

# **CFS NEW WORKERS ACADEMY**

**Service Integration  
Emergency Assistance**

**BOISE STATE UNIVERSITY CHILD WELFARE CENTER**  
In Partnership With  
**Idaho Health & Welfare Department**  
**Children and Family Services**

Round 12  
Session 4  
14-17 Sep 09



# WORKSHEET

Name: \_\_\_\_\_

## Service Integration Emergency Assistance

### Continuous Learning Plan

#### Strengths:

1. What do you already know how to do that relates to this topic?

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2. What do you already do that relates to this topic?

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#### Self Development:

1. What would you like to know more of – related to this topic?

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2. What would you like to do more of – related to this topic?

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Revised 3/13/07

# WORKSHEET

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## PERFORMANCE REVIEW OF COMPETENCIES

*Describe employee performance in specific work areas.*

### **Customer Service**

#### **Competency Description:**

Provides what has been promised to each customer in a timely, dependable and accurate manner; gains customer trust and confidence by conveying knowledge and accurate information; treats customers with courtesy, respect and dignity; communicates with customers in a responsive, productive, clear and appropriate manner.

### **Dependability**

#### **Competency Description:**

Meets commitments, works independently, accepts accountability, handles change, sets personal standards, stays focused under pressure, meets attendance/punctuality requirements.

### **Interpersonal Skills**

#### **Competency Description:**

Has good listening skills, builds strong relationships, is flexible/open-minded, negotiates effectively, solicits performance feedback and handles constructive criticism.

### **Productivity**

#### **Competency Description:**

Manages a fair workload, volunteers for additional work, prioritizes tasks, develops good work procedures, manages time well, and handles information flow.

### **Quality**

#### **Competency Description:**

Is attentive to detail and accuracy, is committed to excellence, looks for improvements continuously, monitors quality levels, finds root cause of quality problems, owns/acts on quality problems.

### **Work Environment/Safety**

#### **Competency Description:**

Promotes mutual respect, keeps workplace clean and safe, supports safety programs.

### **Adaptability/Flexibility**

#### **Competency Description:**

Adapts to change, is open to new ideas, takes on new responsibilities, handles pressure, adjusts plans to meet changing needs.

*Additional competencies for CFS/CMH Employee in CFS/CMH ACADEMY and completing probationary period*

**Integrity/Ethics**

Deals with others in a straightforward and honest manner, is accountable for actions, maintains confidentiality, supports company values, conveys good news and bad.

**Communication**

Communicates well both verbally and in writing, creates accurate and punctual reports, delivers presentations, shares information and ideas with others, has good listening skills.

**Decision Making/Judgment**

Recognizes problems and responds, systematically gathers information, sorts through complex issues, seeks input from others, addresses root cause of issues, makes timely decisions, can make difficult decisions, uses consensus when possible, communicates decisions to others.

**Job Knowledge**

Understands duties and responsibilities, has necessary job knowledge, has necessary technical skills, understands company mission/values, keeps job knowledge current, is in command of critical issues.

**Computer Skills** exceedingly adept at using and integrating the company's operating systems and applications into her day-to-day work. Has knowledge of general PC, network, and operating systems is unsurpassed. Has mastered a variety of applications that enable him/her to produce excellent work. Knows where to find information within the company's databases.

**Self Development -CFS**

Seeks out and accepts feedback, is a proactive learner, takes on tough assignments to improve skills, keeps knowledge and skills up-to-date, turns mistakes into learning opportunities.

**Problem Solving/Analysis**

Breaks down problems into smaller components, understands underlying issues, can simplify and process complex issues, understands the difference between critical details and unimportant facts.

**Planning** Is a thorough and diligent planner. Takes all important details into account and involves project participants to make sure all needs and potential problems are out on the table. Plans contain a level of detail and thought that almost guarantee project success.

**Teamwork**

Meets all team deadlines and responsibilities, listens to others and values opinions, helps team leader to meet goals, welcomes newcomers and promotes a team atmosphere.

**Sales Skills [Social Marketing] -CMH**

Develops new business, identifies and sells to customer needs, translates product features to benefits, has good listening skills, is sensitive to customers, delivers effective presentations, negotiates well, uses closing skills appropriately, develops sales skills.

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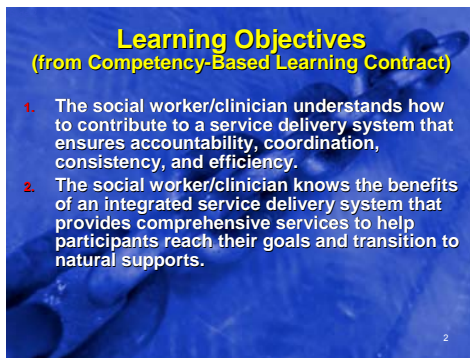
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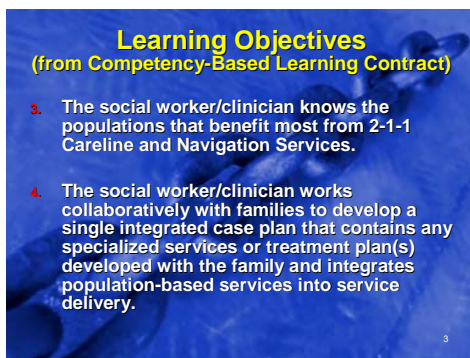
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Slide 3



