Beaufort County Human Services Department

Collaborative Service Coordination:
Collaborative Organization of Services for Youth (COSY)

Overview

Collaborative service coordination is vital for delivering comprehensive, efficient, and effective support to youth and other program participants. It enhances resource accessibility, improves communication, and ensures a holistic approach to service delivery, ultimately leading to better and more sustainable outcomes for individuals and communities.

The Beaufort County Human Services Department works in close partnership with eligible families to coordinate services, collaborating with key stakeholders such as state agencies, local government bodies, the school district, non-profit organizations, and other entities both public and private. Engaging families in decision-making is crucial for creating tailored and effective support plans, as their insights ensure services are relevant and comprehensive. This involvement fosters empowerment, better communication, and stronger relationships, leading to improved and sustainable outcomes for participants.

Target Population and Eligibility

Youth in Beaufort County, ages 0–17 (or up to age 21 if the child qualifies for services under the Individuals with Disabilities Education Act), may be referred to COSY if they receive services from a Human Services partner agency and need coordinated support.

COSY is designed to support children and families with issues including, but not limited to:

- Coping with trauma, loss of a caregiver, abuse, or other life challenges
- Mental health concerns like anxiety, depression, substance use, or developmental needs
- Juvenile justice involvement or legal challenges
- Support with employment, housing, food, or transportation
- Parenting, child development, healthcare, and wellness needs

Agencies working with families facing multiple, complex human service needs are encouraged to refer.

Partner Agencies and Service Planning Team (SPT)

Partner agencies are any human service agency/organization who serves Beaufort County residents that have submitted a ***Collaborator Registration Form*** and received approval from the Human Services Department.

Representatives from partner agencies meet regularly to review and coordinate cases in Service Planning Team (SPT) meetings, where they collaborate to develop comprehensive

support plans for families and youth. Read below for additional information about the Service Planning Team.

Referral Process

Youth and families needing collaborative service coordination can be referred through the online ***Referral*** tool. Once entered, the Human Services Department Program Manager is notified and will follow up with the family and/or referring agency within **two (2) business days**.

Contact with the family and/or referring agency may result in one of two outcomes: a **consultation** or a **case activation**.

Consultation: If a referral does not require ongoing engagement after the initial contact, a summary of the conversation is recorded on an internal consultation log and updated with relevant details, including any additional referrals. No further action is taken.
For example, this may apply when:

- The case is resolved shortly after the referral is submitted.
- The family's immediate needs are met through readily available resources, eliminating the need for further coordination.
- The youth or family declines further support after initial outreach.

Case Activation: A case is activated when ongoing engagement is requested to address complex challenges. Upon activation, an electronic file is created for the family, and intake documents are prepared, including a ***Family Contact Log***, ***Intake Form***, ***Participation Agreement***, ***Technology Informed Consent*** and ***Release of Information***.
A case may be activated when the family meets one, or more, of the following criteria:

- Multiple service providers must collaborate to develop a comprehensive plan of care.
- Unmet needs are revealed that may require sustained coordination and support.
- The family's challenges are complex, with no immediate or readily available solutions.
- The youth or family expresses a need for continued assistance beyond what was initially provided.

Orientation and Intake Process

When the Human Services Department Program Manager, referring agency, and family collectively agree to proceed with Collaborative Service Coordination, the following steps take place:

1. The Program Manager contacts the parent/guardian to schedule an intake, which can be conducted by phone, virtually (audio/video), or in person (preferred). Families are always encouraged to participate in person, but our department is committed to being flexible and sensitive to their needs to ensure a positive and accessible engagement experience.

2. Intake is completed within **30 days** of the referral, depending on family availability.
3. As part of the orientation, the Program Manager explains the process to the family, ensuring they:
    - Understand the purpose of service coordination and how it will support them.
    - Are aware of their rights, responsibilities, and the role of involved agencies.
    - Know the next steps, expected timeline, and what to expect from participation.
    - Have an opportunity to ask questions and clarify concerns before moving forward.
    - Provide informed consent by reviewing and signing the ***Participation Agreement***, which formalizes their decision to engage in the program and the ***Technology Informed Consent*** which outlines the expectations and potential risks of virtual meetings.
4. Upon securing the family's agreement to participate, the program manager explains that the department and all partner agencies operate at the highest ethical and professional standards for maintaining confidentiality, and that their privacy is also protected by law. The Program Manager reviews the ***Release of Information*** form in detail, ensuring families understand:
    - What information will be shared, which agencies will receive it, and why this sharing is necessary for effective service coordination.
    - Their right to control what information is shared and with whom, giving them agency over their data.
    - How information will be used to enhance service delivery while maintaining their privacy and dignity.
    - That they can ask questions, adjust authorizations*, or revoke consent at any time if they have concerns. **Refer to section "Family Guests, Representatives, and Advocates*.
5. Once the Release of Information is secured, the intake process formally begins. The Program Manager verifies the family's contact information to ensure the ***Contact Log*** is accurate and up to date. This includes confirming which family members are authorized to receive case-related information in accordance with the signed Release of Information.
6. The Program Manager begins the intake process by completing the ***Intake Form***, discussing the family's history, and identifying their goals and objectives. Initial assessments, such as a ***Human Needs Screening***, may be conducted to determine urgent concerns like housing, food security, transportation, and financial stability. If no provider has previously conducted in-depth screenings or assessments, the intake may also include a ***Mental Health Screening*** or a ***Risk Profile*** if the Program Manager identifies a need.

