closed.

3. Review the family's record, including the case file and ETO, to ensure that achievement of family goals has been adequately documented.

4. Conduct a home visit to the family in the final 21 days prior to case closure to review the family's progress on the Family Development Plan and to ensure that the family is linked with the appropriate support services.

5. Complete the Post-Family Basic Needs Assessment and the Closing Risk Assessment (if the case closes in <90 days) or the Post -FAF (if the case closes in >90 days) within 21 days of case closure. Use the Closing Assessment to inform the Closing Summary. For cases closed before 30 days, a Closing Risk Assessment is not required.

6. Review the family's case a final time in the case review cycle, if applicable.

7. Complete a Closing Summary in ETO, describing the following in the comments section:

   - progress on the family's goals;
   - the family's strengths and needs;
   - problems/issues/concerns added and resolved within the last three months;
   - support systems and resources for the family; and
   - the follow-up plan regarding service recommendations.

8. Notify CFSA or the service provider leading the case and/or who referred the case to the Collaborative that the Collaborative is terminating services.

9. Submit the case record with all closing documents to the supervisor for final review.

10. Close the case out of ETO citing the appropriate dismissal reason which are:

   - unresponsive to attempts to contact/engage;

- withdrew from services/signed withdrawal form;
- transferred to another Collaborative;
- moved out of the District of Columbia;
- transferred from PCBS (Partnership for Community-Based Services) to Community Diverted;
- basic needs addressed/withdrew from further services;
- family functioning area(s) addressed/no need for further services and
- deceased.

Special Circumstances

Circumstances other than goal achievement may dictate closing a case. The following action steps should be taken, depending on the reason for closure. Please note than in all of these special circumstances it is the worker's responsibility to discuss the closing of a case with his/her supervisor and to document any outstanding risk or safety concerns and the actions taken to address them.

1. Families whose whereabouts become unknown

    - Attempt up to 2 home visits to the address of record (scheduled and unscheduled; vary times of day).
    - Notify the referral source of inability to locate the family.
    - At the supervisor's discretion, for an open CFSA case, request assistance from the Diligent Search Unit.
    - Contact other parties for information if the family has signed the Consent to the Release of Confidential Information form including:
        - conduct a school visit (if school is unknown contact the DCPS attendance office); and
        - interview neighbors, resident managers or landlords to confirm the family's address.
    - Send a certified letter to the family informing them of their service options and requesting the family's response. (See sample letter in appendix.)
    - If the family is not responsive within 15 days, close the case by completing the case closure procedures outlined above and sending a closing letter to the family and service providers.

2. Families who withdraw from services

    - Obtain the client's signature on the Withdrawal from Services Form.
    - Inform family of their right to return to the Collaborative should members desire to resume or receive services.

3. Families who do not comply with basic Collaborative policies/procedures or where there are safety issues, e.g., the client threatens or harasses a staff member

   - Contact the supervisor immediately.
   - Complete a management review to determine the safety risk of the employee who is working with this client.
   - Complete an Unusual Incident Report, as appropriate.

4. Families who relocate outside of the Collaborative service area and are transferred to another Collaborative or service provider for continuing services

   - Review the family's case record with the supervisor to determine the status of the family's goals and any outstanding risk or safety issues. Unmet goals should be included in the closing summary with suggestions for linkages to services.
   - Prepare the family for the case transfer.
   - Secure a Consent for Release of Confidential Information Form from the family.
   - Contact the receiving Collaborative (or other agency) to inform them of the proposed case transfer and to determine if they have the capacity to accept the case. (If a transfer is not possible, the original Collaborative should continue working with the family.)
   - Coordinate a case staffing with both Collaboratives and the family to facilitate a smooth transfer.
   - Prepare a case transfer summary. Other case file documents may be released as described in the Consent for Release of Confidential Information Form. <u>The Collaborative may not copy or release documents received from another source, except as explicitly described in the Consent for Release of Confidential Information Form.</u>

5. Families who are receiving comprehensive and/or duplicate services from another agency, e.g., from an inpatient substance abuse treatment center.

   - Use a case staffing, a joint home visit or another method to determine whether services will be provided and children's risk and safety issues will be addressed. Review the decision with the supervisor.