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Slide 4



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Slide 5



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Slide 6

**The chain that connects...**

2-1-1 Careline – Basic information about almost anything

Navigation – (the one stop shop) resources, referrals, coordination, and community resources development

Case/Service Planning and Management – (let me help with that) monitoring and assisting client to meet goals

RSM process – (meeting of the disciplines) development of an integrated service plan

6 Principles of Partnership – (the golden rule) strengths based

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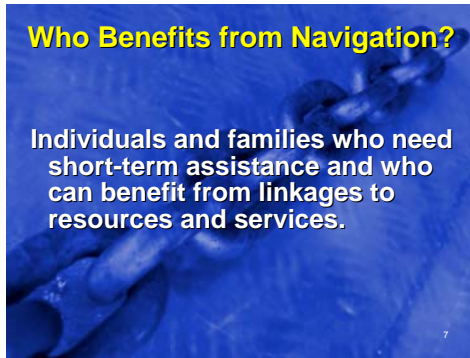
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Slide 7



**Who Benefits from Navigation?**

Individuals and families who need short-term assistance and who can benefit from linkages to resources and services.

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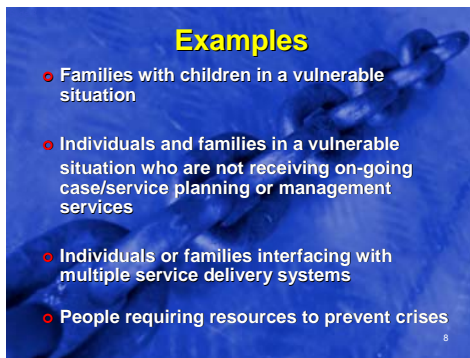
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**Examples**

- o Families with children in a vulnerable situation
- o Individuals and families in a vulnerable situation who are not receiving on-going case/service planning or management services
- o Individuals or families interfacing with multiple service delivery systems
- o People requiring resources to prevent crises

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Slide 9



**Scope of Navigation Services**

- o Coordinate/Facilitate access to services and resources (collaboration)
- o Conduct strength-based assessments
- o Develop/monitor plans
- o Facilitate Resource Services Meetings (RSM)
- o Refer customers to internal/external resources
- o Help develop new resources

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Slide 10

### Navigation Support to Special Cases/Initiatives

- Kinship Care—VISTA Project
- Independent Living (IL) Planning
- Children returning home
- Human Trafficking
- Foster Care Recruitment
- Offender release and client safety (partnership with Dept. of Corrections)

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Slide 11

### How does it work?

I have problems. I feel overwhelmed and I am not sure where to turn.

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Slide 12

### A person named Navigator

The navigator schedules a strengths based interview, in which immediate needs are met, the participant determines goals and receives additional information resources! The participant may then continue on to a resource services meeting for further assistance.

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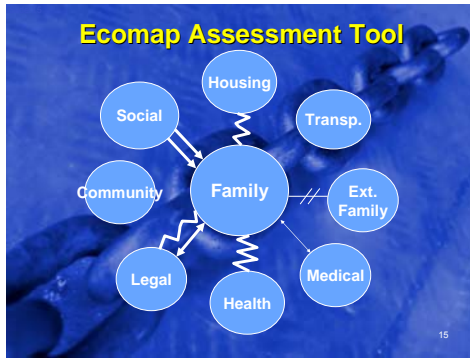
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Slide 13



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Slide 14

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- Other Navigation Tools**
- Access to most Department Host applications
  - I-View – compilation of several data systems
  - COMPASS – a web-based case management system. Better data for Navigation and CRWs.

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Slide 15

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- Primary Roles of Navigators**
- Content Expert
  - Link to Resources and Services
  - Case/Service Plan Manager
  - Facilitator
  - Resource Developer

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Slide 16



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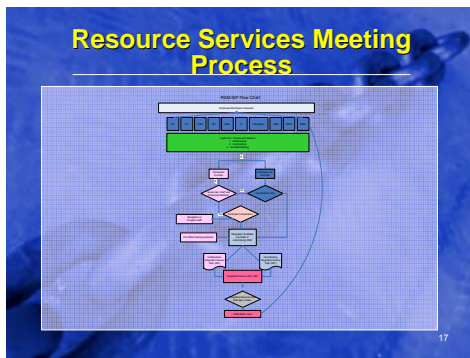
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Slide 17



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Slide 18

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- Regional Support Teams**
- Regional Directors, Program Managers, HUB Managers, Service Integration Team
  - Ensure communication and feedback happens throughout the region
  - Provide the leadership and support necessary for staff to working effectively in an integrated service system
  - Meet program performance goals
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Slide 19

### Service Integration/Navigation: Significant Accomplishments

- Navigation service received a 97% internal customer satisfaction rating
- Consolidation of Emergency Assistance
- Acts as a convener of community partners, coordinating community efforts
- Medicare Part D/Family Medicaid applications and other shifts in capacity
- Relocation of mobile home parks in R4 and R7

19

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Slide 20

### Contact Navigation

The Service Integration Reference Guide, Navigation Referral Form, RSM Flow Chart and more is available by following this link:

<http://hwteamsites/serviceintegration/default.aspx>

To request navigation services, simply complete and e-mail the **Navigation Services Referral Form**

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Slide 21

### What is 2-1-1?

2-1-1 is an easy-to-remember phone number to connect people in need with important community resources. With a resource database of over 3,400 community programs, 2-1-1 is dedicated to providing caring, professional referrals to a comprehensive range of low cost or free health and human services.