7. Finally, the Program Manager coordinates with the family to schedule a collaborative meeting with the COSY Services Planning Team (SPT). This meeting brings together agency providers and partners to develop solutions that address the family's needs and support the best possible outcome for the youth.

Family Guests, Representatives, and Advocates

Families have the option to invite guests or designate a representative to attend the meeting on their behalf during Services Planning Team meetings. These individuals will be documented on the ***Family Representation and Guest Authorization Form***, which can be updated as needed. Some families may prefer to engage in the service planning process but elect not to attend the Services Planning Team meeting. In this scenario, they will still be required to complete a ***Family Representation and Guest Authorization Form***, allowing them to designate an agency or a participating partner agency to represent their interests. The Human Services Department is committed to respecting each family's preferences and ensuring a flexible, responsive approach to service coordination, ensuring that families receive the support they need in a way that aligns with their comfort level.

Service Planning Team Schedule

SPT meets generally at 9 AM on the 2nd and 4th Thursdays of each month, with allowances and exceptions made for holidays and weather events. Meeting cancellations will be delivered **three business days** prior to scheduled staffings.

2025 Meeting Dates:

February 27 (SPT onboarding only)	August 14 & 28
March 27	September 11 & 25
April 10 & 24	October 9 & 23
May 8 & 22	November 6 & 20
June 12 & 26	December 18
July 10 & 24	

The schedule is finalized in Q4 after Beaufort County announces the holiday calendar.

Cases are scheduled based on partner recommendations, time since last staffing, and guardian availability. Cases are generally reviewed every six months, though this may vary based on caseload volume, external collaborations, and agency discretion.

Pre-Meeting Process

To ensure efficient and productive Service Planning Team (SPT) meetings, a structured pre-meeting process has been established. This process enhances preparation, ensures relevant stakeholders are informed, and facilitates seamless collaboration.

Pre-Meeting Steps:

1. **Case Review:**
    - One week before the scheduled SPT meeting, the Program Manager reviews the upcoming cases to determine the necessary attendees.
2. **Family Engagement & Preparation:**
    - Families scheduled for SPT meetings receive a pre-meeting consultation where the Program Manager:
        - Confirms their attendance at the upcoming meeting.
        - Confirms any updates on their needs, preferences, or new concerns.
    - If needed, interpreters or additional supports are arranged to facilitate family participation.
3. **Pre-Meeting Communication with Partner Agencies:**
    - Partner agencies receive a meeting agenda and a ***Pre-Staffing Brief*** for each scheduled case at least **three business days** before the SPT meeting.
    - Agencies review case details and confirm attendance or delegate an informed representative.
    - Any additional relevant updates should be submitted to the Program Manager prior to the meeting.

<u>Service Planning Team Meeting Structure</u>

Services Planning Team (SPT) meetings bring together representatives from partner agencies, service providers, and key stakeholders to develop a coordinated support plan for a youth and their family.

The meeting typically includes:

1. **Introduction & Case Presentation:**
    - The Program Manager introduces the participating family members and any guests or representatives on their behalf to the staffing team, with each team member introducing themselves by Name, Title, and Agency.
    - The referring agency or Program Manager provides an overview of the participant's situation, needs, and current services.
    - The Program Manager invites the family (if present) to share any additional information they feel is pertinent.
2. **Information Gathering & Input from Partner Agencies:**
    - The Program Manager calls upon each participating agency to share insights, available resources, and relevant data regarding the participant's needs.
    - Agency representatives may ask questions of the participant when called upon. Questions must focus on identifying solutions and will be recorded in the staffing notes.
    - Cross-agency discussions should occur privately (via email, chat, or separate follow-ups) rather than within the primary staffing session.
3. **Discussion & Planning:**
    - The team collaborates to identify gaps in services and explore solutions.

