Interagency Collaboration/ Protocol and Guidelines

By

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Supervisor Signature _____

Interagency Collaboration -Protocol and Guidelines

The Managed Treatment Services Division of the Department of Social Services has the responsibility of assuring that emotionally and behaviorally challenged children receive appropriate services while in foster care. These children are managed by the Managed Treatment Services Division when intensive case management services are required as well as a therapeutic placement. The objective is to allow each child to function as normally as possible. Services include obtaining and maintaining appropriate placement, coordinating therapy and other medical appointments as well as assuring that educational rights are protected.

The Managed Treatment Services division does not provide all of these services directly but instead contracts with private providers or other state agencies to assist with service provision so the responsibilities are shared. Front line staff from many agencies and providers had voiced complaints that there was confusion regarding their role in service provision.

A meeting was initiated by this writer to discuss these complaints. After several meetings with local state agency and contract provider directors and supervisors, it became clear that there is often conflict between the MTS service coordinator, other state agency staff and contract provider staff regarding the responsibility for the provision of specific services as well as uncertainty about protocol. (See Appendix B) Some specifics include transportation issues, placement disruption and appointment scheduling.

Due to the circumstances involving these problems, the agency's goal of enhancing the emotional well being of the child is not being met. When there is uncertainty and conflict, promotion of the most normalized community environment through case management services may not be accomplished. As a result, a child may not always receive the most appropriate service and the staff can be confused and become disgruntled.

The goal of this project is to clearly define through concrete guidelines and protocol agreed upon by each state agency and private provider and outline who will have the responsibility for a particular service as well as specific steps to assist both agency and provider staff.

With specifics clearly defined, agency and contract provider staff would be aware of their respective responsibilities. Subsequently, this should decrease frustration and animosity between agencies as well as ensure that needed services are obtained for the client and not duplicated. In addition, the agency's goal of

normalcy and increased social and emotional well being in the least restricted, community environment is accomplished.

Several causes comprised the problem of this project. First, the Department of Social Services is in itself a large agency with several divisions and a diverse staff. There were at times poor communication between the Foster Care division, the In Home Treatment division, the MTS division and Adoptions and most did things their own way. This information was obtained through group meetings with local state agency supervisors and directors. As cases changed hands, from one division to another, confusion arose as to who would be responsible for providing or securing services.

Next, there was confusion among the Department of Social Services staff, the state agency staff and contracted private providers. As stated earlier, the Department of Social Services contracts for some services. There were breakdowns at intake, confusion over who should handle crisis situations with clients and placement disruptions or placement changes. This information was obtained through a meeting initiated by this writer with local state agency directors and supervisors and private provider directors. This group will be referred to throughout this paper as the **Interagency/Provider Committee**. Information was also obtained also thorough a Collaboration Questionnaire and Rating Scale completed by the caseworkers and supervisors from each agency or private provider offices (See Appendix A)

Finally, many times there was poor communication between the Department of Social Services caseworker, the contracted provider and other state agency staff thus causing confusion over who was to provide the service and the kind of service that should be provided. This information was also revealed through the Collaboration Questionnaire and Rating Scale (See Appendix A).

Data collection goals were identified by discussing each agency's process during the Agency/ Provider Committee meeting formed by this writer. Data was collected using a rating scale and a questionnaire compiled by this writer which was distributed to caseworkers and supervisors from several state agencies, three private provider offices and various divisions of the Department of Social Services. Some information regarding the data to be included on the Questionnaire and Rating Scales was gathered through the Interagency/Provider Committee.

The Collaboration Project Problem rating Scale asked participants to rate problems or concerns using the numbers one through five, one being never and five being always (See Appendix A). Ratings obtained through this process were entered into a statistical program and the frequencies and percentages were obtained. The results supported the writer's initial hypothesis that unclear roles

and a general lack of communication were the primary reasons for the lack of collaboration. 50% of the participants rated question number 4 with a 4 which coincides with often. This question asked about the lack of clarity regarding other agency's or contract provider's roles. 50% also rated question 9 with a 3 which coincides with sometimes. This question asked if there is poor communication in general with other agencies and providers (See Appendix A).

The Collaboration Questionnaire asked participants to put an X by the agency or provider that they feel is providing the service and a Y beside the agency that they feel should be responsible. As shown by the statistics labeled Frequency Tables, there was much confusion and uncertainty about who should be providing the services. The numbers were skewed as many participants marked several items with X and several items with a Y. These surveys and Frequency tables give support to the writer's causal analysis.