All calls are free and confidential for access to the following types of services:

- Basic Human Needs Resources
- Medical and Mental Health Resources
- Employment Support
- Support for those with Special Needs
- Support for Children, Youth and Families

Crisis referral services are also available 24/7 through 2-1-1 for reporting child and adult abuse, mental health crisis, and suicide emergencies.

21

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Slide 22

### 2-1-1 Idaho Careline

- **1991:** A program of the Idaho Department of Health and Welfare (IDHW), the Idaho Careline is a toll free, statewide telephone information and referral service since 1991. Services are available to every Idahoan, regardless of their personal or social situation.
- **2000:** The national 2-1-1 initiative allowed the Federal Communications Commission (FCC) to set aside a three digit number (2-1-1) for the sole purpose of providing information and referral (I&R) services to health and human resources. Similar to 911 for emergencies or 511 for transportation information, 2-1-1 is an easy-to-remember phone number to connect people in need with important community resources and volunteer opportunities.
- **2003:** 2-1-1 services became available statewide through the Idaho Careline program. Idaho was the 4<sup>th</sup> state to offer 2-1-1 services statewide with significant support from the community partners including Treasure Valley United Way and Mountain States Group.

22

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Slide 23

### CALL DATA—Partial Breakdown

**RECORD SETTING YEAR**  
**213,730**  
**TOTAL CALLS**  
Averaged over 17,800  
p/month

Out of State	3,898
Region 1	17,186
Region 2	7,643
Region 3	57,373
Region 4	77,158
Region 5	18,269
Region 6	13,523
Region 7	18,680

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Slide 24

### 2-1-1 Core Service: Call Center

- 2-1-1 does not provide direct services—we refer to the “experts”
- We use a statewide resource database of over 3,400 programs for a broad range of health and human services and public assistance topics
- Resource database includes free, low-cost or sliding fee services and programs
- The service is available to anyone
- Web site includes a searchable, online resource database & an e-Library
- Printed materials available for mailing
- Information and Referral Specialists available over the phone in any language (in-house Spanish, all else via Language Line)

The 2-1-1 Call Center is staffed by fully trained Information and Referral Specialists consisting of 12 employees (4 full-time and 8 part-time)

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Slide 25

### 2-1-1 on a National Level

- o 2-1-1 is now available in all but 4 states
- o Only 19 states are operating statewide
- o Idaho was the 4th state to become statewide
- o Idaho is one of two 2-1-1 Centers that are fully funded by the Department of Health and Welfare.
- o 2-1-1's across the nation called into action to respond to disasters
- o 2-1-1's across the nation are networking to build a seamless system & support each other

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Slide 26

### Why Use 2-1-1 Promotions?

**EXAMPLE PROMOS FOR FY-09** →

- o One easy-to-remember number statewide
- o One flyer/brochure statewide
- o Demographic data is gathered on each call, including: date, age and gender, and city of residence, how did they hear about the program
- o Data can be used to evaluate the effectiveness of the advertising

CALL US FIRST TO DISCUSS YOUR PROMOTION

Radon Kits – Indoor Environmental Awareness Campaign.  
**Free Tax Sites** – Free tax preparation for low income and language dependent.  
**Summer Food Program** – providing lists of locations for people to obtain lunches while school is not in session.  
**Foster Child Program** – Awareness and recruiting campaign for foster parents.  
**HIV Testing** – Campaign targeted at the Hispanic community for HIV testing and info.  
**Cervical Cancer** – Awareness and Education  
**Skin Cancer** – Awareness and Education  
**Colorectal Cancer** – Awareness and Education  
**Fit and Fall** – Campaign targeted for seniors on Getting Fit and Preventing Falls.  
**Recreational Water Illness** – Awareness and Education

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Slide 27

### Examples of Where 2-1-1 Is Used

- o Idaho Stars - Child Care System of Care
- o Wednesday's Child
- o Women's Health Check
- o Medicaid / Application for Assistance / Notice of Decisions (Interpreter services)
- o IDHW Fraud Reporting
- o Foster Care System. . . and much more

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Slide 28

**2-1-1 and Disaster Preparedness and Response**

- Information to the public
- Feedback to Health Officials and rumor control during an emergency
- Ability to "ramp up" our service capacity through use of IDHW volunteer operators
- Training and exercise events
- We need YOU!** If interested, talk with your Supervisor and then call 2-1-1 Supervisors.
- MOU with Bureau of Homeland Security relating to volunteer and donation management
- Member of Idaho VO-AD (Volunteer Organizations Active in Disasters)
- IDHW Public Health Emergency Communication Plan

28

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Slide 29

**2-1-1 Web Site: [www.211.Idaho.Gov](http://www.211.Idaho.Gov)**

- Special promotions/announcements/hot topics
- Online searchable resource** (database)
- Call data reports and demographics
- E-Library articles**

