

AUTISTIC SPECTRUM DISORDERS

# Best Practices in Inter-Organizational Collaboration

A How-To Manual for Organizations  
Working to Integrate Services for  
Persons with ASD and Their Families



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Developmental Services

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HOWARD G. COHEN, PhD, “Mr. Collaborator”

December 17, 1946 – March 16, 2007

*This manual is dedicated to Howard G. Cohen, PhD, a great friend and teacher. His work infuses this document. For 27 years, Howard served as the Clinical Director at Valley Mountain Regional Center where, with compassion, leadership, and an undying collaborative spirit, he led teams to provide exceptional services to consumers with developmental disabilities.*





# Contents

Preface	1
How This Manual Is Organized	2
Introduction: What Is Collaboration?	5
Section I: Steps to Organize a Collaboration	9
Step One: Decide Why to Collaborate	10
Step Two: Recruit and Convene Stakeholders	11
Step Three: Define Vision and Desired Outcomes	14
Step Four: Establish Policies to Guide the Collaboration	16
Step Five: Monitor Success	18
Section II: How to Ensure Success: Ten Best Practices	19
Ten Best Practices	20
Section III: What Successful Collaboration Looks Like	23
Case Study One: Autism Connection	25
Case Study Two: Autism Community Team (ACT)	29
Case Study Three: Collaboration Between Regional Center of Orange County and CalOptima, a Managed Care Organization	33
Case Study Four: The Anchor Project	37
Case Study Five: Lanterman/UCLA Neuropsychiatric Institute Specialty Clinic	41
Appendixes	45
Appendix 1: Elements of Cooperation, Coordination, and Collaboration	47
Appendix 2: Sample Ground Rules	48
Appendix 3: Visioning Activity	50
Appendix 4: Collaboration Action Plan	51
Appendix 5: Evaluation of Best Practices	52
Appendix 6: Evaluation Questions	54
Bibliography	57
Acknowledgments	61
For Help in Developing Best Practices	61
For Help in Developing Case Studies	63
For Help in Developing the Manual	64



# Preface

Over the past five years, the California Department of Developmental Services (DDS) has developed several documents to improve care for persons with autistic spectrum disorders (ASD) and their families. In 2002, DDS released *Autistic Spectrum Disorders: Best Practice Guidelines for Screening, Diagnosis and Assessment*. In 2008, DDS expects to release a new document: *ASD Guidelines for Effective Interventions*. This manual, *Autistic Spectrum Disorders: Best Practices in Inter-Organizational Collaboration*, is intended to complement these publications.

The need for this manual is significant. For families and professionals confronting issues related to ASD, the increasing number of cases is troubling. A recent study from the Centers for Disease Control and Prevention estimates that 1 of every 150 children has an ASD. To improve functioning for many of these children requires coordinated and integrated services among many organizations and interested individuals. To reach this goal diverse stakeholders must pool their resources and problem solve collectively — in short, it requires collaboration.

*Autistic Spectrum Disorders: Best Practices in Inter-Organizational Collaboration* provides information and tools that interested persons can use to strengthen their skills in collaboration. This manual contains input from more than sixty individuals who participated as focus group members, reviewers, and consultants. Contributors include experts in collaboration, regional center and school district personnel, and key members of successful collaboratives in which regional center personnel had a leadership role. As a result of this input and a review of relevant literature, “Ten Best Practices” are presented as a helpful resource as you consider the “best” ways to “practice” collaborative actions. Some may use the best practices as a guide in the development of a new collaborative. Others may use the material to improve an existing collaborative. In this way the manual will serve to improve collaboration among organizations serving persons with developmental disabilities, and in doing so, enhance the lives of the families and individuals who live with ASD.