There is much research to support the problem's statement and assists with verifying the data of this project. One such study supports the belief that the absence of interagency collaboration negatively effected communication among agencies thereby hindering the delivery of services or increasing the likelihood of duplication of services (Bryant, Rivard, Addy, Hinkle, Cowan & Wright 1995).

Another study, (Drisko 1998) documents that the lack of understanding regarding the coordination process hindered effective collaboration among agencies that work with at risk children and families. A lack of rapport and positive relationships between agencies inhibited coordination (Malluccio, Fein & Davis 1994). Further, disagreements regarding goals, roles and responsibilities caused difficulty regarding interagency collaboration thereby decreasing the distribution of effective services (Iles & Akluk, 1990). Finally, (Glisson & James, 1992) found that uncertainty regarding roles and responsibilities and territorial issues caused conflict among agencies thereby hindering collaboration.

In conclusion, the data collected supported the problem statement, obstacles to appropriate and effective service delivery were poor interagency collaboration and ineffective communication as well as uncertainty as to each agency or provider's role. Lack of precise, structured guidelines was the significant cause along with a general lack of communication. The plan of this project is to compile these structured guidelines using key stakeholders and train staff on the use of these guidelines to avoid duplication of services and assure that clients receive all needed services.

The purpose of this project is to assure that the department of Social Services clients receive adequate, effective and complete services. Specific guidelines will

assist agency workers and service providers by specifying who should be providing a particular service.

Expected outcomes include structured guidelines drafted by and agreed upon by the Interagency/Provider local directors and a statement of endorsement will be signed. These guidelines will be distributed to front line staff and a training session on these guidelines will be provided. Any deviations or problems with service provision directed by the guidelines will be discussed with the supervisor of the agency or provider who will inform the Interagency/Provider Committee. All involved agencies and providers will follow these guidelines, collaborate and share information freely with other agencies and Providers. The Interagency /Provider Committee will meet monthly throughout this project to assist with drafting guidelines based on this writers research, data collection, statistical analysis and information from group meetings. The committee will continue to meet throughout implementation to follow up and discuss the effects of the guidelines as well define problems with the guidelines and make any changes necessary.

To measure outcomes, the initial checklist (appendix A) will be given to front line workers 1 month after the implementation plan is put into place. Statistics will be obtained and a frequency table will be developed. This frequency table will be compared to the frequency table developed before the implementation of the guidelines. It is expected that the rating of problems and concerns should be significantly decreased.

A front line staff member from each agency and provider will meet monthly for 3 months with the Interagency/ Provider Committee to discuss the effectiveness of the guidelines and the collaboration efforts. Any concerns, problems or questions will be addressed in this meeting.

The Interagency/ Provider Committee will meet monthly for 3 months after implementation and on a quarterly basis after to maintain collaborative efforts and deal with any problems that may arise.

Solution strategies regarding interagency collaboration, disagreements or confusion regarding roles and responsibilities were reviewed in the current literature. The following shows how this writer used the collected research data to increase the likelihood of a positive outcome.

All collaborative efforts needed to be documented, agreed upon and explained in depth to all involved agencies (Nelson, 1990). During this project, the procedures were documented and explained at the monthly interagency/provider meetings. After data collection and problem identification, the

interagency/provider group collaborated on guidelines and agreed to finalized guidelines through a memorandum of agreement.

Education regarding service provider roles and agency policies was vital to promoting respect and collaboration between agencies (Baglow, 1990). Education was provided during interagency meetings. All local agency and provider directors were invited to present their agency's pertinent information. Information regarding each agency's current protocol was discussed during earlier meetings to familiarize all parties involved with the way each agency/ provider conducts day to day business.

Dissemination of information was necessary for effective interagency collaboration. (Berry, 1992). All data collected, statistical analysis, drafted guidelines and finalized guidelines were recorded and disseminated to interagency/provider team members.

At this time the guidelines have been completed. (See Appendix C) The Interagency/ Provider Committee has agreed upon the Guidelines (See Appendix D). Training has been completed on guidelines and they are currently in place. Interagency/ Provider Committee will meet within the month and a front line staff from each agency and provider office will be interviewed. Follow up will be as explained in the Implementation and Evaluation sections.