Articles are broken down by area of interest:

- Children and Families
- Community Life
- Disabled and Seniors
- Education and Employment
- Health
- Legal and Government
- Mental Health and Substance Abuse
- Military Resources
- Public Assistance Programs

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Slide 30

**Contact 2-1-1**

**SUPERVISOR CONTACTS:**  
 Alberto Gonzalez- Office Service Supv  
 287-1030  
 Landis Rossi - Prog Mgr Svc  
 Integration  
 334-5688

- By Phone:** Dial 2-1-1 or **1-800-926-2588**
- By E-mail:** [careline@dhw.idaho.gov](mailto:careline@dhw.idaho.gov)
- Online:** [www.211.idaho.gov](http://www.211.idaho.gov)
- Fax:** 208-334-5531
- TTY:** 208-322-7205
- ADDRESS:** 1720 Westgate Drive, Room 206

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Slide 31

**Learning Organization Disciplines**

- o Shared Vision
- o Personal Mastery
- o Team Learning
- o Systems Thinking
- o Mental Models



31

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Slide 32

**6 Principles of Partnership**

1. Everyone desires respect
2. Everyone needs to be heard
3. Everyone has strengths
4. Judgments can wait
5. Partners share power
6. Partnership is a process



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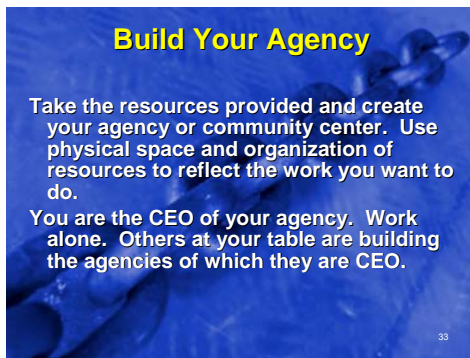
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Slide 33

**Build Your Agency**

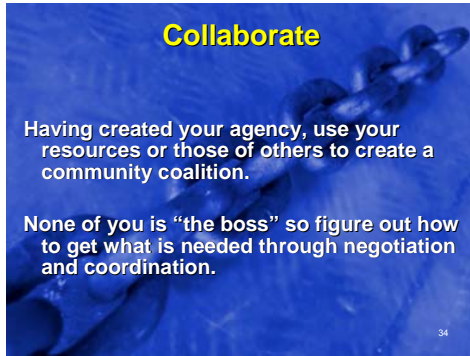
Take the resources provided and create your agency or community center. Use physical space and organization of resources to reflect the work you want to do.

You are the CEO of your agency. Work alone. Others at your table are building the agencies of which they are CEO.



33

Slide 34



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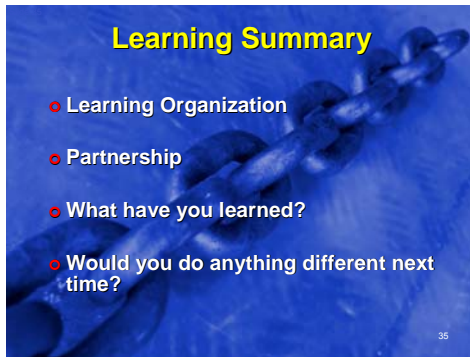
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Slide 35



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Slide 36



# Navigation Services Referral Form



## Referral Source

<i>Referred by:</i>	<i>Phone:</i>
<i>Your Supervisor:</i>	<i>Referral Date:</i>
<i>Referring Program:</i>	<i>Referring Program Address:</i>

## Participant Demographics

<i>Individual or Family Name:</i>		<i>Phone:</i>
<i>Address</i>		<i>City, State, Zip</i>
<i>Social Security Number:</i>	<i>Program ID Number</i>	<i>Date of Birth:</i>

## Presenting Issue(s) *(check all that apply)*

<input type="checkbox"/>	This is a family where children are at physical, health, or emotional risk and in a vulnerable/destitute situation because of the lack of parental care or the lack of sufficient resources.
<input type="checkbox"/>	This is an individual or family in a vulnerable situation who may benefit from linkage to resources and/or services in the community.
<input type="checkbox"/>	This is a family and/or an individual interfacing with multiple service delivery systems who may benefit from communication and coordination of service provision.
<input type="checkbox"/>	This is a family or individual who belongs to a group requiring linkage to resources and/or services to prevent crisis and/or preserve community well being.