**Julia Mullen, PhD**

DEPUTY DIRECTOR

Department of  
Developmental Services  
March 2008




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*“Collaboration has become a new buzz word and a new way of interacting — generating a mix of reactions from professionals and the public alike.”*

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## How This Manual Is Organized

This manual is designed to assist you in your work to integrate and streamline services for persons with autistic spectrum disorders (ASD) and their families. Collaboration has become a new buzz word and a new way of interacting — generating a mix of reactions from professionals and the public alike. Like many others in California, you may have participated in several different models of collaboration that are emerging across the state. These models include strategic alliances and partnerships of two or three stakeholders, coalitions of five or more stakeholders, and community-wide efforts that engage numerous organizations as well as the public. And, like many, your rating of the quality of these experiences may be mixed.

This manual will probably not be the first you have seen on the topic of collaboration, nor will it solve all of the issues you face when working to improve services. But it is a tool developed specifically for those of you working in this field, and it will offer many solutions, ideas, and examples to support and enhance your efforts. The manual has three major sections. Each section provides practical advice on how collaborating partners can build success factors into their projects.

## SECTION I

Following an introduction that defines collaboration, the first part of the manual describes the five steps to organize a collaboration. Although no two collaborations will progress in exactly the same way, the five-step sequence is typical of many collaborations. It answers the question, “What actions should I take?”

## SECTION II

Simply following the steps to organize a collaborative will not necessarily result in a *successful* collaboration. Numerous characteristics, collectively, contribute to the quality of the collaborative effort. These characteristics constitute the “best” way to “practice” collaborative action — or best practices for successful collaborations. The second part of this manual highlights ten best practices.

## SECTION III

The third part of the manual offers readers a solid glimpse of successful collaborations. Five case studies describe different models and stages of collaboration.

These case studies are intended to inspire you either to begin or continue your work. They will heighten your awareness of successful methods and strategies as they detail the “how-to’s” of initiating, maintaining, and evaluating efforts to improve services. Importantly, although all of the collaboratives showcased as case studies have devoted attention to many of the ten best practices, several success factors are highlighted to translate best practice theory into everyday practice.

In addition to the three major parts of the document, the manual includes several resources on collaboration for your use. The appendix includes six tools for use in organizing a collaborative and the bibliography points you to several important documents on collaboration and related issues.



## INTRODUCTION:

## What Is Collaboration?

The term collaboration is overused and underappreciated. Research demonstrates that collaboration among agencies and organizations offers an important mechanism to meet multiple needs of families (Bruner, Knuth, Kunes, p. 14). This discussion of collaboration is intended to assist you in your work to improve services for persons with autistic spectrum disorders (ASD) and their families. The manual goes further than just telling you how to establish a collaborative; it tells you how to establish a *successful* collaborative.

### Working Definition of Collaboration

Collaboration has many definitions. In popular use, collaboration refers to people working together to achieve a goal. It is commonly used interchangeably with the terms “cooperation” and “coordination.” In this manual, however, collaboration is more narrowly defined and is distinguished from those terms.

Collaborations are organizational and inter-organizational structures where resources, power, and authority are shared and where people are brought together to achieve common goals that could not be accomplished by a single individual or organization independently (Bruner, p. 22).

Implicit in this definition, both cooperation and coordination often occur as part of the process of collaborating. “Cooperation” is generally characterized by *informal* relationships; whereas, “coordination” refers to *formal* institutionalized relationships among existing networks of organizations (Gray, p. 15). Appendix 1 contains a table that describes and distinguishes the essential elements of cooperation, coordination, and collaboration.




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*“Collaborations are organizational and inter-organizational structures where resources, power, and authority are shared and where people are brought together to achieve common goals that could not be accomplished by a single individual or organization independently.”*

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*“Collaboration changes the way organizations work.”*

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Once initiated, collaboration creates a structure within which participants can seek consensus about the problem and create mutually agreeable solutions. When collaboration is successful, new solutions emerge that no single party could have envisioned.

Collaboration changes the way organizations work. With collaboration, there is less competition and more consensus; less working alone and more inclusion of others; less thinking about activities, services, and programs and more thinking about larger results and strategies (Ray and Winer, p. 24). Collaboration is likely to be time consuming, as collaborators must learn about each other’s roles and responsibilities, as well as explain their own. Collaborators must also acquire expertise in the process of group goal setting and decision sharing, which may not be part of their day-to-day work.