ROLE OF THE SUPERVISOR

- To provide oversight of the case closure process and to ensure that policies of the agency are adhered to
- To provide clinical consultation and support in determining the appropriateness of the closure of a case
- To ensure that appropriate referrals and linkage to community resources are provided when applicable
- To review the case record (i.e., the case file and ETO file) upon closure to ensure that all documentation has been completed.
- To ensure that the case is closed out of ETO with the appropriate dismissal reason

TOOLS AND FORMS

- Case Transfer Form
- Client Satisfaction Survey
- Closing Summary
- Notice of Case Action Form
- Risk Assessments
- Sample letters to families unable to engage, who withdraw from services or whose whereabouts are unknown
- Withdrawal from Services Form

SUPERVISION

PURPOSE

Supervision is the process for providing Collaborative staff the training, support and feedback they need to ensure effective, appropriate and strength-based service delivery to children and families. The purpose of supervision is to ensure quality services, adherence to practice standards and staff development. As in the work with families, supervision should model helping strategies that build on the supervisee's strengths, experience and training. Supervision not only guides the supervisee's work with families; it also informs his/her interaction with the community and other service providers.

OBJECTIVES

- To support Collaborative staff in their work
- To ensure that staff understand their roles and responsibilities and that they maintain appropriate boundaries at all times
- To promote the development of skills in the areas of engagement, assessment and implementation of a strengths-based, family-centered and solution-focused approach to working with families
- To assist staff in developing an awareness of their own biases and to work toward minimizing the impact of bias on client relationships
- To ensure staff are able to assess families for risk and safety
- To promote adherence to the practice standards

COMPETENCIES AND SKILLS

The competencies and skills listed below are needed by the Collaborative supervisor to achieve the Supervision objectives.

1. Baseline knowledge

   - Family dynamics
   - A range of clinical supervision techniques such as parallel process, transference, counter-transference and boundary setting
   - Social work ethics
   - Coaching techniques
   - Family Development Training and Credentialing Program

2. Implementation skills, including the ability to

- Communicate expectations around performance standards
- Individually assess each supervisee's relative strengths and weaknesses and tailor the supervision accordingly
- Structure supervisory sessions to address priority risk and safety issues while meeting the worker's learning needs
- Utilize a range of techniques to develop the supervisee's skills such as role playing, modeling, effective listening, open-ended questioning and reframing
- Maximize the use of ETO as a supervisory tool
- Model and coach supervisees to achieve effective time management

ACTION STEPS

Supervision is a one-on-one or group conference between a worker and a supervisor that is structured and interactive. Supervision is provided through scheduled appointments or emergency walk-ins as needed.

1. Schedule weekly supervision of at least one hour duration with each individual worker.

2. Prepare for supervision by reviewing previous sessions and ensuring that the highest risk cases get priority attention.

3. Utilize ETO to review service plans, case notes, current assessments and other relevant information in advance of scheduled supervision sessions.

4. Supervisors should document in ETO and print out results. The results of each supervisory session and agreed-upon next steps should be put in the individual case record.

ROLE OF THE SUPERVISOR

- To coach staff in their efforts to plan and implement their work
- To provide staff orientation and training on needed skills and new practice techniques
- To support supervisees in identifying and working with each family's strengths
- To support staff in monitoring risk and safety factors and in anticipating and managing crises

- To help supervisees identify and develop their own strengths through clinical feedback and modeling of the solution-focused approach
- To support staff in developing their career plans and goals
- To reinforce the Family Development Training and Credentialing Program principles

ROLE OF THE SUPERVISEE

Supervision is a reciprocal process and, therefore, it is important that the supervisee share responsibility for the success of their supervision. The role of the supervisee is to:

- bring to each supervisory session the required documents and information (e.g., case file, case plan, Family Development Plan and the FAF);
- prioritize the issues that are of the greatest concern and ensure that they are addressed;
- follow through on the “next steps” that were identified in the previous supervisory session and to be prepared to discuss them in the supervisory session;
- articulate areas where guidance and support are most needed by the worker; and
- to accept feedback as a necessary part of supervision.

TOOLS AND FORMS

- Family Assessment Form (FAF)
- Notice of Case Action Form
- ETO supervision notes

CASE RECORD MANAGEMENT

PURPOSE

Each Collaborative must create and maintain a case record for each family receiving services from the Collaborative. A family's case record is comprised of a case file (a compilation of paper documents, forms and instruments) and an electronic file (documentation in ETO or another database). A family's case record is used to document all service delivery and to monitor practice standard compliance and contract deliverables.

OBJECTIVES

- To ensure the development of a system for creating and managing client case records
- To maintain the confidentiality and safety of client case records

COMPETENCIES AND SKILLS

The competencies and skills listed below are needed by the Collaborative worker to achieve Case Record Management objectives.