Appendix A
Collaboration Project/ Problem Rating Scale
Collaboration Check Sheet
Statistical Analysis of Data Collect Sheets

COLLABORATION PROJECT/RATING SCALE

PLEASE MARK THE FOLLOWING PROBLEMS OR CONCERNS WITH:

1. NEVER
2. RARELY
3. SOMETIMES
4. OFTEN
5. ALWAYS

AGENCY OR PROVIDER NOT RETURNING PHONE CALLS _____

AGENCY OR PROVIDER NOT KEEPING YOU UPDATED OR DISTORTING FACTS _____

AGENCY OR PROVIDER NOT GIVING ALL INFORMATION ABOUT CLIENT OR CASE _____

UNCLEAR AS TO AGENCY OR PROVIDERS RESPECTIVE RESPONSIBILITIES _____

REPORTS NOT SENT FROM AGENCY OR PROVIDER _____

UNRESOLVED CONFLICT WITH STAFF FROM ANOTHER AGENCY OR PROVIDER _____

AGENCY OR PROVIDER NOT PROVIDING THE SERVICE _____

ACCESS TO AGENCY OR PROVIDER RECORDS _____

SUPERVISOR WITH AGENCY NOT INVOLVED _____

POOR COMMUNICATION IN GENERAL WITH OTHER AGENCY OR PROVIDER _____

Agency Or Provider Not Returning Phone Calls

Value Label	Value	Frequency	Percent	Valid Percent	Cum Percent
Rarely	2.00	17	77.3	77.3	77.3
Sometimes	3.00	5	22.7	22.7	100.0
	Total	22	100.0	100.0	

Valid cases 22 Missing cases 0

Agency or provider not returning phone calls

Value Label	Value	Frequency	Percent	Valid Percent	Cum Percent
Rarely	2.00	17	77.3	77.3	77.3
Sometimes	3.00	5	22.7	22.7	100.0
	Total	22	100.0	100.0	

Valid cases 22 Missing cases 0

Agency or provider not keeping you updated or distorting facts

Value Label	Value	Frequency	Percent	Valid Percent	Cum Percent
Rarely	2.00	12	54.5	54.5	54.5
Sometimes	3.00	9	40.9	40.9	95.5
	4.00	1	4.5	4.5	100.0
	Total	22	100.0	100.0	

Valid cases 22 Missing cases 0

Agency or provider not giving all information about client or case

Value Label	Value	Frequency	Percent	Valid Percent	Cum Percent
Rarely	2.00	8	36.4	36.4	36.4
Sometimes	3.00	14	63.6	63.6	100.0
	Total	22	100.0	100.0	

Valid cases 22 Missing cases 0

Unclear as to agency or providers respective responsibilities

Value Label	Value	Frequency	Percent	Valid Percent	Cum Percent
Never	1.00	2	9.1	9.1	9.1
Rarely	2.00	6	27.3	27.3	36.4
Sometimes	3.00	3	13.6	13.6	50.0
Often	4.00	11	50.0	50.0	100.0
Total		22	100.0	100.0	

Valid cases 22 Missing cases 0

Reports not sent from agency or provider

Value Label	Value	Frequency	Percent	Valid Percent	Cum Percent
Rarely	2.00	6	27.3	27.3	27.3
Sometimes	3.00	12	54.5	54.5	81.8
Often	4.00	4	18.2	18.2	100.0
Total		22	100.0	100.0	

Valid cases 22 Missing cases 0

Unresolved conflict with staff from another agency or provider

Value Label	Value	Frequency	Percent	Valid Percent	Cum Percent
Never	1.00	8	36.4	36.4	36.4
Rarely	2.00	12	54.5	54.5	90.9
Sometimes	3.00	2	9.1	9.1	100.0
Total		22	100.0	100.0	

Valid cases 22 Missing cases 0

Poor communication in general with other agency or provider

Value Label	Value	Frequency	Percent	Valid Percent	Cum Percent
Never	1.00	1	4.5	4.5	4.5
Rarely	2.00	7	31.8	31.8	36.4
Sometimes	3.00	11	50.0	50.0	86.4
Often	4.00	3	13.6	13.6	100.0
	Total	22	100.0	100.0	

Valid cases 22 Missing cases 0

Number of valid observations (listless) = .00

Variable	Mean	Std Dev	Minimum	Maximum	Valid N	Label
VAR00001	2.23	.43	2.00	3.00	22	Rarely
VAR00002	2.50	.60	2.00	4.00	22	Rarely
VAR00003	2.64	.49	2.00	3.00	22	Rarely
VAR00004	3.05	1.09	1.00	4.00	22	Sometimes
VAR00005	2.91	.68	2.00	4.00	22	Rarely
VAR00006	1.73	.63	1.00	3.00	22	Never
VAR00007	1.86	.71	1.00	3.00	22	Never
VAR00008	2.18	.80	1.00	4.00	22	Rarely
VAR00009	1.55	.60	1.00	3.00	22	Never
VAR00010	2.73	.77	1.00	4.00	22	Rarely

