

Service Coordination Standard Operating Procedures: Tools for Family Centered Care

Navigating complex public systems to find the right help for your family can be a challenging experience. Some parents have reported that going through systems feels a bit like riding a roller coaster. Just when things seem to be getting smoother, it feels like there's another loop or curve when you find out that your family doesn't fit, or the service wasn't what you thought it was or that you are no longer eligible. Families who enter public service systems are on a journey. Some families will experience that journey as moving away from something or moving to something. In the former, families may say they want the challenge or frustration to end. That family journey often feels most like an evacuation or an escape. In other settings, families come to public services because they want something to happen and believe that it can. In those cases, navigating public systems can feel more like planning for a trip that once you get there you expect to enjoy.

Whenever we think about families who end up at the front door of a county FCFC and are in need of either Service Coordination or the Wraparound Planning process, it's helpful to consider that we get to go with families on their journey from *Hello* to *Healing*. This framework serves as the outline for both Service Coordination and the Wraparound Process. Framing it this way holds the promise of staying absolutely focused on the experience of the families we get to serve, no matter whether we are following the Service Coordinator or Wraparound Road Maps. When using this framework, we recognize the feeling that families get from an encounter is the same whether we follow Wraparound or Service Coordination. Thinking about either process around the family's experience is described below:

- **Hello:** All families deserve to feel welcomed. Service Coordinators or Wraparound Facilitators should remember that from the other side of the counter, it all starts with a warm welcome. Staff should seek to communicate their interest in the family and their commitment to building a thorough understanding of their experience. Activities in this area are not about engaging families in our process but instead communicating our sense of interest in the family's experience so that we can position ourselves to go with each family on a journey that is most helpful for them. Hello stage tools can be found at <https://wraparoundohio.org/ofcf-handbook-hello-stage/>
- **Help:** All families deserve a sense of expectancy. Once a staff member has established that warm welcome, they should be prepared to help families get to the right help, provided in the right way to produce the right result, in the shortest amount of wait time. While both Service Coordinators and Wraparound Coordinators often host meetings that bring people together, the point of this is not to host a meeting. Instead, it's about making sure that families feel that they've been heard and that we can help them find and link with people, programs, resources, and things that are going to address their concerns. Not every family will find every option helpful. Every Service Coordinator should be open to partnering with a family until they find the right response that creates a sense of

what is most helpful for the family. Help stage tools can be found at

<https://wraparoundohio.org/ofcf-handbook-help-stage/>

- **Healing:** All families deserve to know that their situation is improving. Once help has been negotiated, Service Coordinators and county FCFC Wraparound Coordinators will follow the process of accessing help over time to ensure that families have access to the results they deserve. Service Coordinators/Wraparound Facilitators check with families and others over time to ensure that not only are we providing a resource but that it is making a difference. If the resource, intervention or support isn't working, they should be changed. Maintaining a focus on that outcome and keeping the team together working towards results takes the most time in either Service Coordination or Wraparound Facilitation. Healing stage tools can be found at <https://wraparoundohio.org/ofcf-handbook-healing-stage/>
- **Hope:** All families have a right to hope that guides their experience and life. As family, staff and communities work together over time, families should see they can look forward to the future with a sense of expectancy. Coordinators work with families and team members to set targets for what life will look like and continue these efforts through the last minute of connection, and a formal team is no longer needed. The Coordinator introduces the concept of transition to a hope filled life, works with the family and team to be specific about what those elements look like and guides the team in moving towards that target. At this stage, families should feel an increased sense of confidence that things can work out as well as a sense of competence or skill that they can handle bumps in the road. The Coordinator works to ensure the family has a sense of connection to community, system, family, or support resources that they can access, if necessary, in the future. Hope stage tools can be found at <https://wraparoundohio.org/ofcf-handbook-hope-stage/>

It's not about engaging a family into our process but instead how we can meet families and arrange system and community resources to help them move to *Hope*. *Hope* relates to increased engagement. *Hope* associates with better service outcomes. *Hope* builds family resiliency. *Hope* is everything for families who find themselves navigating complex systems. County FCFCs work with families to ensure that their time in systems is driven by the family and not the system. This is true whether the road map leads one to Service Coordination or Wraparound.

Establishing Referrals within County FCFCs

Rule: O.R.C. 121.37(C)(1) Each county service coordination mechanism shall include “A procedure for an agency, including a juvenile court, or a family voluntarily seeking service coordination, to refer the child and family to the county council for service coordination in accordance with the mechanism.”¹

System of Care Value: Transparent and Accessible

County FCFCs ensure that families and communities have information that allows them to make an informed decision about whether Service Coordination may be helpful and work to continuously eliminate barriers to engaging in Service Coordination.

Situation: Abigail Baker is the 20-year-old mother of 3-year-old Collin. Abigail is employed at the local plant and lives in her own apartment. Collin has been struggling in Pre-School and often gets upset during nap time. When upset, Collin will scream and cry until the pre-school calls Abigail. When she comes to pick him up, he calms down, goes home and naps. She has been asked to remove him from two other daycare/preschool options. The pre-school has indicated that they don't think they can keep him until they get some help. The Pre-School suggests she call the county FCFC. When she makes that call, she is welcomed by a Service Coordinator who sets an appointment for an initial meeting at the pre-school to begin talking about how resources can be pulled together to help this young family.

County FCFC Responsibilities and Considerations

County FCFCs should identify clear pathways for families to access Service Coordination by identifying natural spots for a family to discover the option for Service Coordination. County FCFCs should review their process to make sure it's streamlined and easily navigated. All referral processes should minimally include:

- The date of the receipt of the referral;
- Contact information for the youth being referred;
 - Birthdate
 - Social Security Number
 - Gender
 - Ethnicity
 - Race
 - Address
- A brief description of the problems being experienced;
- Systems/agencies that have been involved with the person to date;
- Contact information for the person referring;
- Identification of Medicaid Managed Care Plan, if applicable;
- FCFC response to the referral or the outcome of the referral.