One important variable that affects *interagency* collaboration is the set of governing policies that each agency brings to the table. These policies include: federal and state rules and regulations; guidelines and definitions that establish the agency’s institutional mandate; target population and eligibility requirements; budgets and programmatic reporting cycles; and methods of evaluation, among others (Blank, p. 26). Partners committed to shared goals can often overcome the barriers that differences in policy and organizational culture create.

### Opportunities for Collaboration

Many situations provide opportunities for collaboration. Often these situations can be thought of either as resolving conflict or advancing shared visions (Gray, p. 8).

## Resolving Conflict

Collaboration can transform adversarial interaction into joint problem-solving efforts. Parties in conflict are motivated to try collaboration when other approaches have reached an impasse. However, parties will try collaboration only if they believe they have something to gain from it.

## Advancing Shared Visions

Successfully advancing a shared vision requires identification and coordination of a diverse set of stakeholders, each of whom holds some, but not all, of the parts of the vision to address the issue or concern. As the initiators of the collaborative convene, they agree to the purpose of the collaborative and create its shared vision (see Step One, p. 10).

## Why Collaborate?

Interagency and inter-organizational collaboration (on behalf of persons with ASD and their families) can represent an important effort to restructure services to be more responsive to the needs of consumers. This involves new relationships between and among service providers and consumers. Collaborations have the potential to:

- Solve problems in creative ways — ways that lie beyond the scope of any single organization.
- Address economic realities of stakeholders, since collaboratives have the ability to share resources.
- Prevent escalation of conflict.
- Create services that are more accessible and effective and that meet the changing needs of the consumer.
- Achieve greater credibility than actions by a single entity can achieve.
- Address concerns by reducing duplication of efforts and services.
- Discourage fragmentation.
- Create sustained change.
- Focus on improved outcomes.
- Provide for continuity in the delivery of services and support.
- Build in guarantees that protect each party's interests.

Adapted from Center for Collaborative Planning, *Collaboration: Concepts to Consider*; Bruner, 2005, p. 7; Mattessich, p. 3; Gray, p. 110.




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*“Collaboration is a tool to achieve a desired result.”*

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## How to Decide Whether to Join a Collaborative

Collaboration is a tool to achieve a desired result. When considering whether or not to collaborate, interested organizations seek to identify common interests and to be assured that each organization has something to gain from the process. Several questions facilitate making the decision to join or not join a collaborative (adapted from Bruner, p. 8):

- Is the result I want to achieve beyond my organization’s ability to achieve by acting alone?
- Are there other organizations that desire similar results?
- Will this collaboration also help other organizations achieve the results they want?
- Do I have the time required to develop a collaborative relationship with other organizations?
- Do I have the support of my organization’s management to participate fully in a collaborative?




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*“The quality of leadership of a collaborative greatly influences the collaborative’s process.”*

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## A Few Words about Leadership

The quality of leadership of a collaborative greatly influences the collaborative’s process (Blank, p. 25). Effective leaders press each side to understand their partner’s point of view and the way they perceive the issues and problems at hand. Leaders generate alternative solutions and pursue those that constitute common ground. This manual mentions several types of leaders — initiator, champion, and facilitator. Importantly, Robert Greenleaf argues that nurturing leadership in others is as essential to the prudent exercise of leadership as leading itself (Blank, p. 26).

## SECTION I:

## Steps to Organize a Collaboration

Collaboration begins by bringing people together — perhaps a few people, perhaps many. No two collaborations will progress in exactly the same way. Some collaboratives convene and disband over a short time period. Others may continue for years. Although the steps to develop a collaborative vary, the following five-step sequence is typical of many successful collaborations.