1. Baseline knowledge

   - Collaborative case file procedures
   - Procedures for entering data into ETO and other databases used by the Collaboratives

2. Implementation skills, including the ability to

   - Organize and maintain case files
   - Navigate database software

ACTION STEPS: Creating Case Files

Note: Once a case is assigned, it is the assigned worker's responsibility to manage and update the case file.

1. Create a case file during intake. (See Intake protocol.)

2. Organize the case file into sections.

   - Each section should contain related content consisting of forms, documents and instruments.
   - Each Collaborative must establish and follow written procedures that specify the case file sections and contents.

3. At a minimum, include the following sections in each case file:

   - identifying/legal information (e.g., birth certificate, drivers license, social security card);
   - case recordings (e.g., case closure summary, progress notes, supervision notes);
   - case planning (e.g., Case Review Forms, Family Development Plan);
   - evaluations (e.g., medical reports, psychosocial reports);
   - correspondence (e.g., attempted home visit letters, lease documents); and
   - finance (e.g., Flex Fund requests, receipts).

   Note: These items may vary in order across the Collaboratives.

4. Ensure that the following items are in every case file:

   - Referral Form;
   - Intake Information Form ;
   - signed Confidentiality and Consent to Receive Services Form;
   - any documents provided by the family;
   - signed Consent for Release of Confidential Information Form;
   - risk and safety assessments;
   - case notes;
   - additional forms that the family has signed;
   - Family Development Plan;
   - supervision notes; and
   - Case Review Forms.

Note: Paper copies of all ETO documents related to a case should be included in the case file. Also, specific contracts may require the inclusion of additional forms and documents in the case file. For example, the System Transformation contract requires the completion of a monthly Home Visit Form which would need to be included in the case file.

ACTION STEPS: Securing Case Files

1. Keep all case files in a locked file cabinet in a locked office when not in use during the workday and after-hours.

2. Ensure that only the assigned staff, supervisor, program manager and executive director have access to a case file.

   - Collaborative staff can access only the files of families with whom they are working.
   - Appropriate CFSA staff may be given access to case files for those families with open CFSA cases with the approval of the Collaborative program manager.

3. Secure the signature of the staff member removing the file from the designated cabinet on a Case File Sign-In/Out Form.

4. Ensure that all case files are returned to their designated location at the end of the work day.

5. Ensure that case files are not removed from the Collaborative office except for purposes of supervision and/or quality assurance audit purposes.

6. Maintain case files on-site in a secure location for 3 years after case closure.

7. Archive case files after 3 years in a secure location and ensure that only authorized individuals have access to the files.

8. If desired, destroy case files 5 years after case closure. (All papers must be shredded.)

ACTION STEPS: Creating Electronic Files

See ETO manual for action steps. Workers will be trained in ETO.

ROLE OF THE SUPERVISOR

- To ensure that case records are created and maintained in a timely way
- To ensure that case records are in compliance with the minimum format and content requirements

- To ensure compliance with case record maintenance and storage procedures
- To ensure that case records are adequately prepared for quality assurance reviews

TOOLS AND FORMS

- Case files and locked cabinets
- Case File Sign-In/Out Forms
- ETO

QUALITY ASSURANCE

PURPOSE

The purpose of quality assurance is to ensure that all programs and services are in compliance with the practice standards and relevant professional standards. Quality assurance is a shared responsibility between the Collaboratives and the HFTC Council.

OBJECTIVES

- To ensure that the standards set forth in this practice manual and the standards of the individual Collaborative are met
- To collect, analyze and utilize quantitative and qualitative information for practice improvement and staff training
- To ensure continuous quality improvement of Collaborative programs, operations and systems
- To monitor compliance with grants and internal Collaborative policies

COMPETENCIES AND SKILLS

The competencies and skills listed below are needed to achieve the Quality Assurance objectives.

1. Baseline knowledge

   - Collaborative practice standards and relevant professional standards
   - Collaborative programs and operations
   - Data collection and management methods
   - Program services
   - Program eligibility
   - Contract deliverables
   - Trends in best practices

2. Implementation skills, including the ability to

   - Assess the effectiveness of programs and services and make recommendations for improvement
   - Demonstrate proficiency in ETO

- Analyze and interpret quality assurance information
- Communicate effectively, verbally and in written form

ACTION STEPS

Note: Ongoing supervision and case review are critical to quality assurance and are addressed in separate protocols.