County FCFCs should evaluate their referral process to ensure that families can access Service Coordination, that information is shared in a way that is relevant and anchored to families and that the process creates a “no wrong door” option for families seeking help.

¹ <https://codes.ohio.gov/ohio-revised-code/section-121.37>

While not all the families who access the county FCFC will end up participating in Service Coordination, each family should know how to access the county FCFC and the outcome of their referral.

The FCFC Intake Form is below.



Ohio Family
Children First

Intake Form

Referral Information

County: Butler

Referral Date: 5/4/2023

Referral Source: Managed Care Organization

Youth Id: 91279

Referral Source Information

Referral Source Name: Sarah Socialworker
First Last

Agency Name: Insurance Plan
(if applicable)

Phone: (555)565-5555

Email Address: _____

Signed consent/release of information has been uploaded Date(s) of signature: _____

Youth Information

Full Name: Tree Maple H Birth Date: 6/13/2006
Last First M.I.

Preferred Name: _____
if different from Legal Name

Gender: Male Female Nonbinary Other _____

Preferred Language: English

Race: American Indian

Ethnicity: Declined to specify Hispanic or Latino Not Hispanic or Latino

Was youth previously adopted? Yes No

If yes, age at adoption: ___ years

Address: 444 Dedduous Way _____
Street Address Apartment/Unit #
Leaf OH 76977
City State ZIP Code

Youth Information (continued)

Email Address: _____

Phone: _____ Primary Yes No
_____ Primary Yes No

Can receive text messages? Yes No

Current living situation: _____

If independent living selected, what is the current living arrangement?

Insurance and Physician Section

Does youth have insurance? Yes No

If yes, what kind? Medicaid Private

If private,

Insurance Carrier: _____ Plan #: _____

Coverage Number: _____ Start Date: _____ End Date: _____

Does the youth have a primary care physician? Yes No

If yes,

Primary Care Physician Name: _____

Primary Care Physician Phone: _____

Primary Care Physician Email Address: _____

Services and Support Section

Youth Strengths:

Family Strengths:

What other systems are involved in the care of the youth?

Household/Family Section

Are interpreter services needed to communicate with any members of the household? Yes No

If yes, language needed: _____

Safety Hazards within the home? Yes No

If yes, select all that apply:

When is the best time to reach the family? _____

Other Household Members

Name	Age	Relationship	System Involved?
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Out of Home Placement Information

Has the youth ever been in any out-of-home placement (not including respite care)? Yes No

Has the youth ever been in a residential placement? Yes No

Was youth in out-of-home placement at the time of referral? Yes No

If you answered yes to any of the questions above, provide where the youth was placed and dates of placement:

Placement Location/Name	From (mo/year)	To (mo/year)
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Is the youth at risk of a residential placement? Yes No

History and Desired Outcomes

Brief history:

How would the youth benefit from a multi-system team? What is the desired outcome from participation in Service Coordination/Wraparound:

Precipitating events leading to this referral:

What services and supports have been utilized to date?

Any additional information we should know as part of this referral?

(If the youth has a caseworker/probation officer/case manager/etc., please include this person(s) name and contact information)

Resource Eligibility

Resource Explored?	Child/Family Eligible?			Reasonably Exhausted?		
Adoption Assistance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Child Support	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Home Energy Assistance Program(HEAP)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Local Developmental Disabilities Board	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Local Mental Health/Addiction Board	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Medicaid/Medicaid Managed Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Metropolitan Housing Authority	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Post Adoption Special Services Subsidy (PASS)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Prevention, Retention and Contingency (PRC)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Private health insurance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Social Security/Disability Insurance (SSI/SSDI)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Social Security Survivor's Benefits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
State Adoption Maintenance Subsidy (SAMS)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Supplemental Nutrition Assistance Program (SNAP)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Temporary Assistance for Needy Families/ Case Ass.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure

If you indicated yes to any of the above,
please provide detailed information about amounts and how funds have been used.

Physical and Behavioral Health History

Mental health and community services

Current Provider(s)

Service Type	Provider Name and Contact Information	Begin Date	End Date

Previous Provider(s)

Service Type	Provider Name and Contact Information	Begin Date	End Date

Does the Youth have a current DSM 5 Diagnosis? Yes No

Youth Diagnoses:

Medications:

Education

Financially Responsible School District: _____

Enrolled in School? Yes No

Start Date: 6/1/2023 End Date: 6/1/2023

District of Residence: _____ District of Attendance: _____

School Name: _____

Address:

Street Address

City

State

ZIP Code

Phone Number(s): _____

Current Grade: _____ School Year: _____

_____ School Placement

General Education Special Education

Is the youth on an IEP? Yes No

Does the youth have a 504 accommodation? Yes No School

Placement Type: _____

Are there attendance or truancy issues? Yes No

For Office Use Only

County Youth Identifier: _____

Welcoming and Engaging Families within County FCFC Service Coordination

Rules:

ORC 121.37(D)(3) Each county shall develop a family service coordination plan that “Ensures that assistance and services to be provided are responsive to the strengths and needs of the family, as well as the family's culture, race, and ethnic group, by allowing the family to offer information and suggestions and participate in decisions. Identified assistance and services shall be provided in the least restrictive environment possible.”²

ORC 121.37(D)(6) Each county shall develop a family service coordination plan that “Includes a plan for dealing with short-term crisis situations and safety concerns.”³

System of Care Value: Respectful

Families should feel respected and appreciated from their first contact with a Service Coordinator. Families should feel as if their story is welcomed and that their story matters throughout their entire relationship with Service Coordination.

Situation: 16-year-old Shawna is the youngest of three children and has attempted suicide 3 times in the last 6 months. She has one adult older sister, and one adult older brother. Parents, Jim and Nancy, contacted Family and Children First for help. A team is formed and meets weekly. After 3 months of service coordination, Shawna announces that she is gay, and that she is planning to go to prom with her girlfriend. Jim and Nancy share religious beliefs that conflict with this and have refused to accept that she is gay. Shawna begins to run away frequently and stops attending the team meetings because her parents are critical during the meetings. The Service Coordinator shares resources with her parents and counselor on LGBTQ+, as well as creates new rules for the team meetings on being respectful. The team begins to focus on Shawna's need to be accepted. They create more family bonding activities around Shawna's interests, such as cooking together. Shawna is also religious. The team searches for youth groups that may be more accepting of Shawna's preferences. The parents agree.