- Step One: Decide Why to Collaborate
- Step Two: Recruit and Convene Stakeholders
- Step Three: Define Vision and Desired Outcomes
- Step Four: Establish Policies to Guide the Collaboration
- Step Five: Monitor Success

In a collaborative, people are called upon to take an active problem-solving role. They do so in ways that are extremely flexible. The same person may play different roles at different points in the collaborative building process. Literature on the steps to organizing collaboration makes reference to several roles: initiator, champion, facilitator, and stakeholder.



*“No two collaborations will progress in exactly the same way.”*

### Various Roles of Members of Collaboratives

- The *initiator*'s role is to assess the likelihood of a collaborative achieving resolution of the issue under consideration. The initiator identifies essential collaborative members and plans for the first organizational meeting. The initiator is one of the collaborative's leaders.
- A *champion* is also a leader — a leader who is passionate about the collaborative's issue and has the energy to drive the process of collaboration. Champions generate followers. The importance of the champion's role cannot be over-emphasized (Community Tool Box, p. 1). Also referred to in literature as an “organization driver,” a champion is critical to successful collaboration. Many initiators are also champions.
- The *facilitator* works to help the group increase its effectiveness by improving its process and constantly working toward building consensus. The facilitator can be a member of the collaborative; often, the initiator or champion will assume this role. Alternatively, the facilitator can come from outside the collaborative and function as a neutral third party who focuses only on group process.
- A *stakeholder* is an individual, group, or organization directly influenced by actions others take to solve the problem being addressed by the collaborative.



*“Organizing a collaborative requires creativity, tenacity, focus, vision, and the capacity to negotiate and persuade.”*

## Step One: Decide Why to Collaborate

Collaborations usually begin with one or more *initiators* who see collaboration as a process to achieve a solution they have in mind — whether the proposed solution is in response to a conflict or based on a desire to improve services and/or programs. Organizing a collaborative requires creativity, tenacity, focus, vision, and the capacity to negotiate and persuade (Partners in Policymaking, p. 1). The initiator reaches out to others, explains the rationale for forming a collaborative, and engages others to work together to define the *purpose* of the collaboration. Purpose refers to the reasons for the development of a collaborative — the result the group seeks and the specific tasks or project the group will undertake.

Getting agreement on the purpose of a proposed collaboration involves finding some overlap in how the parties define the major issues of concern. Getting parties to the table is often accomplished by emphasizing mutual gains and heightening the parties’ awareness of the forces that join them.

Once this small group of initiators agrees on the purpose of the collaboration, the group often makes some preliminary decisions regarding the scope and parameters of the effort. The initiators could also discuss who else in the community should be formally included in the process as a stakeholder, which is further discussed in Step Two.

Throughout this process it is helpful for the initiators to have tolerance for ambiguity as the purpose of the collaborative is articulated and agreed to by the group.

### Recruiting Collaborative Team Participants

Start with those genuinely interested even if the team is small. As the team has successes others will likely want to join.

Research shows that task-oriented teams function best with between 5 and 9 members, 12 maximum.

Reprinted from *The Collaborative Planning Project*, 2001, p. 3. Permission to publish given.

## Step Two: Recruit and Convene Stakeholders

Once the initiators agree on the purpose of the collaborative, they identify potential participants to be members of the collaborative — others interested in the problem at hand. Those participants are termed “stakeholders” and include all individuals, groups, or organizations that are directly influenced by actions others take to solve the problem. Each stakeholder has a unique appreciation of the problem. In his book, *How to Make Collaboration Work*, David Straus identifies four types of stakeholders (Straus, p. 40):

- Those with the formal power to make a decision.
- Those with the power to block a decision.
- Those affected by a decision.
- Those with relevant information or expertise.

Effective collaborations include stakeholders representing different types of expertise — system leadership, technical expertise, and day-to-day leadership — and it is useful for all three areas to be represented. One or more individuals on the team may have expertise in one of the areas, or a single individual may have expertise in more than one of the three areas.

### Who to Involve

In general, the power of a collaborative comes from inclusion, not exclusion. Stakeholders should represent an appropriate cross-section of each community segment that will be affected by the collaborative’s activities. “It’s far more powerful to have someone inside the tent than outside. The long-term payoff is immeasurable.” (Straus, p. 8). At the same time, the cross-section of members cannot be so broad or the number so great that the collaborative process is unmanageable.