1. Audit a random sample of at least 10% of open case files each quarter.

   - Use the Case File Audit Form to document the status of each file.
   - Review during the audit:
     - the completeness and adequacy of the documentation in the file which involves reviewing case notes, timeliness of assessments and case plans;
     - the appropriateness and effectiveness of services provided which involves reviewing the needs identified at intake vs. those addressed in the case plans; and
     - the necessity for continued service to the family.
   - Document the completed audit in the case file, including corrective actions prescribed.
   - Develop a corrective action plan for each case audited within 30 days of the audit.

2. Administer and evaluate Customer Satisfaction Surveys.

   Note: A policy is being developed on Customer Satisfaction Surveys which will be presented to the Executive Directors and Program Managers when it is completed.

   - Complete a Customer Satisfaction Survey at case closure.
   - Survey all clients confidentially at least once a year regarding their satisfaction with services.
   - Use feedback from the surveys to provide recommendations for practice improvement.

3. Ensure the collection of quality data and good data management.

   - Ensure quality and timely data entry into ETO. (See the Documentation protocol.)
   - Review ETO management reports monthly at a minimum.
   - Use data to track family progress.

- Use data to track the status of contract deliverables.

4. Utilize data reports and data analysis for continuous quality improvement to inform practice, contract compliance and documentation.

    - Examine trends and patterns.
    - Identify areas for improvement.
    - Provide recommendations and/or feedback for programmatic and policy improvement.

ROLE OF THE COUNCIL

- **Provide continuous and reliable feedback on collected data.** Data quality reports provide information about the completeness and accuracy of the data entered each month. Monthly and annual reports provide information about the status of contract deliverables and services provided.

- **Monitor contract compliance on specialized initiatives and services**. The Council facilitates the process through which programs operated jointly across Collaboratives implement standardized practices. The Council also compiles, monitors and submits reports in adherence to contract guidelines.

- **Provide technical assistance to the Collaboratives**. The Council should - directly or through coordination – support the improvement of staff competence, data quality or program efficacy by researching best practices, providing ETO training and promoting strategic development and new initiatives.

ROLE OF THE SUPERVISOR

Quality assurance involves three levels of supervision and accountability to ensure continuous quality improvement:

Executive Director

- To review data reports
- To work with senior management to develop a program improvement plan based on data analysis

Program Manager / Clinical Director

- To review data reports
- To oversee the implementation of the quality improvement plan
- To oversee the direct supervisors

Supervisors

- To ensure the individual worker's adherence to the practice standards
- To provide workers with the feedback, coaching and training necessary to improve their practice in a timely manner
- To hold workers accountable for meeting the expectations and time lines established for improving their practice

TOOLS AND FORMS

- Case File Audit Form
- Client Satisfaction Survey
- Efforts to Outcomes database
- Employee Evaluation Form
- Other data collection and management systems

TRAINING

PURPOSE

Training ensures that all Collaborative staff members have the knowledge and skills to provide effective services in support of families and in accordance with our practice standards. Training is a continuous process that increases a worker's awareness of and confidence in his/her own abilities and develops new competencies to assist families in achieving their goals. The focus of the training may be on the practice approach, a particular subject area or specific skills and protocols.

OBJECTIVES

- To increase staff understanding, knowledge and skills in a strengths-based, solution-focused approach to working with families and the community
- To achieve basic competency in engaging families, assessing risk and safety, co-developing and implementing a family plan and documenting the work

COMPETENCIES AND SKILLS

The competencies and skills listed below are needed by trainers to achieve the Training protocol objectives.

1. Baseline knowledge

   - The subject being taught
   - Adult learning styles
   - The Collaborative model

2. Implementation skills, including the ability to

   - Coach and communicate with staff with different experience levels and cultural backgrounds
   - Utilize a strengths-based approach to working with families
   - Utilize relevant training and facilitation skills

ACTION STEPS

Collaborative Council Staff

1. Administer the Family Development Training and Credentialing Program training.

2. Provide ETO training as needed.

3. Identify trainers in specialized areas based on Collaborative needs and contractual requirements.

4. Disseminate a city-wide training calendar and registration materials.

5. In conjunction with Collaborative executive directors, develop the training plan and budget.

6. Maintain a record of individual participation in Council-sponsored courses.

7. Maintain a library of all training materials used in Council-sponsored courses.

Senior Management

1. Ensure that the training requirements of the HFTC Collaboratives, internal personnel policy and contracts are satisfied.