County FCFC Responsibilities and Considerations

Service Coordinators are on the front line of communicating a sense of welcome for families. They take the value of respect and put it into practical application by setting up a series of trust-based interactions designed to build a sense of equal partnership. Service Coordinators take responsibility to ensure families feel welcomed. This is foundational to engagement. Rather than asking families to commit, Service Coordinators welcome each family in a way that reinforces their unique experience. There is no universal tool or technique that creates this sense of welcome. It is about the Service Coordinator always

² <https://codes.ohio.gov/ohio-revised-code/section-121.373>

³ <https://codes.ohio.gov/ohio-revised-code/section-121.373>

remembering the family is a highly valued partner in this process and conveying that in all their interactions.

Tools

- [Implicit Bias Module Series](#)
- [Harvard Project Implicit](#)

Assessing and Applying Strengths

Rule: ORC 121.37(C)(7) Each county service coordination mechanism shall include “A procedure for assessing the needs and strengths of any child or family that has been referred to the council for service coordination, including a child whose parent or custodian is voluntarily seeking services, and for ensuring that parents and custodians are afforded the opportunity to participate.”⁴

System of Care Value: Honoring

Exploring and honoring the experiences of those participating in Service Coordination allows for a deeper understanding of what is important to the youth and families being served. In sharing their stories, families should feel affirmed, their knowledge valued, and their resilience recognized.

Situation: James is a 15-year-old male on the autism spectrum. He lives with his mother Jean and his grandfather Robert in his grandfather’s home. James loves the feel of soil and will dig in his family’s garden for hours when weather permits. He’s also curious and regularly takes things apart to see how they work. At the initial team meeting, the Service Coordinator asked everyone to introduce themselves and share something about their relationship with James. When it was Grandfather Robert’s turn, he shared how “exhausting” James can be. Not only does James regularly track dirt into the house from his gardening and leave disassembled parts for grandfather to repair, but when upset, James has increased strength and will remove every piece of furniture from his room to the living room, then sits in his bare room to quiet himself. Once calm, grandfather helps James move his furniture back to his room. One team member who was meeting the family for the first time listened to Robert and responded, “You are the most patient person I have ever met!” Hearing that, Robert’s eyes welled up and he replied, “No one has ever said that to me before.” It was evident that from such a simple, spontaneous comment, Robert felt affirmed, valued, and recognized. And it elicited from Jean additional stories of Robert’s calm manner, generosity and kindness during the time she and James have lived with him.

County FCFC Responsibilities and Considerations

In all interactions with families, Service Coordinators should convey their interest and privilege to be a part of the family’s journey. Summarizing the family’s story in a way that honors their experience has the potential to change how people view and interact with the family and inspire new possibilities for *Help* and *Healing*. Steps a Service Coordinator can take in the process of gathering, promoting, and utilizing strengths include:

- Set the stage for a friendly and respectful conversation with the youth and family members
 - Consider the right setting for both the parent and youth to be most comfortable

⁴ <https://codes.ohio.gov/ohio-revised-code/section-121.37>

- Make collaborative decisions with the parent and youth about when to meet and whether you should connect with the parent and youth together or separately
- Actively attend to the way that each family member tells their story
 - Use empathy to gather more information
 - Listen to how the story is told to understand what events mean to each member
- Formalize your understanding of the story through a narrative summary or timeline
 - Empowers others to better understand what is important to the family
 - Promotes empathy for what the family has experienced
- Summarize strengths and share with family and others involved in service coordination
 - Develop strength lists for each member of the family and for the family as a whole
 - Continuously update strength lists and make them available to everyone involved in the process
- Develop strength-based plans by selecting options that have the strongest tie to real strengths

Assessing and Addressing Needs

Rule: ORC 121.37(C)(7) Each county service coordination mechanism shall include "A procedure for assessing the needs and strengths of any child or family that has been referred to the council for service coordination, including a child whose parent or custodian is voluntarily seeking services, and for ensuring that parents and custodians are afforded the opportunity to participate."

System of Care Value: Responsive

When Service Coordinators focus on need, they can empower helpers to understand the "why" of a situation and adjust their response to the why. Service Coordinators should work to understand what is beneath a situation. Service Coordinators use this understanding to build bridges with community and service providers along with the family to come up with new ways to respond to the underlying causes. This creates a responsive versus reactive system.

Situation: The Service Coordinator receives a call from a school saying that they need help reaching a parent. The school says the parent is overprotective and is almost hostile to the school, accusing them of hurting her son who is in third grade. They think she could use some help. The Service Coordinator agrees to reach out to the mother, who says that her son, who has Autism, often has small scratches on his neck and scalp. She says she's worried that other kids are bullying him, and the school isn't protecting him. The mother and Service Coordinator agreed the Service Coordinator will drop in at school in the next few days. When the Service Coordinator arrives at the classroom, she notices that the young man sits near the window. While she is observing, a custodial staff starts mowing the lawn. At that time, the young man begins pulling at his ear and swatting at his head. The Service Coordinator mentions it to the teacher who says she's never really noticed this behavior. The teacher and Service Coordinator call his mother and they decide to move his desk away from the window. The teacher and mother agree to connect early next week to follow up.

County FCFC Responsibilities and Considerations

Needs are defined as the underlying reasons or cause of a situation. People communicate their needs in one of three ways.

- Most frequently, people communicate their need in their behavior. Unfortunately, if the behavior is seen as challenging, helpers may rush to manage the behavior rather than understand the need.
- People may communicate their need in the patterns of their behavior. When the need is embedded in their history, helpers may work to either keep the event from repeating or make assumptions about the person's motivation.
- Least often needs are communicated verbally. People may communicate what they want but that's not the same as talking about why it's important. Additionally, individuals may communicate what they must or should do rather than talking about how it matters to them. When helpers hear a "want" or a "must" they will try to make something available without understanding the importance.