When identifying potential collaborative members, initiators tend to choose people based on who they know, the connections the potential stakeholders might have, or the resources to which those potential members have access. Ray and Winer in their book, *Collaboration Handbook*, suggest other criteria may also be helpful and recommend the following as criteria for membership: persons with special relationships outside the collaboration that can affect the work of the collaborative; persons with a history of positive working relationships; and persons who have an ability to attract others to the collaborative because of their position in the community, such as famous personalities (Ray and Winer, pp. 48–49).




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*“Effective collaborations include stakeholders representing different types of expertise — system leadership, technical expertise, and day-to-day leadership — and it is useful for all three areas to be represented.”*

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## Facilitating Effective Meetings

### ROLE OF FACILITATOR

Most collaborative processes involve face-to-face meetings, and the effectiveness of these meetings is critical to the success of the collaborative effort. The effectiveness of a meeting depends on how well “process issues” are handled — procedural concerns of running a successful meeting such as developing the agenda, deciding how to handle conflict, and ensuring that everyone has a chance to speak.

In his book, *How to Make Collaboration Work*, David Straus recommends the use of an independent facilitator — someone from outside the collaborative—to deal with these process issues (Straus, p. 107). There are a variety of ways to use facilitators; however, most agree that a facilitator acts as a neutral third party who focuses on the process to make the group powerful enough to accomplish its designated outcomes and desired results.

Members of the collaborative can also assume the role of facilitator. Often, collaborative leaders — initiators or champions — act as facilitators. This model is referred to as “facilitative leadership,” in which the leader serves mainly as the facilitator of the process (Cruikshank, p. 34). The Policy Consensus Institute has assembled a series of articles offering practical advice for leaders in their role as facilitators (*Resources for Leaders and Convenors*, p. 1).

## How to Involve Stakeholders

Once the potential stakeholder members have been identified, someone from the initiating group can contact the individual either directly — if the initiator knows the potential member — or indirectly through someone else who knows the individual. The Collaborative Planning Project at the University of Colorado at Denver suggests that a personal meeting or a phone call increases the likelihood of involvement (Broudy, p. 5).

Regardless of your approach, as you plan to contact potential stakeholders, you may want to prepare a list of “talking points” that summarize the information you intend to convey about involvement in the collaboration, for example:

- Why the collaboration is important.
- Benefits to the participating organizations.
- Commitments expected of each organization.
- Date and time for first meeting and overall time commitment.

## The Initial Stakeholder Meeting

### THE MEETING STRUCTURE

As you plan for the first meeting, keep the purpose in mind: to help the collaborative team get organized. Agenda planning is one of the most powerful tools for ensuring the success of a meeting in which collaborative problem solving will take place. To develop an agenda, the facilitator and/or the designated meeting organizer must understand the desired outcomes. An effective agenda:

- Clearly states desired outcomes and meeting content.
- Identifies stakeholders who are participating in the meeting.
- Clarifies the decision-making process.
- Covers the logistics of location, time, and background materials for the meeting.

In addition to agenda planning, you will want to pay attention to other basic standards for effective meetings. For example, meetings should have minutes summarizing discussions and decisions. Minutes should include specific next steps for follow through by team members (Broudy, pp.10–12). Further, plan to incorporate into the meeting a process for participants to develop ground rules for the collaborative's operation. Appendix 2 includes an example of ground rules.

### THE MEETING PROCESS

Collaborative leaders should work together to plan a meeting that is friendly, efficient, and effective. To build trust at the beginning of an effort, collaborating participants should devote energy to learning about each other.

Whether the facilitator is a member of the collaborative or has been selected from outside the collaborative to assist with group process, the facilitator's role will include encouraging everyone to participate in the meeting. In addition, the facilitator will guide collaborative participants to establish a communication process that grants permission to disagree and uses conflict resolution as a constructive means of moving forward.