## Purpose of Referral


*What specific needs does this family or individual have?*

## Strengths

*What specific strengths/abilities does this family or individual have?*

Assigned to: \_\_\_\_\_

Date: \_\_\_\_\_

<h2 style="margin: 0;">RESOURCE AND SERVICES MEETING (RSM) REFERRAL FORM</h2>	 <p style="margin: 0; font-size: small;">IDAHO DEPARTMENT OF HEALTH &amp; WELFARE</p>
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**Referral Source**

Referred by:	Phone:
Your Supervisor:	Referral Date:
Referring Program:	Referring Program Address:
Has a Supervisory review been completed? <input type="checkbox"/> YES <input type="checkbox"/> NO	Has the family agreed to this RSM? <input type="checkbox"/> YES <input type="checkbox"/> NO

*What specific outcomes do you or the participant/family expect from the meeting?*

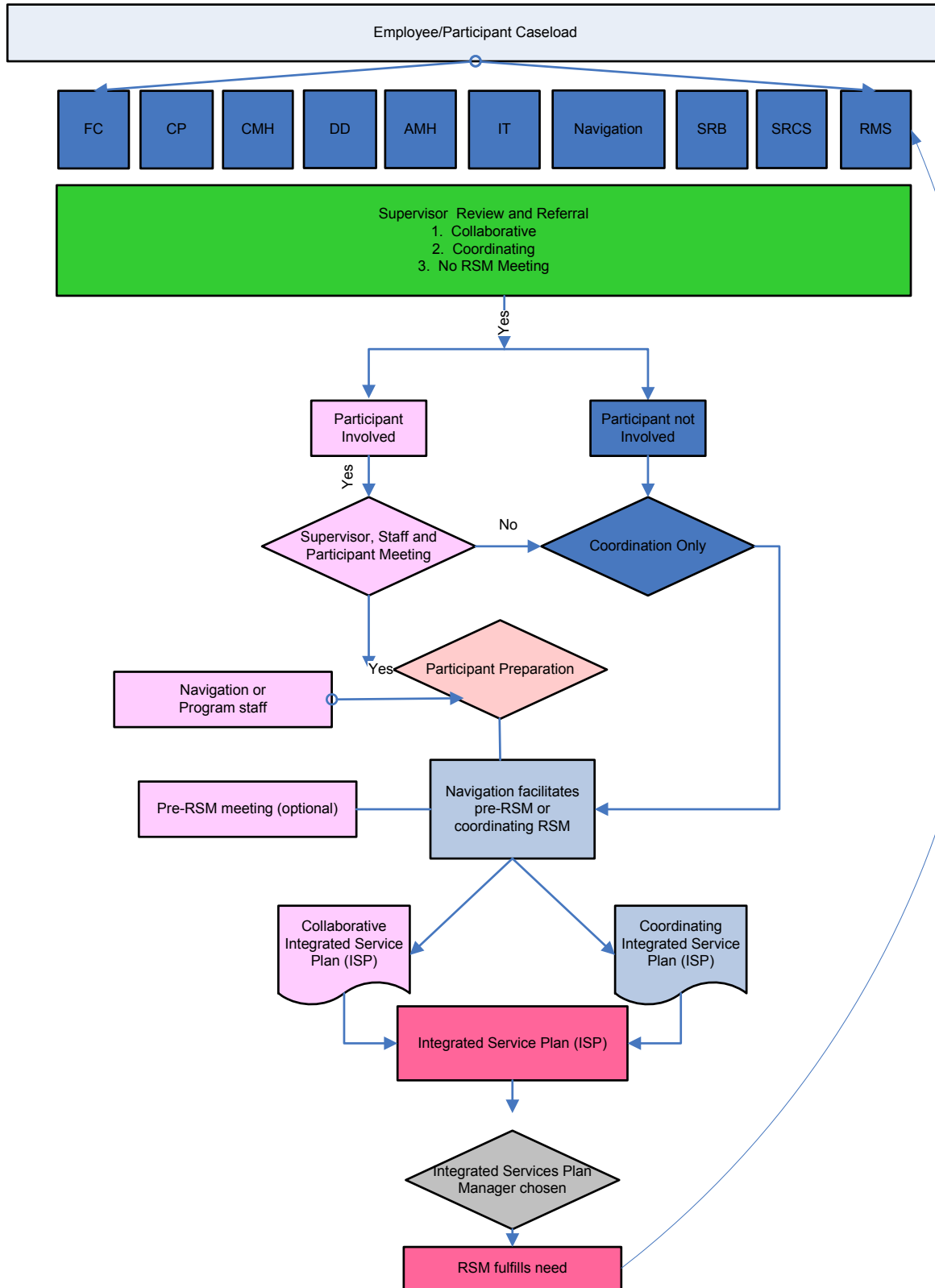
**PERSONS TO BE INVITED TO THE RSM**  
(Please Include Participant Name and Contact Information)

Name	Address & Zip	Phone#	Relationship To Family

*Additional information that would be helpful planning this RSM, including specific strengths and supports for the participant/family:*

**Please attach any supporting documents such as current case plans, assessment information, eligibility determinations, eco-maps, etc.**

### RSM/ISP Flow Chart



## RSM FLOW CHART NARRATIVE

### RESOURCE SERVICES MEETING/INTEGRATED SERVICE PLAN FLOW CHART NARRATIVE

Instructions: The following narrative describes intended roles and activities of the Participant, DHW employees, the Navigator, and Community Resources as portrayed by the Resource Services Meeting/Integrated Service Plan Flow Chart.

#### **Description of Participants and Personnel:**

*Participant:* Individual, family, group or community requesting or receiving services from Health and Welfare. A legal guardian or other appointee may act on the behalf of a participant who is deemed to be incapable of making an informed decision. Participants may also invite guests acting as a natural support.

*Line Staff/Worker:* Staff involved with direct participant care and program services. These staff may be providing services for the participant, or they may be attending to provide service information and recommendations.