Developing a Specific Team for Each Family

Rules:

ORC 121.37(D)(2) Each county shall develop a family service coordination plan that “Designates an individual, approved by the family, to track progress of the family service coordination plan, schedule reviews as necessary, and facilitate the family service coordination meeting process.”⁵

ORC 121.37(C)(6) Each county service coordination mechanism shall include “A procedure for protecting the confidentiality of all personal family information disclosed during service coordination meetings or contained in the comprehensive family service coordination plan.”⁶

System of Care Value: Collaborative

Service Coordination doesn't happen in a vacuum. County FCFCs set the stage for families to have an experience of coming together in authentic partnership around the family's priorities. This doesn't mean that each family's story is an open book that is read out. Instead, the Service Coordinator works with the family to identify how to best build a team and strategically guides the process and shortens the wait from *Hello* to *Hope*.

Situation: Mike, 12, lives with his grandmother, Michelle. She works as a Clerk for the county and agreed to take in Mike last summer when things were getting tough at his home. He seems to do better in the quiet of her home as there are four younger siblings at his mom's home. She is happy to help and actually likes having him around but last month she was diagnosed with cancer and is worried about how he will do as she goes through treatment. Both she and her daughter, Michaela, agree that her home is the best place for Mike, but they have concerns about his supervision. The Service Coordinator works with Michelle, Michaela, and Mike to generate a team that will identify meaningful help for the family. Team members include Michelle, Mike, his aide at school, Michaela, Michelle's doctor's office and three of Michelle's friends from work. They begin a meeting by considering everyone's strengths and then put together a mission statement about keeping the household together. Everyone leaves the first meeting with a schedule to share the household care during each week of Michelle's treatment. This includes naming a Team Captain each week as well as a schedule to pick up Mike at school and for delivering meals.

County FCFC Responsibilities and Considerations

When families are receiving lots of services, their biggest unmet need may often be loneliness. When youth, parents or caregivers feel like they're being served rather than being seen, they may feel invisible. When families feel like they're being interviewed rather than being understood, they can feel erased. County FCFCs set the table to bring individuals together with each family so that parents and youth feel that others are paying attention, their perspective is heard, and their input is valued. This doesn't mean that the family's story is an open book, but instead the Service Coordinator works with the parent

⁵ <https://codes.ohio.gov/ohio-revised-code/section-121.37>

⁶ <https://codes.ohio.gov/ohio-revised-code/section-121.37>

and youth to identify who and what resources may be helpful in moving the family to a sense of connection and hope. Building a team is a means to an end rather than the end itself. Good teams in Service Coordination will be:

- *Efficient:* Bringing resources together around the family rather than sending them out to seek it on their own
- *Individualized:* No two teams should be exactly alike. Team membership should be driven by the family's sense of identity, priority, and culture.
- *Comprehensive:* Each team should be reflective of a whole life rather than a single dimension of a family's life.
- *Effective:* Teams and team members should have the ability to blend strategies in the areas of services, support, and community membership.

Teams don't spontaneously come together. Service Coordinators should be prepared to build a team with the family and to guide the team. This requires bringing people together in the form of family focused team meetings; leading the team to collaboratively develop a future oriented direction; and summarizing those results in the form of an ongoing plan with various levels of crisis contingency. Over time, teams continue building a sense of community. Their collaboration can ensure strategies are effective, adjustments are made based on family input and preferences, and desired outcomes are achieved. **A team can do far more damage than any single individual, but a well-structured and supported team can produce so much more than one individual.** Service Coordinators work with the team, including the family, to co-create the plan. Finally, a Service Coordinator must strike the right balance between each family's right to privacy with a team's need for transparency.

Planning With the Family

Rules:

ORC 121.37(C)(3) Each county service coordination mechanism shall include “A procedure that permits a family to initiate a meeting to develop or review the family's service coordination plan and allows the family to invite a family advocate, mentor, or support person of the family's choice to participate in any such meeting.”⁷

ORC 121.37(C)(8) Each county service coordination mechanism shall include “A procedure for development of an individual family service coordination plan.”⁸

ORC 121.37(D)(3) Each county shall develop a family service coordination plan that “Ensures that assistance and services to be provided are responsive to the strengths and needs of the family, as well as the family's culture, race, and ethnic group, by allowing the family to offer information and suggestions and participate in decisions. Identified assistance and services shall be provided in the least restrictive environment possible.”⁹

System of Care Value: Partnering

Service Coordination is not something that is simply given to a family but instead is a set of purposeful activities that are done with a family.

Situation: Lori and her daughter Ruth, 15, have participated in a range of system services for years. At times, it seemed like the family found the services provided helpful. Unfortunately, that sense of progress is usually short lived, and Ruth begins to refuse to attend. When this occurs, Lori feels pressured to get Ruth to participate. Lori felt fed up and left a message on Ruth's PO's voice mail that said, “I've had enough, and I'm just done. You keep telling me to do this and that, but you don't hold her accountable. I won't kick her out but I'm not fighting this anymore. If you want to contact her, don't go through me.” This call caused the PO to make the referral to the county FCFC. The Service Coordinator reached out to the family by starting with Lori. During that initial call, the Service Coordinator indicated that the process would involve meeting over time with Lori, Ruth, and others but throughout the process they would meet to check in with how the family is feeling about how things are working. Lori continues to be reluctant about getting involved with another process that will tell her what to do until the Service Coordinator says “Lori, we're not here to tell you what to do. Instead, what we do with Service Coordination is asking you and Ruth what you need and then try to address it. When we check in, we're going to ask you if it's working and here at the Service Coordination table, we won't blame you if you change your mind.” Lori takes a deep breath and agrees to try it but only for a couple of months. Ruth says that this sounds different and if it keeps her mom from getting more frustrated, she's all for it.

