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Care Coordinator/Family Partner Supervisory Coaching Tool

To develop staff to make the shift from more traditional case practice approaches to a wraparound approach it is important that supervisors employ a series of strategies that will promote and reinforce the desired change. This includes: coaching, mentoring and structured supervision.

- Coaching:
- Mentoring:
- Structured Supervision:
  - Assess comfort
  - Assess competency
  - Assess training and development needs
  - Use the wraparound process in individual and team supervision
  - Use the "phases of wraparound" document to assess where the care coordinator/family partner is in the process with the youth and family. Ascertain if they have overlooked any key steps in the process, and to ensure progress toward fidelity to the model.
  - Model and use the wraparound team process when you meet with your team
  - Conduct team based case reviews to model wraparound

1. State the employee's ***strengths*** each time you have an opportunity. This is a motivational strategy that builds confidence and comfort, and creates a climate more conducive for constructive feedback.

Always begin supervision by stating the care coordinator's strengths in a natural conversational style. This mirrors how they are to identify and state the strengths of youth and families.
"I see you are really dedicated to your families."
"I commend you for doing whatever it takes to get the job done."

Especially note and reinforce the strengths surrounding the positive change in case practice you observe. (examples)

- Increased frequency of high fidelity wraparound family team meetings;
- Increased use and inclusion of informal supports;
- Meetings held at times and locations convenient for the family;
- Camaraderie and partnership with the family partner;
- Cultural sensitivity;
- Being inclusive;
- Being flexible and responsive;
- Thinking outside the box;
- Remaining strength based and family centered amidst challenges and resistance;
- Setting incremental and attainable goals;
- Safety and transition planning
- Celebrating success

2. In the individual supervision session ask the employee what their ***vision*** is in their role as a CC/FP, for the SOC, and for their families; and/or a specific youth or family. Document their vision statement and refer to it long term.

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3. Ask the care coordinator/FP *what they need* from you, the system, and in general to achieve their goals and vision. Document their needs and follow up on the status and achievement over time. Support the staff and check in to see if their needs are being met.

4. Work with the employee to prioritize their needs. Similarly as with families, it is important to hone in on the most pressing needs first, gradually over time as the employees needs change alter the priorities and discuss the strategies that worked.

5. Discuss any barriers that may exist. This is one of the most overlooked aspects of successful care planning. You can devise a great plan but if the team does not account for barriers to achieving the plan or goals, the plan is more likely to fail. Outline with your employee the barriers that may exist that would prohibit them from having their needs met.

6. Devise a plan to meet their needs. Outline specific action steps and tasks. Use a care plan format to reinforce the process.

7. Set measurable incremental goals for the employee.
- Increasing number of Strength and Cultural discoveries
- Increasing number of FTM's
- Members attending FTM's (formal vs. informal)
- Use of community resources vs. all paid services
- Family voice, choice and inclusion
- Using a strength based approach/semantics
- Facilitation of FTM's vs. participation
- Safety planning
- Transition planning
- Increased collaboration with Family Partner

8. In case specific dialogue use role play and a sketch board to model the process for the employee. When discussing cases, walk through the wraparound process in a casual way.
So tell me about the youths strength's and vision. What are the 3 top needs the youth and family identified? What barriers or challenges exists that could prevent them from having their needs me? Are there any imminent safety needs? Reframe any deficit based language casually throughout the supervision session. Reframe service statements as need statements. i.e. "The family needs therapy" verses "the family needs to learn to manage stress and function in a healthy manner."
9. Discuss the family team process. Assess who was at the team, the plans for expanding the team and ensuring the presence of informal and community supports. Did the CC feel comfortable leading, were they assuming a lead role in facilitating or participating as a member.
10. Initially attend FTM's and provide mentoring and coaching and moral support. In cases of complex teams or cases offer to co-facilitate and model the process.
11. Discuss the role and relationship between the FP and CC.
- Ensure pre FTM time together
- Travel together to meetings when possible
- Understanding the CC/FP role and perspective is intended to be different. Both are experts.
- Open and frequent communication exists

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