*Supervisor:* Staff involved in the direct supervision of Line Staff.

*Community Resource:* Individuals or agencies outside the Department who assist people with access to medical care, housing, rental assistance, food, clothing, utilities, and other services. Include these community partners in the RSM process as appropriate.

*Navigator:* An employee of the Department, in the Navigation unit, who acts as a neutral third party in the facilitation of resource services meetings and may prepare individuals to participate in an RSM.

*Community Service Provider:* An extender of Department service delivery, for example, contractors or other providers performing services on behalf of the Department.

Department staff are responsible to identify participants who may benefit from an RSM. New participants (those seeking services) and existing participants (those currently receiving services) may qualify for a resource services meeting. The opportunity for an RSM may be identified when a participant inquires about services, applies for services, or continuing eligibility for services is determined. The opportunity for an RSM may also be identified during routine interaction between staff and existing participants. RSM members must prepare to attend and participate at the RSM by reviewing case information prior to the RSM meeting.

To qualify for an RSM, the participant or family must meet one of the following criteria:

- Planning, collaborating, communicating, and consultation between programs may benefit the participant or family.
- The dynamics of the participant's needs or service utilization history present a potential for future risk to the well-being of individuals, families, or community. The potential of higher cost of services exists if clear definition of service outcomes and services provided is not coordinated.
- The participant or family member may be potentially eligible for, or currently receiving, two or more Department-provided treatment or case management services.

#### Referring Staff's Responsibilities:

- Review the proposed RSM referral with the Program Supervisor;
- Assure that required releases have been obtained;
- Complete the *Referral Form for Navigation Services* and submit to Navigation;
- Invite the participant to the RSM;
- Notify Navigation that the participant has agreed to attend the RSM.
- Attend and participate in the RSM; and
- Identify agencies and resources that should be present at the RSM.

#### **SUPERVISOR REVIEW & REFERRAL:**

The staff member who identifies the potential for an RSM will review the proposed referral with his/her immediate supervisor. They will determine if the RSM process is the most effective route to follow in contributing to improved outcomes for the participant. If an RSM is indicated, the referring staff member will complete the referral forms and submit to Navigation.

Prior to the referral to Navigation for an RSM, the staff and supervisor will ensure that the participant understands that the RSM is a voluntary process.

***Coordinating RSM:*** The Coordinating RSM is a meeting of program staff and/or contract staff members, other organizations or providers who provide DHW services to a participant, or participating family. The purpose of the meeting is to share information, coordinate, and increase awareness of the roles and responsibilities of each program regarding services provided to the participant/family. Minutes of the RSM meeting are recorded and distributed to each member of the RSM. Additional meetings may be scheduled on a periodic basis according to ongoing or emerging need. A Coordinating RSM may also be held if the participant chooses not to attend a proposed Collaborating RSM. At any time, the participant may enter the RSM process should s/he desire involvement.

***Collaborating RSM:*** A Collaborating RSM is a participant-driven meeting facilitated by the Navigator. The purpose of the meeting is to understand the needs of the family and development of an Integrated Service Plan (ISP) that prioritizes and coordinates the multiple services that a participant and/or family is receiving or is eligible to receive.

This meeting may also address a plan for unmet needs. The participant, parents, family members, natural supports, and staff members representing programs or services are typically present at this meeting. Additional participants may include representatives of mandated services such as Probation and Parole.

### **PARTICIPANT PREPARATION:**

If the referring program has obtained the agreement of the participant to attend an RSM meeting, the Navigator will contact the participant and/or their guest(s) to ensure:

- The participant is prepared to discuss their concerns, goals, and outcomes.
- Understands their roles and responsibilities in an RSM meeting.

To assist the participant prepare for the meeting, the following information will be shared (this list is not all-inclusive and additional questions pertinent to participant preparation should be added as needed):

- Why an RSM has been scheduled.
- Who would the participant like to be present as a natural support at the RSM.
- Who will be at the RSM meeting.
- What the RSM process looks like, and what the benefits are for the participant.
- The participant's rights, choices, and role in the RSM.

### **PRE-RSM MEETINGS:** (optional)

When a Collaborative RSM has been scheduled and pre-existing internal conflicts or cross-program clarification needs have been identified or are anticipated, a Pre-RSM meeting will be scheduled and facilitated by the Navigator to prepare DHW staff to present a unified approach to the delivery of services.

### **NAVIGATOR RESPONSIBILITIES:**

Navigator responsibilities in the RSM include, but may not be limited to, the following activities:

- Assures that the participant has been through the participant preparation process;
- Disseminates the referral forms and supporting information to RSM members;
- Schedules meetings;
- Arranges room and materials;
- Prepares the RSM meeting agenda.
- Facilitates the RSM

- The role of the facilitator is to work towards the best possible outcomes for the participant; encourage collaboration by all in attendance; share expertise on resources and supports; mediate when necessary; work towards consensus in planning; and assure that decisions have been recorded. The process of building collaboration begins before the RSM meeting.
- See the appendix Resource Services Meeting Tool for a list of tools and a process outline that will help Navigators conduct the RSM meeting;
- Assures that everyone's concerns and goals are identified and articulated;
- Writes Integrated Service Plans
  - For details, please refer to the section on The Integrated Service Plan (ISP).
  - Assists the participant in choosing an Integrated Services Plan Manager from involved Department staff. See the section on Integrated Services Plan Manager (ISPM) for more details.
- Maintains a record of RSM's conducted in the region
- Tracks outcomes of RSM meetings by completing an RSM evaluation.
- Facilitates dialogue about the roles and responsibilities of each program involved. To assist the participant achieve their desired goals, the Navigator helps RSM members see what they might do better together, within the parameters of each involved program.