⁷ <https://codes.ohio.gov/ohio-revised-code/section-121.37>

⁸ <https://codes.ohio.gov/ohio-revised-code/section-121.37>

⁹ <https://codes.ohio.gov/ohio-revised-code/section-121.37>

County FCFC Responsibilities and Considerations

Service Coordination requires bringing a group of people together around a common sense of the family's strength to focus on those needs prioritized by the family to develop a comprehensive plan. Planning is an action rather than a thing. The first plan represents a team's best first efforts and all families deserve to know they are working with Service Coordinators and teams that are appreciative of their unique identity and that are empowered to keep trying new things until the last thing becomes the best thing. Service Coordinators may focus on the following when developing a process for planning with a family:

- Ensure families understand the process. Find ways to communicate your process including ensuring that families have access to other families who have gone through the process.
- Prepare for team meetings.
 - Get to know the family and other team members before the meeting. Identify what is likely to make the process work for each family.
 - Prepare team members with information about what is expected in the meeting. This includes the family and other community/system members who will be participating. Everyone deserves to be oriented. This promotes cohesion and sets the stage for understanding.
 - Structure your agenda with the family in mind. Service Coordinators should use a standard agenda as a starting point and outline but be prepared to tailor it to the individual needs and unique identity of the family.
 - Create a sense of welcome and appreciation at each encounter. Return to the family's strengths at each encounter and remind others to do the same.
- Review your plans to make sure the goals are realistic and attainable.
 - Review your plans at least quarterly. If all your plans use the same resource, it's highly likely that your coordination process fits families to it rather than tailoring the process to families.
 - Challenge your teams to be creative and individualize. Challenge yourself and teams to consider the fact there is no "one size fits all" when it comes to families. Use the axiom that "one size fits one."

Develop a Crisis Response/Safety Plan

Rules:

ORC 121.37(D)(4) “Each county shall develop a family service coordination plan that “Includes a process for dealing with a youth who is alleged to be an unruly child. The process shall include methods to divert the child away from the juvenile court system.”¹⁰

ORC 121.37(D)(6) Each county shall develop a family service coordination plan that “Includes a plan for dealing with short-term crisis situations and safety concerns.”¹¹

System of Care Value: Promoting Safety

Families define their own crisis. Communities set the stage for managing safety. There is a difference between a crisis and a safety situation. Service Coordination involves maximizing protective capacity on a personal, system and community level.

Situation: Tricia and her daughter Meredith, 15, were referred to the county FCFC for Service Coordination. They have been receiving services from the Behavioral Health system for the past two years after Child Welfare received a referral because two of them were living in a hotel and possibly were going to be unhoused. Child Welfare didn't open a case since Tricia was always able to make sure Meredith was safe. They were concerned about how closely entwined the two of them were and referred them to the Mental Health Center for services. They have received therapy and Community Support Services. During this time, the Community Support Specialist has worked with them to access stable housing. Most recently they were set to move into a subsidized housing unit, and, at the last minute, Tricia indicated that they might have to leave town to go see her mother (Meredith's Grandmother) because she is ill. The Community Support Specialist is frustrated and keeps referring to the fact that the family isn't safe due to housing instability. The Service Coordinator takes the referral and sorts through the risk situations that present a specific danger to the family. Finding there is minimal danger, the Service Coordinator goes on to meet with Tricia and Meredith to sort through what worries them and what they perceive as dangerous. She discovers that these two don't really experience housing instability as a crisis as they always know where to go to make sure they are warm, well-fed, and okay. They indicate their biggest worry is that they will get separated. The Service Coordinator works with them about what to do if that should happen and what steps to take to keep it from happening. The Service Coordinator gets together with the Community Support Specialist, Meredith, and Tricia to address those items and everyone agrees to work on making sure the family doesn't have to experience those things that represent a crisis for them. Additionally, the Community Support Specialist is supported to explain her worry about safety and what steps she will take if things start to present a risk. They agree to move forward with this understanding.

¹⁰ <https://codes.ohio.gov/ohio-revised-code/section-121.37>

¹¹ <https://codes.ohio.gov/ohio-revised-code/section-121.37>

County FCFC Responsibilities and Considerations

County FCFCs should identify a process to ensure that all family members are safe and to help system partners understand the difference between crisis and safety. This is not just about filling out a form but ensuring that two things happen. The first is that all family members should have confidence that others work to ensure that they're safe. The second is that Service Coordinators will help family members define their own crisis and work with them so they can manage that crisis.

Service Coordinators should be prepared to differentiate between a crisis situation and safety situation. Service Coordinators have options and time when dealing with a crisis situation. This protocol outlines the crisis response. In situations where there is a risk of harm or danger, Service Coordinators should have a range of resources for immediate response. In those high risk or threat circumstances, Service Coordinators should follow a clear logic that begins with asking people what happened. As quickly as possible, a Service Coordinator should ask whether a person is safe. If the answer is "Yes" then the immediate risk is low and the process outlined below can be followed. If the answer is "No", a Service Coordinator should follow up with how soon will someone be harmed?

If the answer is immediately (an hour or less, typically), the Service Coordinator should link to the right community resource designed to help citizens be safe. If the answer is soon (usually under two hours), the Service Coordinator should tailor access to the resource in a way that reflects the family's wishes. Finally, if the answer is later the Service Coordinator can follow the process listed below to gather more information. While this process is outlined in the *Hello* stage, this logic should be applied throughout the process of working with a family to ensure that families who are experiencing a high threat or danger get access to the right resource in the right way at the right time.

A Service Coordinator will address Crisis and/or Safety in different ways as they work with a family over time. In building this capacity, Service Coordinators should identify the tools and techniques that will promote a sense of safety and allow families to define their own sense of crisis throughout the service coordination process. In developing those capacities consider the following stages of the Service Coordination Process:

- At Intake and Initial Connection (The *Hello* Stage)
 - Service Coordinators should always check with the youth and caregiver to identify any areas of risk or threat. This involves a dialogue with the parent/youth about what they see as risk as well as checking with the original referring partner. This will involve sorting those risky situations on two levels:
 - Immediacy: This involves determining what is likely to happen and when. This is done so the Service Coordinator can gauge how quickly they must act
 - Impact: This involves how dangerous the risk and how many will be impacted. This produces a sense of how much the Service Coordinator must put in place to ensure a minimal amount of safety.