2. Plan and budget for staff development.

Program Managers and Supervisors

1. Assess their supervisees' skills and work with them to develop a training plan that reflects their interests and need for professional growth.

2. Maintain a Collaborative-specific training calendar.

3. Ensure that staff's duties and responsibilities are adequately covered to enable their participation in training.

4. Identify training opportunities that address the needs of their staff.

5. Monitor and evaluate the effectiveness of Collaborative training.

6. Ensure the integration of training in day-to-day practice.

Staff Members

1. Communicate their training needs and interests.

2. Complete the necessary registration forms.

3. Adhere to the expectations of the training and their home Collaborative.

4. Be willing to receive new information.

5. Provide feedback on the training upon completion of the course.

6. Document the training in ETO.

7. Integrate training into day-to-day practice.

ROLE OF THE SUPERVISOR

The role of the supervisor is addressed above.

TOOLS AND FORMS

- Training Registration Form - Sample
- Training Evaluation Form - Sample

GLOSSARY

Assessment – the process of identifying and evaluating the current level of family functioning, the current risk to children of abuse and/or neglect and a family's strengths, assets, resources and service needs.

At-risk – the probability of maltreatment, homelessness or other facts that would compromise the safety of a child or family.

Boundaries – the recognition and maintenance of a professional, not personal, relationship between staff and client.

Case action – any action that changes the status of a case, including opening or closing it or transferring it from one family support worker to another.

Case closure – the process of planning, implementing and documenting the termination of a family's case management services.

Case disposition – the status of a referral or case.

Case file – a client's paper file which includes copies of such documents as the Referral Form, Intake Information Form, risk and safety assessments, case notes, the Family Development Plan, supervision notes, Case Review Forms, signed documents, documents provided by the family and all appropriate ETO documentation.

Case file/record audit -- the process of regularly reviewing client case files for the completeness and adequacy of the documentation, the appropriateness and effectiveness of services provided and the need for continued service to a family.

Case management – the coordination and delivery of services to a family including assessment of needs and service/case planning and monitoring.

Case notes – the documentation of all interactions with or about a client using a standard case note format.

Case record – all documentation, electronic and paper, pertaining to a Collaborative's interaction with or on behalf of a family.

Case record management – the process of creating, maintaining and securing client case records according to established Collaborative procedures.

Case review – a consultative and collaborative process involving case-carrying staff and their supervisors designed to provide clinical and administrative oversight of service delivery to families.

Case transfer – the act of reassigning a case from one Collaborative to another Collaborative or service provider for continuing services.

Client contact – the process of engaging families for the purpose of ongoing assessment, planning and monitoring of safety and progress and providing services to the family.

Closing summary – a worker's description of a family's progress, achieved goals and a follow-up plan regarding future services.

Confidentiality – the ethical principle or legal right that a professional will hold secret all information relating to a client unless the client gives consent permitting disclosure or there is a legal exception, e.g. the individual poses a risk to self or others.

Conflict of interest – any situation in which the personal or professional interests of a staff member might affect his/her ability to act in the best interests of the organization.

Cultural competency – the ability to understand and communicate effectively with people across cultures. There are four components to cultural competency: awareness of one's own cultural worldview; attitude toward cultural differences; knowledge of different cultural practices and worldviews; and cross-cultural skills.

Documentation – a written and/or electronic record of all interactions with, about or on behalf of a family.

Ecomap - a graphical representation that shows all of the systems at play in a family's life. It is used to develop an understanding of the family in its social environment.

Emergency services – Services that are rendered at any time, including during intake, to address unsafe conditions; to prevent harm to children/family members; to prevent eviction or cut-off of utilities; and/or to deal with an immediate and critical need for food, transportation, clothing and/or emergency funds.

Engagement - the ongoing process of building a positive and effective working relationship between the family and the Collaborative worker that begins with the initial contact with the family.

ETO ("Efforts to Outcomes") - an internet-based case management database that enables workers and staff to monitor and improve programs and services by linking their interactions with families directly to measurable program outcomes.

ETO file – the electronic documentation of service delivery to a family that includes client contact efforts, intake data, assessments, the family development plan, case notes and supervision notes. The ETO file is part of a family's case record.

Family – those individuals designated by the client as included in their family constellation, whether or not related by birth or other legal relationship.

Family Assessment Form (FAF) – the standard family assessment instrument used by the Collaboratives to capture family circumstances such as living conditions, financial conditions, caregiver supports and caregiver/child interactions and to track changes in family functioning. The FAF was developed by Children's Bureau and is now published and distributed by the Child Welfare League of America.