The Navigator is neutral and doesn't have decision making authority. If an impasse occurs the Navigator thanks everyone for their hard work on the ISP, documents the areas of agreement and disagreement, and informs the RSM that any unresolved issue(s) will be referred to the Regional Support Team. The Regional Support Team is responsible for resolving cross-program issues.

### **INTEGRATED SERVICES PLAN (ISP):**

The Integrated Services Planning process will consist of the following components:

- Participant goals
- Timelines
- Clarification of roles
- Coordination of services
- Action steps
- Reviews/Outcome Measures
- Signatures (Participant(s), DHW staff, community partners)
- Integrated Services Plan Manager (to be selected by the participant)

### **INTEGRATED SERVICES PLAN (ISP)**

See the template and instructions for the ISP (both can be accessed at the Service Integration SharePoint site).

**SELECTION OF THE INTEGRATED SERVICES PLAN MANAGER:**

AN Integrated Services Plan Manager is selected through the resource services meeting process. The ISPM may be selected by the participant, or designated by the RSM. The relationship a program staff member has with the participant or family should be considered in the selection process. For example, staff for a child protective case, or for an ACT team case, may be in the best position to assume the responsibilities outlined in the Service Integration Reference Guide.



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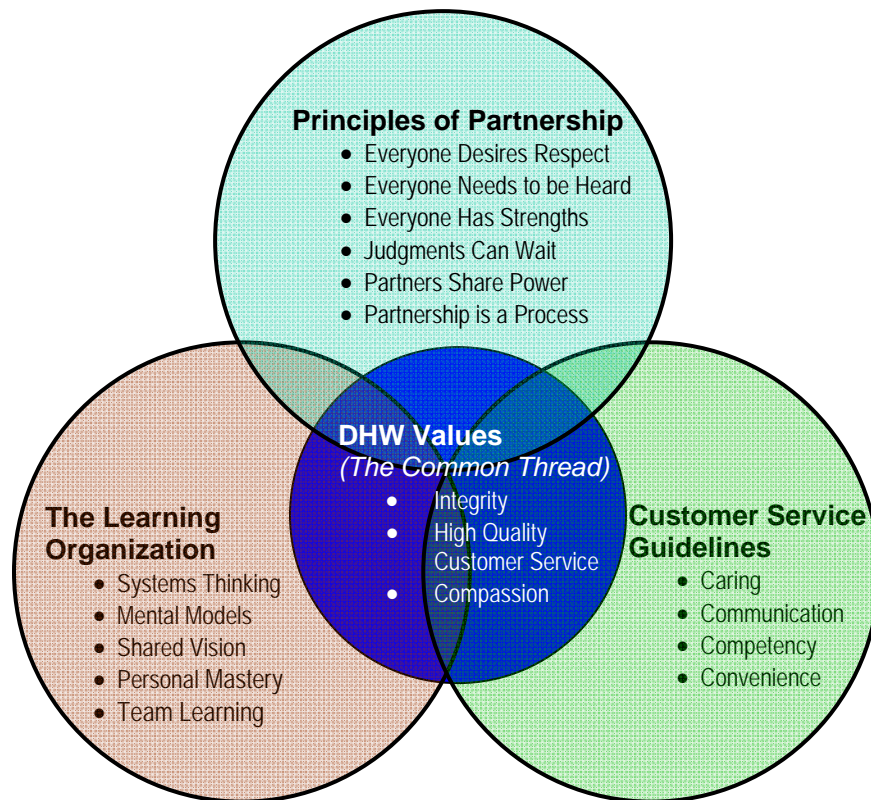
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HEALTH & WELFARE

# Department Philosophy and Standards of Performance

Prepared by Tamara Prisock  
IDHW Division of Human Resources  
Updated 15 September 2008

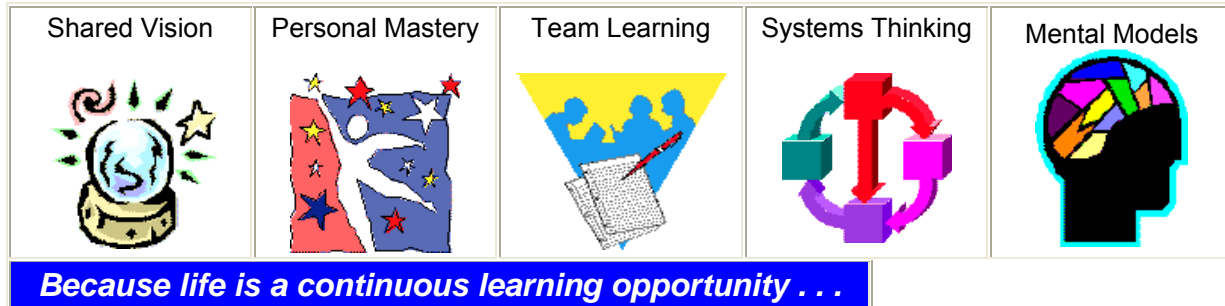
# Department Ideals and Standards of Performance