Number of valid observations (listless) = 22.00

COLLABORATION CHECK SHEET

1. PLEASE PUT AN X BY THE PROVIDER OR AGENCY THAT YOU FEEL *IS* RESPONSIBLE FOR EACH SERVICE.

2. NEXT PUT A ✓ BESIDE THE PROVIDER OR AGENCY THAT YOU FEEL *SHOULD BE* RESPONSIBLE.

	DSS/MTS	DMH	MENTOR YAP HSA	FOSTER PARENT GROUP HOME HOSPITAL ETC.	OTHER
SCHEDULING APPTS.					
ASSURING THAT FOSTER PARENTS PARTICIPATE IN TREATMENT					
TRANSPORTATION					
HANDLING CRISIS SITUATIONS					
MAKING DECISIONS ABOUT TREATMENT					
SCHEDULING VISITATION					
MAKING PLACEMENT DECISIONS					
ATTENDING IEP MEETINGS AND PARTICIPATING IN EDUCATIONAL DECISIONS					

Y

Frequency Tables

Twenty Two Surveys
19 Valid Surveys

Scheduling Appointments		
DSS/MTS	8	
DMH	7	
Mentor/ Yap/ HSA		8
Foster Parent/Group Home/ Hospital etc.	16	
Other	0	
Assuring That Foster Parents Participate in Treatment		
DSS/MTS	0	
DMH	0	
Mentor/ Yap/ HSA	18	
Foster Parent/Group Home/ Hospital etc.	3	
Other	0	
Transportation		
DSS/MTS	8	
DMH	0	
Mentor/ Yap/ HSA	11	
Foster Parent/Group Home/ Hospital etc.	15	
Other	0	
Handling Crisis Situations		
DSS/MTS	6	
DMH	8	
Mentor/ Yap/ HSA	17	
Foster Parent/Group Home/ Hospital etc.	15	
Other	0	
Making Decisions About Treatment		
DSS/MTS	15	
DMH	13	
Mentor/ Yap/ HSA	11	
Foster Parent/Group Home/ Hospital etc.	12	
Other	0	
Scheduling Visitation		
DSS/MTS	21	
DMH	7	
Mentor/ Yap/ HSA	5	
Foster Parent/Group Home/ Hospital etc.	4	
Other	0	
Making Placement Decisions		
DSS/MTS	20	
DMH	8	
Mentor/ Yap/ HSA	12	
Foster Parent/Group Home/ Hospital etc.	4	

