Coordinated Services Teams (CST)
Working with Hospitals and Residential Care Centers

A full continuum of care ranging from supporting a child in the home of their birth parent to admittance in hospitals are viewed as options to meet the needs of children and families. The emphasis is to meet the needs in the least restrictive setting – home, community, and school of residence. Rather than utilize traditional placements to meet needs, the wraparound team process seeks to identify the strengths of the child, family and community and build on the strengths to meet needs. This requires creativity and flexibility, especially in rural areas that lack many of the traditional, formal services found in larger communities.

Statewide, there have been several instances where teams have recommended the use of hospitals and/or Residential Care Centers (RCCs) as ways to meet needs. Some referrals have resulted in very appropriate supports and services, as well as strong partnerships with families and CST teams. Other experiences, however, have not been so positive.

Following is a summary of suggestions for improving the way CST teams and hospitals/RCCs work together when children are placed in a facility. This information has been collected over the past several years, including the results of two focus groups with staff of Winnebago Mental Health Institute.

General/Ongoing Suggestions:

- Provide cross-system education
- Develop trusting relationships
- Foster "attitude change" by talking, breaking down turf barriers, getting to know each other, and putting names with faces
- Have strong administrative/supervisory support for collaboration with families and providers
- Have reliable and responsible people as contacts for anyone who has questions or issues
- Hospital staff conduct in-services at the county level to clarify commitments, referral processes and services
- Hospital staff have access to current statewide list of Coordinated Services Team contacts
- Hospital staff have access to advocacy resources such as Wisconsin Family Ties
- Continue discussions regarding ways to improve partnerships

At Point of Referral to a Hospital or RCC:

- Joint intake planning (in person) – at hospitals/RCCs and in the community
- When making a referral provide background information on what works and what doesn't
- Provide a clear request of what is desired/needed as part of the referral

Suggestions for Team Meetings/Collaborative Work:

- Maintain regular personal contact
- It is important for both community and hospital/RCC staff to respond to calls/questions in a timely manner.
- Meet with hospital staff prior to, during, and after a placement occurs to discuss issues such as therapy, medication, and treatment planning
- Include everyone who plays an important role in the child's life at joint team meetings
- Consider video conferencing as a tool to involve hospital/RCC staff in local team meetings, as well as community teams involvement in hospital/RCC team meetings or staffings
- More use of phone conferencing when possible
- Actively listen to each person involved in supporting the child and family before any long-term decisions are made

- ***Collaboration activities are committed to preserving the integrity of the family unit***
  - All meetings include parent and child as equal partners with providers
  - Parents are informed and involved in a manner that allows them to understand the information and to shape decisions made about their child.
  - Meetings are flexibly scheduled so families can attend.
  - Needs of family members, other than the identified child, are recognized and steps are taken to meet them.

- ***Collaboration is family centered, with strengths and needs of the child and family determining services provided.***
  - Families are "listened to" and viewed as the primary source of information about their child and their own needs. They know what has worked and what has not worked for their child
  - Plans of care are developed from a strength-based assessment and build upon child and family strengths.
  - Team members recognize that service providers bring a body of well-developed knowledge in their field of expertise
  - Team members have equal "voice", and value the comments and insights of other team members, working jointly to develop a care plan and to solve problems on the child's behalf.
  - The strengths and unique contributions of each team member are utilized
  - Everyone benefits from each other's knowledge and expertise.
  - Responsibility for implementing the plan is shared; each person on the team knows his or her role.

- ***The collaborative system of care is community-based. Services, case management and decision making responsibility rests at the community level.***
  - The community-based child and family team is included prior to admission and attends joint staffing meetings during hospital stays to provide information and participate in decision making.
  - Staffing meetings are held at both sites as needed.
  - Community child and family team, and institute team jointly plan for discharge (beginning at or prior to admission)
  - Communication liaisons and pathways are clearly developed so that all team members communicate with each other and keep everyone equally informed.
  - Child and family team partnering with institute team results in a joint unified comprehensive plan of care.

- ***Collaboration is responsive to the unique cultural differences, needs and preferences of each child and family.***
  - Services are tailored to fit family needs, preferences and choices.
  - Strengths of the cultural context in which the child and family live are respected and utilized.

Suggestions for Discharge Planning

- Joint discharge planning (in person) – at hospital/RCC and in the community
- Better explanation of the "local system of response" and resources in case of "crisis" when home visits occur and in planning for discharge.

Post-Discharge Follow-up

- Share follow-up information about the children and families with the staff of hospital or RCC. Oftentimes, hospital staff don't hear about how a child/family is doing after discharge.