- Service Coordinators should recognize that these initial responses are meant to produce a sense of enough stability to begin a robust process of Service Coordination. Things that are put in place may be put in place temporarily. If the timing is very short, the Service Coordinator should begin planning and implementing faster rather than waiting for risk or stabilization issues to be resolved before the planning process begins. When there is a risk or crisis, Service Coordinators should plan faster.
- During Initial Plan Development (The Help Stage)
 - As the Service Coordinator moves from initial safety promotion, they move to a planning approach focused on the family's sense of hope and future. This is the stage where the underlying causes (unmet needs) will begin to be articulated and addressed throughout the process. This involves identifying protective capacities of family members as well as protective capacities in the community to develop an ongoing set of coping strategies that minimize danger.
 - Service Coordinators continue to sort crisis and safety situations during this stage. In crisis situations, they work to implement wellness promotion activities to help families be able to manage crisis while practicing recovery techniques. This may involve a set of tools that promote self-care techniques, working on building alternative habits or ensuring access to people, places, and things the family is likely to find helpful during crisis. The Service Coordinator also works with the family and team to continue to reinforce the fact that some families choose to live more in crisis than others and as long as the line into unsafe isn't crossed, crisis may occur without system intervention.
- During Plan Implementation (The *Healing* Stage)

Over time the Service Coordinator works with the family and team to ensure that risk situations are minimized and well managed. The Service Coordinator keeps track of data about frequency, duration, and intensity of events and summarizes that for the family and team to review. Families and team members adjust based on data. This is also a time when a series of safety rehearsals may occur that allow the family to try on new pathways for managing risk as well as informing team members what works and what doesn't. This process occurs for both crisis and safety circumstances.
- As Service Coordination Comes to a Close (The *Hope* Stage)

The Service Coordinator works with the family and team to project a future without a formal service coordination process. This will involve implementing some unplanned risk and crisis drills that allow the family to test their response. It also asks the family and team to project their worries about both crisis and safety and build a set of resources the family can access if needed. This may involve making personal introductions to community resources, providing families with letters for future emergency responders as well as establishing a wellness calendar that families can use as a reminder to use the tools that have been developed throughout the process.
- The FCFC Crisis Plan/Form and Crisis Plan Contact List are below.

Crisis Plan/Form

Youth Name: DOB:	Case ID/ Youth ID:	Parent/Caregivers Names:	Plan Date: Previous Plan Date:
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County:

Facilitator:

<u>Family Concern/Worry:</u>	
ACTION STEPS (What works best?)	PERSON(S) RESPONSIBLE
1. 2. 3.	1. 2. 3.
PLAN "B" (What if the above does not work)	PERSON(S) RESPONSIBLE
1. 2. 3.	1. 2. 3.

<u>Family Concern/Worry:</u>	
ACTION STEPS (What works best?)	PERSON(S) RESPONSIBLE
1. 2. 3.	
PLAN "B" (What if the above does not work)	PERSON(S) RESPONSIBLE
People or organizations I can contact during a Crisis:	

Crisis Plan Contact List
Important People, Services & Contact #'s

NAME	RELATIONSHIP	CONTACT #s (Phone and email address fields)

SIGNATURES:

Name	Relationship/Role	Agree or Disagree	Date

Measuring for Outcomes

Rule: ORC 121.37(D)(5) Each county shall develop a family service coordination plan that “Includes timelines for completion of goals specified in the plan with regular reviews scheduled to monitor progress toward those goals.”¹²

System of Care Value: Adaptable

Expectancy is defined as “the state of thinking or hoping that something, especially something pleasant will happen or be the case.” Families deserve expectancy throughout their participation in Service Coordination. That expectancy is not only about holding ourselves accountable for follow-through and results but should also focus on the fact that Service Coordination will involve adjusting services and resources based on whether they are producing results or not.

Situation: Maureen and her son Ben, 13, have recently started participating in Service Coordination through the county FCFC. Ben and Maureen started therapy about a year ago after Ben’s dad died suddenly in an accident. Maureen reports that Ben has become more argumentative and combative during this time. Maureen has persevered and continued to get Ben to see the therapist. The Service Coordinator asks the therapist, Ben’s informal Probation Officer and the school counselor to get together. Ben’s paternal Aunt from another state calls in. During this meeting, everyone agrees that therapy sessions should increase and include Maureen. After six weeks, the Service Coordinator checks with Maureen who indicates that she and Ben are fighting a lot on the way to family therapy. Maureen indicates that while she knows better, she keeps avoiding the conflict. As a result, Maureen and Ben keep showing up late to therapy. Maureen goes on to say that while she wishes it would work, it doesn’t feel like it’s helping. The Service Coordinator facilitates a discussion between Maureen, Ben, and the Therapist where they explore some options. During that discussion, the Therapist suggests they meet twice monthly for twice as long rather than weekly. They all agree to try it for two months. During that time, the Service Coordinator agrees to keep track of whether they get to appointments on time, whether arguments happen less often and whether Ben and Maureen report that they feel better. This is an example of adapting response based on Outcome.

County FCFC Responsibilities and Considerations

Service Coordinators track three levels of response in pursuing an outcome-based approach. The first is *follow-through* that begins with Service Coordinators following through with promises they make and actions they take in reaching agreement with families. The second component is about a *fact-based approach* which details results or outcomes in behavioral terms. These outcomes should be easily countable and clearly defined so that all members of the team can see progress as it occurs. The third level is *feeling-based* and involves the parent and youth reporting that they feel that things are getting better.

¹² <https://codes.ohio.gov/ohio-revised-code/section-121.37>

Service Coordinators summarize all three levels throughout the process and use this information to adjust and adapt services and supports. Tips for all three levels include:

- **Follow-Through**

- Track follow-through for all team members rather than focusing on a single team member such as a parent or youth
- Positively note when any team member follows through, even when people start a job rather than finish it, recognize the accomplishment
- If follow-through is a challenge, find ways to bring different team members together to work on task completion
- Provide an overview of team progress on follow-through to build a sense of accomplishment among all team members

- **Fact-Based**

- Pick behavioral counts that are relevant to what brought the family in
- Build targets for what you want to see in terms of behavior rather than what you want to stop
- It's often easier to count the challenge but always report on the positive, such as the number of days a youth attended school.
- Reward progress along the way. It is likely to take time to reach the ultimate target.