Other	0

Attending IEP Meetings and Participating in Educational Decisions

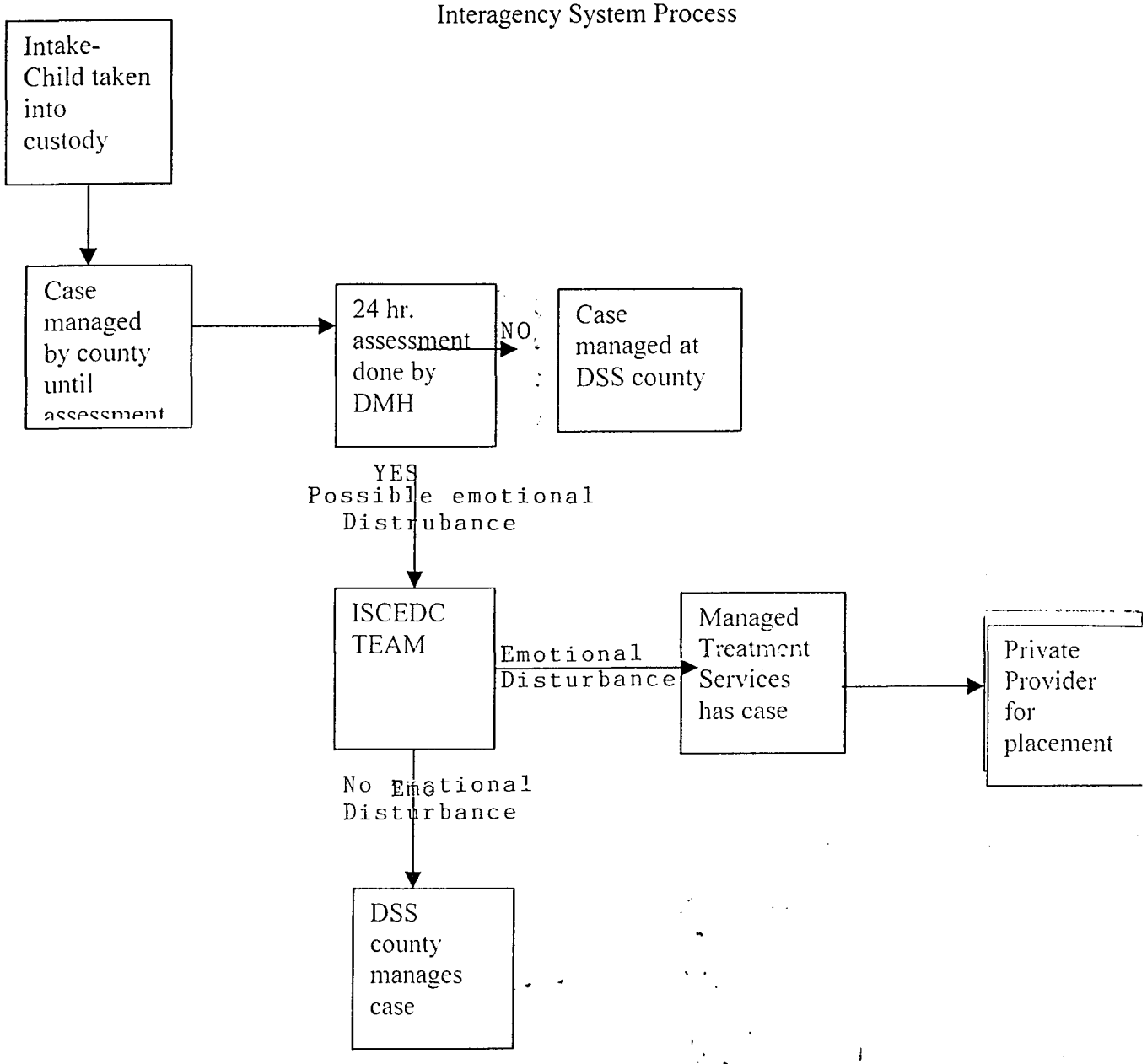
DSS/MTS	18
DMH	12
Mentor/ Yap/ HSA	16
Foster Parent/Group Home/ Hospital etc.	16
Other	2

Appendix B
Interagency/Provider Committee Members
Interagency System Process Flowchart

Interagency/ Provider Committee Members

J. Gary Martin, Regional Director- Managed Treatment Services
Teresa L. Vassar, Program Director- Managed Treatment Services
David Mincey, County Director- Horry Co. Dept. of Social Services
Rick Shelley, Program Director - Horry Co. Dept. of Social Services
Monica Kelly, Regional Director - S.C. Youth Advocate Program
Susan Walters, Program Director - S.C. Mentor
Tommy Vaughn, Director - Growing Home
Greg Killian- CAF Director -Waccamaw Mental Health
Joanne Ford- Program Director- Georgetown Dept. of Social Services

Interagency System Process



Child taken into custody. DSS county maintains case until 24 hr. assessment by the Dept. of Mental Health. Should DMH feel that client may besuffering from some emotional disturbance and may need therapeutic placement, they will fer to the ISCEDC (Interagency System for Caring for Emotionally Disturbed children) Team. ISCEDC team includes representatives of the Dept. of Mental He. Health, Dept. of Social Services, Managed Treatment Services andDept. of Education. Dept.of Juvenile Justice and Dept. of Disabilities and Special needs Attend if the child staffed needs their servcies. ISCEDC teamdecides if client needs a therapeutic placement based on history and psychological information. If client needs a therapeutic placement, the case is transfered to managedTreatment Services to case manage.Managed Treatment Services contracts with private roviders (therapeutic foster home agebcies, group homes and Resedential Treatment facilities.

Appendix C
Guidelines and Protocol
Memorandum of Agreement

Interagency/ Provider Guidelines and Protocol

1. Scheduling Appointments-

DSS/MTS informs the Treatment Coordinator who will contact the Therapeutic Foster Parents and notify them of appointments needing to be scheduled, who needs to be contacted, how to contact and therapeutic foster parent will schedule. Any appointments that are out of the norm will be scheduled by the Treatment Coordinator.