## Earlier Iterations:

- **High Performance Organization (HPO)**
- **Total Quality Management (TQM)**
- **Continuous Quality Improvement (CQI)**

Learning Organization disciplines were first introduced in the Department in 1992 as the foundation of our management philosophy and organizational culture. The Principles of Partnership and Family-Centered Practice were first implemented in the Department in the late 80's and then later revived in 2004 as part of the Department's Child Welfare Performance Improvement Plan. Family-Centered Practice was adopted as the Department's standard practice in 2004. Both sets of principles continue to be key elements of our Department's management philosophy and organizational culture.



## What is a Learning Organization?

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A Learning Organization is one skilled at creating, acquiring, and sharing knowledge; modifying behavior to reflect new knowledge and insights; and changing to meet new demands of customers.

The Learning Organization is based on a book by Peter Senge, called "The 5th Discipline." It is based on helping each other to learn and apply the "disciplines" which are tools and strategies to use as we become a Learning Organization. There are 5 disciplines.

## What Are "The Five Disciplines?"

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### Shared Vision

Building a sense of commitment in a group by developing shared images of the future we seek to create, and principles and guiding practices by which we hope to get there.

### Personal Mastery

Learning to expand our personal capacity to create results we most desire, and creating an organization which encourages all members to develop themselves toward the goals and purposes they choose.

### Team Learning

Transforming conversational and collective thinking skills, so that groups of people can reliably develop intelligence and ability greater than the sum of individual members' talents.

### Systems Thinking

A way of thinking about, and a language for describing and understanding, the forces and interrelationships that shape the behavior of a system.

### Mental Models

Reflecting upon, continually clarifying, and improving our internal pictures of the world, and seeing how they shape our actions and decisions.

## Six Principles of Partnership in Family-Centered Practice

### 1. Everyone desires respect

This principle is based on the idea that all people have worth and recognized everyone's right to self-determination, to make their own decisions about their lives. Acceptance of this principle leads one to treat clients with respect and to honor their opinions and world view. True partnership is impossible without mutual respect.

### 2. Everyone needs to be heard

This principle is based on Covey's "seek first to understand" and is accomplished primarily through empathic listening. While empathic listening looks very much like active or reflective listening, what differentiates it is the listener's motivation. Active and reflective listening are techniques that are often used to manage or manipulate someone's behavior so that the listener can advance his own agenda. Empathic listening is motivated the listener's desire to truly understand someone's point of view---to enter someone's frame of reference---without a personal agenda. When one feels heard and understood, defensiveness and resistance are unnecessary, and solutions can be sought.

### 3. Everyone has strengths

This principle recognizes that all people have many resources, past successes, abilities, talents, dreams, etc. that provide the raw material for solutions and future success. As "helpers" we become involved with people because of their problems; these problems then become a filter that obscures our ability to see strengths. Acceptance of this principle doesn't mean that one ignores or minimizes problems; it means that one works hard to identify strengths as well as problems so that the helper and the client have a more balanced, accurate, and hopeful picture.

### 4. Judgments can wait

This principle recognizes that once a judgment is made, one's tendency is to stop gathering new information or to interpret in light of the prior judgment. Therefore, since a helper's judgments can have an immense impact on a client's life, it is only fair to delay judgment as long as possible, then to hold it lightly, while remaining open to new information and willing to change one's mind. Acceptance of this principle does not mean that decisions regarding safety cannot be made quickly; it simply requires that ultimate judgments be very well considered.

### 5. Partners share power

This principle is based on the premise that power differentials create obstacles to partnership. Since society confers power upon the helper, it is the helper's responsibility to create a partnership with a client, especially those who appear hostile, resistant, etc. Clients do not owe us their cooperation: we must earn it.

### 6. Partnership is a process

This principle recognizes that each of the six principles is part of a greater whole. While each has merit on its own, all are necessary for partnership. Each principle supports and strengthens the others. In addition, this principle acknowledges that putting the principles into practice consistently is hard. Acceptance of the principles is not enough; it requires intention and attention to practice the principles.

Source: Bringing It All Back Home Study Center (2002) Partners in change: A new perspective on child protective services (curriculum). Morganton, NC Author What's Good For Families Is Good For Workers: Session One © 2004 Resources for Change, Inc.

## Service Integration, Emergency Assistance, Principles, and Learning Organization Disciplines

### Comprehension

Self Assessment after Academy Topic:

1 Low	2	3	4	5 High
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Worker Journal Notes: (Example: thoughts, experiences, perceptions, actions)

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Question for Weekly Supervision:

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Self-Rating Scale after Activities to Demonstrate Competency:

1 Low	2	3	4	5 High
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Supervisor Rating Scale:

1 Low	2	3	4	5 High
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Plan for Continuous Learning:

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Supervisor – Date of Continuous Learning Plan

**This completes the Service Integration/Emergency Assistance topic.**