- **Feeling-Based**

- Find a way to discuss the family's sense of well-being. This may be asking the parent/caregiver or youth if they feel more confident or whether they feel that needs are met.
- Recognize that you can have strong outcomes but if people don't feel better things are unlikely to actually become better
- Check for the family's sense of confidence or well-being throughout the process. If you don't see progress, make changes to your approach.

As Service Coordinators work through this process with families, team members and communities, an outcome focus creates a dashboard for data driven decision making. Identifying and measuring outcome as an ongoing part of Service Coordination sets the stage for Service Coordinators to work with families about their expectancy while holding themselves and team members accountable. An outcome focus allows everyone to work smarter and ensures families get the right response in the right time to produce the right results.

Adjusting Response to Family Transitions

Rule: ORC 121.37(C)(5) Each county service coordination mechanism shall include “A procedure for monitoring the progress and tracking the outcomes of each service coordination plan requested in the county including monitoring and tracking children in out-of-home placements to ensure continued progress, appropriateness of placement, and continuity of care after discharge from placement with appropriate arrangements for housing, treatment, and education.”¹³

System of Care Value: Family-Focused

Transition means things are changing. Families are always in some state of transition. For youth and families involved in Service Coordination, the intent is that things change for the better and that over time families experience a sense of growth and hope for the future. If Service Coordinators can understand enough in the *Hello* component to deliver help in the shortest amount of time while joining with the family in reviewing and improving help, then *Hope* will blossom. In essence, *Hope* happens when *Healing Help* is provided.

Situation: Catherine, 17, was placed in a therapeutic foster home following several suicide attempts that resulted in repeated psychiatric hospitalizations. The foster home was in a rural community about 30 miles south of the apartment Catherine shared with her mother Marjorie in an urban area. Traditional weekend visits to prepare for Catherine’s return home were not doable because Marjorie was employed as a nurse and was routinely scheduled to work weekends. Catherine’s Children’s Services worker made the referral to Service Coordination for support in developing a plan that would bring Catherine safely home. The Service Coordinator, Susan, met with Catherine, Marjorie and the foster parents Stacy and Mike to welcome them all to Service Coordination and to hear their story. During that conversation Catherine talked about her time at the hospital and how much she enjoyed the art projects there. She also shared that she was most nervous about returning to her large metropolitan high school. Marjorie was worried about the amount of time Catherine would be on her own while she was at work and hoped they could figure out some things for her to do. Stacy and Mike talked about the progress Catherine has made during the six months she has been with them and mentioned how helpful she is, routinely helping out at the bike shop they own and at their friend’s stable. Hearing their story provided direction and the Service Coordinator suggested pulling in a representative from the school ASAP. All agreed and within a week they held a meeting with the school’s special education director to discuss alternative education options. The district had a contract with a small alternative school that served only high school students with “internalizing behaviors.” Catherine, Marjorie, and Susan visited the school and thought it would be a good fit. With a school placement secured, a team and plan were developed. The plan included a “reverse foster care” arrangement that had a neighbor of Stacy’s who worked near the new school driving Catherine in on Monday mornings and returning her to the foster home Friday after work. During the week Catherine went home from school daily and spent time with her mom. With the help of the team, they located a

¹³ <https://codes.ohio.gov/ohio-revised-code/section-121.37>

community center with a strong arts program. They identified weekend volunteer opportunities that Catherine was interested in and planned to work with the vocational counselor at the school to prepare her for part-time employment on the weekends. The formal team stayed involved for several months after Catherine went home “full time.” As it became apparent that the support of a formal team was no longer needed, the team discussed Catherine and Marjorie’s accomplishments. They identified who would stay involved, both the formal services and the informal personal and community supports. Healing help had led Catherine, Marjorie, and the entire team to a place of hope.

County FCFC Responsibilities and Considerations

In Service Coordination, transition often refers to the time when a family has made significant progress and is ready to manage future challenges without the support of a formal team. But just as *Hello* isn’t something that only happens at the outset of the arc of care, *Hope* isn’t confined to the closing moments. *Hello* should kindle and nurture *Hope* throughout the course of the process. *Help* should be delivered in the context of a powerful optimism designed to increase expectancy on the part of all team members, including families. *Healing* should be recognized throughout the entire Service Coordination process to acknowledge and celebrate gains and set the stage for a future of possibilities.

- From their very first contacts with a youth and family, the Service Coordinator should be focused on taking purposeful action to ensure a family has the help necessary for continued success.
- Throughout the process, the Service Coordinator should look for and summarize positive changes in the youth and family’s ability to manage challenges and access necessary support.
- Service Coordinators should work to customize services and resources to the family and prepare to adjust those resources based on a family’s ongoing transition.
- As a family gets closer to moving out of formal service coordination, the Service Coordinator, should guide the team in preparing a detailed strengths-based transition plan to support the youth and family when new challenges happen. The transition plan should include:
 - A brief summary of what brought the youth and family to Service Coordination, what they worked on and where they are now.
 - Youth and family accomplishments including skills developed, positive changes made, successes celebrated, and anything else the family wants to include.
 - Strengths of family members and the family as a whole.
 - Steps for diffusing or managing potential family identified crises situations.
 - Contact information for persons the family can turn to for support and the kinds of help they can provide.

- Contact information for service providers who will be staying involved with the family.
- A list of community resources the family can access to meet family identified future needs.