2. Therapeutic Foster Parents are responsible for assuring that client attends any medical or therapy appointments and participating in any treatment required of them. If Therapeutic Foster Parent does not, the therapist will contact Mentor/YAP or Growing Home Treatment Coordinator. Coordinator will get with therapeutic foster parent to assure that therapeutic foster parent complies.

Therapeutic Foster Parent will participate in Foster Care Review Board or complete the Foster Care Review Board report and attend Managed Treatment Services' TSP meetings. Should this become a problem, MTS/DSS will contact Treatment Coordinator who will assure that therapeutic foster parent complies.

MTS Service Coordinator and Treatment Coordinator will attempt to hold the respective meetings together and at the TFC parent's home as much as possible to minimize therapeutic foster parents travel and time in meetings.

* Initially DSS/MTS will contact the therapeutic foster parent to notify of needed services for client.

ISCEDC IST sheet and ISCEDC application will be sent to the Provider Agency and forwarded by that agency to the appropriate Coordinator.

Coordinator will discuss treatment with TFC parent each month and inquire as client's attendance and participation in treatment.

Therapist will contact the Coordinator after a missed appointment and Coordinator will contact TFC parent.

3. Transportation will be provider by Therapeutic Foster Parent to any reasonable MD, therapy or school related appointments unless discussed with DSS/MTS Supervisor or Director by the Provider Supervisor or Director. Should the Therapeutic Foster Parent not perform this duty, the therapist or MD will contact DSS/MTS who contacts the Treatment Coordinator. The Treatment Coordinator will contact the TFC parent.

4. Crisis situation- Should the child need to go to ER, TFC parent is responsible for transporting unless there is a danger to child or TFC parent.

Should placement disrupt and child needs to be moved, treatment coordinator will move child to another TFC home if the client is being moved to a home with in their office. Treatment Coordinator will contact MTS/DSS and notify of any placement changes. If the client is moved to an alternate provider, DSS/MTS will be responsible for transporting client.

5. Provider will notify MTS/DSS of any runaways within 24 hours. Providers will be given a copy of all MTS Service Coordinators, Supervisors and Director pagers as well as a copy of the MTS on call schedule with Schedule Supervisor backup.

6. MTS/DSS will schedule the visitation and will notify the therapeutic foster parent and Treatment Coordinator. TFC parent will assure that client attends the visitation regularly. TFC parent will not be responsible for taking client to a parent's home. A neutral location for the child to be taken will be arranged with DSS/MTS. MTS/DSS will attend the supervised visitation. Therapist will attend the therapeutic supervised visitation.

7. Provider Coordinator should discuss placement changes prior to whenever possible with the MTS/DSS worker. A step up in placement is always staffed with the ISCEDC team. Should a Treatment Coordinator feel that this may be necessary, they should contact their supervisor who contacts an MTS/ DSS supervisor. The MTS/DSS supervisor will set up ISCEDC meeting. MTS Service Coordinator or DSS caseworker should notify the Treatment Coordinator as soon as possible when ISCEDC approves a step up in placement unless admitted in an emergency situation.

If MTS service coordinator and their respective supervisor agree that clients therapeutic foster care placement should be changed to an independent living placement, the MTS Supervisor will contact the Supervisor or Director of the provider agency. When agreed, client will be placed or their placement will change to independent living.

8. Educational Obligations and Issues - Therapeutic Foster Parents should attend all IEP meetings. TFC parent will notify the MTS Service Coordinator of the time and date of IEP meetings. MTS service coordinator will attend. TFC parent should also send a copy of any educational information the to MTS service coordinator

especially a copy of the IEP should the MTS service coordinator not get notified of the meeting, or can not be there due to an emergency situation. MTS will do the same should the TFC parent have an emergency and can not be there.

STATEMENT OF ENDORSEMENT

We, the undersigned, do hereby agree with the Guidelines and Protocol established by the Interagency/ Provider Committee.

Teresa L. Vassar

Teresa L. Vassar, Program Director
Managed Treatment Services

J. Gary Martin

J. Gary Martin, Regional Director
Managed Treatment Services

Rick Shelley

Rick Shelley, Program Coordinator
Dept. Of Social Services

Greg Killian

Greg Killian, CAF Director
Waccamaw Mental Health

Monica Kelly

Monica Kelly, Regional Director
S.C. Youth Advocate Program

Susan Walters

Susan Walters, Program Coordinator
S.C. Mentor

T. Vaughn

Tommy Vaughn, Director Of Social Services
Growing Home

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