- Partner agencies provide recommendations focused on task-oriented, agency-specific solutions to address the participant's needs.
- Recommendations must meet the following minimum criteria:
  - Have an assigned responsible party (family, an agency staff member, or a Human Services Department staff member).
  - Be actionable and relevant to the case.
  - Include a timeline for completion.
  - Follow SMART goal principles (Specific, Measurable, Attainable, Relevant, Time-bound) whenever possible.
- Agencies must assign themselves or their organization to follow-up tasks and should refrain from assigning tasks to the family unless necessary.
- All participating agencies should be given opportunities to comment on the discussion. "No response" or "No recommendation" will be noted in the staffing report.

4. **Family Engagement (if applicable):**
   - If appropriate, the youth and family may participate in the meeting to share their perspectives, goals, and preferences.
   - The team ensures that family input is considered in the Service Plan and that recommendations align with the participant's needs and goals.
5. **Finalizing Recommendations & Next Steps:**
   - The Program Manager reviews recommendations with the team for accuracy.
   - The family is given the opportunity to ask questions and seek clarification.
   - The Program Manager asks for any final input from agency participants. Additional considerations may be included in the final report but not recorded as tasks.
   - Follow-up procedures and expected timeframes for a written report are explained.
   - The Program Manager ensures contact information for Human Services Department staff and all team members is included in the final report.
   - A **30-day follow-up** is scheduled if the participant does not initiate contact with Human Services before then.
6. **Follow-Up with Missing Partners:**
   - Within **three business days**, the Program Manager follows up with any agency partners who were unable to attend, sharing the recommendations.
   - Absent agencies have an opportunity to provide additional recommendations or feedback before the final report is submitted.
   - "No response" or "No recommendation" will be noted in the staffing report.

SPT meetings are categorized as **Initial Meetings** or **Follow-Up Meetings**:

- **Initial Meetings**: The family's first introduction to the Services Planning Team (SPT), focused on information-sharing, discussion, and solution planning.
- **Follow-Up Meetings**: Service Plan review, assess family progress and satisfaction, and make adjustments, or to close if closure criteria has been met.

Initial Meeting Process

1. **Meeting Summary and Documentation:**
    - The Program Manager compiles a ***Progress Summary***, including the Service Plan action items, assigned responsibilities and current goals and barriers.
    - Case notes are updated in the system, and any new agency referrals are recorded.
    - Families receive a ***Service Recommendations Parent/Guardian Letter*** using their preferred method of contact (email or phone + US Mail) within **three business days** of the meeting.
    - Partner agencies actively involved with the family's service plan receive a copy of the Progress Summary to confirm their assigned action items within **three business days** of the meeting.
2. **Ongoing Monitoring and Support:**
    - Service Plan Check-in: The Program Manager contacts families **two weeks** after the Initial SPT Meeting to assess the progress of action items, ensure active engagement, and address emerging issues.
    - Follow-up calls with partner agencies may be needed if action items are stalled.
    - Additional check-ins are scheduled in two-to-three-week intervals based on circumstances surrounding the completion of action items.
3. **Follow-Up SPT Meeting Scheduled:**
    - Once substantial progress is made towards the Service Plan's action items, a Follow-Up SPT Meeting is scheduled. This meeting should take place within six months following the Initial SPT Meeting.

Follow-Up Meeting Process

- Review the family's progress and assess next steps.
- Determine whether to:
    - Close the case (if criteria are met), **OR**
    - Repeat the intake process with a reassessment, ensuring updates to family goals as needed.

This comprehensive process enhances preparation, improves communication, ensures accountability, and maximizes the effectiveness of SPT meetings to achieve the best outcomes for youth and families.

Closure Criteria

A case is closed when one or more of the following criteria are met:

- Service Plan action items completed
- Moved out of Beaufort County
- Withdrew from Program
- Change of guardianship

- Receiving services from only one partner agency
- Not receiving services from any partner agency
- Non-responsive
- Incarcerated
- Deceased

Closure does not preclude a case from being re-referred and re-opened if deemed necessary. Re-opening a case would start with a reassessment, effectively restarting the process.

Closure Process

1. **Finalize Documentation:**
    - The Program Manager completes a ***Case Closure Summary*** detailing the progress made and reason(s) for closure.
    - Update case records, ensuring all notes and documents are properly filed.
2. **Notify Relevant Parties:**
    - Inform the family and partner agencies of the case closure.
    - Provide families with a ***Case Closure Summary Parent/Guardian Letter*** within **two weeks** of status change.
3. **Post-Closure Follow-Up:**
    - Offer a final check-in withing 30-60 days to confirm stability and address any lingering concerns.
    - If new needs arise, discuss potential resources or repeat the intake process if necessary.