Tools

- The Transition Worksheet and Road Map can be found at <https://wraparoundohio.org/tools-for-the-hope-stage-transition-worksheet-and-road-map/>

Planning with Youth, Families and Congregate Care

Rules:

ORC 121.37(C)(5) Each county service coordination mechanism shall include “A procedure for monitoring the progress and tracking the outcomes of each service coordination plan requested in the county including monitoring and tracking children in out-of-home placements to ensure continued progress, appropriateness of placement, and continuity of care after discharge from placement with appropriate arrangements for housing, treatment, and education”¹⁴

ORC 121.37(D)(3) Each county shall develop a family service coordination plan that “Ensures that assistance and services to be provided are responsive to the strengths and needs of the family, as well as the family's culture, race, and ethnic group, by allowing the family to offer information and suggestions and participate in decisions. Identified assistance and services shall be provided in the least restrictive environment possible.”¹⁵

System of Care Value: Ongoing

When circumstances result in a youth being placed in out-of-home care it's imperative that helpers recognize the importance of ongoing involvement with the youth and family, and in those instances when a custodial agency is involved, a representative from that agency. Service Coordinators recognize that this is more than a single event and should be prepared to work with families regardless of the service environment. From the moment of referral until the youth returns to their family and community, the focus should be on creating the conditions for ongoing, long-term stability and success.

Situation: Tyrone is 14 years old. He lives with his mother Latecia and 6-year-old brother Gregory in the upstairs of a two-family home. The home's owner Andre lives downstairs with his family. Tyrone has been involved with the Board of Developmental Disabilities since he was a young child and Latecia has a good relationship with the Service and Support Administrator (SSA) Dave. Recently Tyrone had an outburst and threw a television through the window. When Latecia was unable to calm him, Andre called the police who took him to the hospital. The hospital social worker felt the home situation was unsafe and called child protective services (CPS). CPS sought emergency temporary custody and at the hearing Latecia made it clear she did not want Tyrone taken from her. The judge recommended he be placed in a residential center for evaluation before she made a determination about custody and assigned an investigative probation officer (PO). With so many professionals now involved, the SSA Dave recommended Service Coordination. Latecia had previous involvement with Service Coordination and was agreeable to the referral. The Service Coordinator quickly worked with Latecia to bring together the professionals to figure out exactly what was to be evaluated during the residential stay. They began ongoing weekly meetings to ensure the treatment staff was meeting their expectations about what they wanted addressed while Tyrone was at the center.

¹⁴ <https://codes.ohio.gov/ohio-revised-code/section-121.37>

¹⁵ <https://codes.ohio.gov/ohio-revised-code/section-121.37>

Additionally, the Service Coordinator and Latecia used the time Tyrone was in placement to build a family focused team that, along with the professionals, included the homeowner Andre, several relatives, Tyrone's father James, and a respite provider Ed whose services were funded by DD. As a team they began planning for Tyrone's return home with emphasis on safety. At one point Latecia wanted to remove Tyrone from the center. The PO explained that Latecia could do that since she is the parent and has custody, but that it was very likely the judge would view that as a safety risk and order CPS to take custody. She also assured Latecia that with all that she has been doing to care for her two sons and her openness to additional forms of help, she would advocate with the judge that Tyrone be returned home. Reluctantly, Latecia chose to continue placement as she did not want to risk losing custody. As the hearing approached, the team wrote a letter, signed by every member, stating why Tyrone should return home, outlining the plan for ongoing supports and services and emphasizing the contingencies included to ensure ongoing safety. Additionally, as many team members as were able attended the hearing to demonstrate their support for Tyrone's return to Latecia and to answer any questions the judge might have about their ongoing involvement.

County FCFC Responsibilities and Considerations

When a youth is referred for congregate care, the Service Coordinator should consider both long and short-term objectives, as congregate care is only one step in an ongoing process. Being clear about the long-term plan allows the Service Coordinator to guide the team in identifying what is expected while a youth is in care that will allow for their safe return to family and community. Ongoing planning before, during and after placement sets the stage for long term stability and success. Steps that a Service Coordinator and family team can take during the time a youth is in congregate care include:

1. Before or as soon as possible upon placement the service coordinator should:
 - Identify with the family, and in those instances when a custodial agency is involved, a representative from that agency, and other team members with concerns they want addressed/treated during the congregate care stay
 - Clarify with the team how progress will be evaluated
 - Ensure that providers are clear about treatment expectations
 - **Remind the team that they will need to meet more frequently during the youth's stay in placement to monitor for results**
2. Throughout the time the youth is in care, the team should monitor progress in treatment by:
 - Holding regularly scheduled, preferably weekly, progress monitoring meetings that include congregate care staff as temporary team members
 - Ensuring congregate care goals align with family team goals
 - Monitoring progress toward achievement of identified goals
 - Where progress is not occurring, the team should consider the reasons and ensure the center is making necessary adjustments to shift progress

3. Ongoing, the Service Coordinator should guide the team to identify the steps necessary to prepare the youth and family for the youth's return to family and community and, as appropriate, facilitate the process to ensure the family is not overwhelmed. Those steps should include:
- Ensuring the youth has positive connections in the community based on their strengths, interests, and culture by identifying and, whenever possible, continuing or introducing new connections (e.g., peer support, youth programs) while the youth is still at the center
 - Determining what services and supports, both formal and informal, will be needed for the youth's successful return to the community, making linkages to initiate services while the youth is still at the center and considering barriers (e.g., funding, transportation) and strategies to overcome those barriers
 - Identifying with the family what they need to support family connectedness while the youth is in congregate care
 - As soon as possible while balancing safety and attachment concerns, scheduling community and home visits to prepare family, youth, siblings, other caregivers, and household members for the youth's return
 - Identifying opportunities that exist or can be created for the family to practice new skills learned while the youth is in placement
 - Determining what additional support (e.g., respite, mentoring) the youth and family need for ongoing success
 - Identifying and preparing the youth and the school for the youth's return including enrolling, determining needed accommodations, and creating personal connections prior to the youth's return

Ongoing planning results in a strengths-based plan for the youth's return that takes into consideration: promoting safety; rebuilding relationships; developing reasonable expectations; predicting and problem-solving potential challenges and needs. It requires the team continue their commitment to working with the family and supporting them in their healing journey toward long term stability, success, and hope.