Family Basic Needs Assessment – An assessment tool used by the Collaboratives during intake to provide an initial evaluation of a family's basic needs.

Family development planning – the creation of a family service plan that addresses the family's goals as well as any risk and safety issues identified in the assessment process.

Family development planning team – the group that creates the family development plan including the family, Collaborative worker and community partners.

Family Development Training and Credentialing Program (FDC) – a training and credentialing program, originating from Cornell University, for all Collaborative case managers that focuses on a strength-based approach to working with families and communities. The FDC is designed to reorient service providers to support families in becoming self-reliant by sharing with them the power to make decisions that move them toward their goals.

Family dynamics – the patterns of relating, or interactions, among family members that can have a powerful impact on family functioning.

Family Group Decision Making – a group meeting that brings together a family and professionals from agencies that provide needed services to develop a comprehensive family plan. Families are supported by staff to make decisions and develop the plan that addresses their needs.

Flex funds – monies designated for direct family assistance. These funds can be used to provide emergency or non-emergency assistance to families who are receiving Collaborative services.

Genogram - a tool used to assess family functioning. The genogram is a graphic representation of a family tree that displays detailed data on relationships among individuals and allows the user to identify and understand the various patterns in a family's history that affect state-of-mind and behavior.

Grievance – the expression by an individual of his/her dissatisfaction with Collaborative services or a service provider.

Home visit – a face-to-face contact with an individual or family in their place of residence.

Information and referral services – provision of information about and/or referrals to community resources to meet immediate and long-term needs such as job placement, legal services, food and transportation, mental health services, domestic violence services, shelter care, health and medical services and housing assistance programs.

Intake – the process of gathering information to make a determination of a referred family's eligibility for Collaborative programs and services and to ascertain the family's presenting service needs and immediate level of risk and safety.

Mandatory reporting – a legal requirement to report any suspected child abuse or neglect.

Open-ended questioning – the process of asking questions that encourage a full, meaningful answer using the respondent's own knowledge and/or feelings. Open-ended questions typically begin with the words "Why," "How" or "Tell me about."

Protective factors – conditions/circumstances that decrease the possibility of child abuse and neglect, e.g. 1) parental resilience; 2) social connections; 3) knowledge of parenting and child development; 4) concrete support in times of need; and 5) social and emotional development of children. A focus on developing these factors in families is central to the Collaboratives' strategy for preventing child abuse and neglect.

Quality assurance – the process of ensuring that all Collaborative programs and services are in compliance with practice standards and relevant professional standards. Quality assurance is a shared responsibility between the Collaboratives and the HFTC Council.

Rapport – a trusting or harmonious working relationship with a client.

Risk assessment – an evaluation of the possibility of maltreatment of a child. The risk assessment examines risk factors (defined below.) The evaluation responses have assigned values that are combined to determine the risk score for the family. The risk score is used to determine the risk level of high, moderate or low. The risk level provides guidance to the family support worker on the minimum number of monthly contacts with the family that the worker must make.

Risk Factors – conditions/circumstances that increase the possibility of maltreatment, e.g. poor caregiver-child interactions, caregiver support, housing, finances, stress, mental health, substance abuse and family history of abuse.

Safety assessment – an evaluation of a child's present danger and any interventions needed to protect the child.

Solution-focused approach – a way of working with a family that invites family members to envision their preferred future based on past successes and to articulate steps they could take to achieve their goals. This approach focuses on solutions rather than problems.

Strengths-based approach – a set of ideas, assumptions and techniques that view families as having strengths that are often untapped or unrecognized; that identify the resources of families and children; and that engage families as active participants in the helping process.

Structured Decision Making Tool (SDM) – a CFSA assessment tool designed to focus on critical characteristics related to a specific area of concern around neglect or abuse.

Supervision – a one-on-one or group conference between a worker and a supervisor that is structured and interactive and is designed to provide staff with the training, support and feedback they need to ensure effective, appropriate and strength-based service delivery to children and families.

Training – the process of providing Collaborative staff with the skills and knowledge they need to deliver effective services in accordance with practice standards.

Unusual incident – An event affecting a family that is significantly different from the regular course of events and/or one that threatens to destabilize the family. Examples include death; injury; allegations of physical or sexual abuse of a family member; fire; sudden serious problem(s) in the physical plant of the family's home; or a complaint from the family about client services.