Consensus building is fundamental to collaboration. However, it is only one type of decision making used by collaboratives. Other types of decision making include: decisions made by straw polling; and decisions made by delegating the responsibility to small groups, committees, or an individual (Center for Collaborative Planning, *Collaborative Decision-Making*, p. 2).

Facilitators should build consensus slowly, and collaborators should clarify a fallback decision-making process in the event that members cannot reach consensus (Straus, p. 104).



*“Consensus building is  
fundamental to collaboration.”*

## Step Three: Define Vision and Desired Outcomes

A vision articulates a broad sense of the collaborative's common purpose. It establishes the arena in which the collaborative wants to work. It is helpful to link the vision to desired outcomes.

### Write a Vision Statement

Work with your collaborative team to write a vision statement. A vision is a compelling statement of what collaborative members want to create. A shared vision is responsive to participating agencies and organizations, but it transcends individual concerns and focuses on the common goals on which all members are united. A vision focuses on possibilities, not on problems.

Whether the vision exists at the outset of the collaborative's development or whether stakeholders develop a vision as they work together, creating a vision is a critical early step that establishes an effective structure to support collaboration. Successful collaborating partners have the same vision — with clearly agreed upon mission, objectives, and strategy. The vision may motivate collaborating partners to resolve conflicts and work persistently toward common goals.

The Healthcare Forum's publication *Best Practices in Collaboration to Improve Health* suggests that prior to beginning the discussion about vision, participants interview each other and ask each other questions about what motivates their involvement in the collaborative and what they want to accomplish through their involvement. Using the words and phrases from these interviews can assist in drafting the vision statement.

Appendix 3 includes an example of a visioning activity.

### Creating Your Vision

Target the scope of your vision depending on the developmental stage and interests of the team. Research shows it is preferable to “think big and start small.”

Reprinted from *The Collaborative Planning Project*, 2001, p. 13. Permission to publish given.

## Agree on Desired Outcomes and Develop Action Plans

Once the vision statement has been developed and agreed to, move the collaborative team to a discussion of “desired outcomes” and the development of a specific action plan with which to guide the activities of the collaborative.

“Desired outcomes” is a declaration of the accomplishments the participants must achieve to realize the vision. Desired outcomes are concrete, attainable, and measurable. Desired outcomes answer the following questions:

- How will we know when we have achieved our vision?
- What will happen?
- What will be created?
- What will change?

To realize the vision and desired outcomes, the collaborative team must develop an action plan. A variety of formats exist for developing action plans, many of which have emerged from strategic and organizational planning literature and experiences. Appendix 4 provides an example of this action plan format.

Review your action plans regularly to guide the team’s activities and to keep to them on track. Make efforts to maintain focus on the desired outcomes as collaborative initiatives can easily bog down in the difficulty of day-to-day operations and disagreements, and cause members to lose sight of goals and interest in continued participation in the collaborative.

Develop a plan for termination of the collaborative once the desired outcomes have been achieved. As the group evaluates its effectiveness, consider whether or not the benefits from the team’s continued existence are sufficient to justify its continuation. If not, celebrate accomplishments and bring the team to an end.



*“Make efforts to maintain focus on the desired outcomes.”*




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*“Members of a collaborative are also members of the organization they represent in the collaborative, or their ‘parent’ organization.”*

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## Step Four: Establish Policies to Guide the Collaborative

Concurrent with the development of action plans, several final steps regarding process are important.

### **Confirm Commitment of Collaborative Parent Organizations**

Members of a collaborative are also members of the organization they represent in the collaborative, or their “parent” organization. Each member of the collaborative obtains approval to act on behalf of his or her parent organization. Sometimes this approval is in the form of a “letter of commitment” from the parent organization to the collaborative. These letters might include the organization’s commitment to the mission of the collaboration; what the organization expects in return for its participation; how much time the organization’s representative(s) may commit to the collaboration; and the authority of the representative to act for the collaboration.

Throughout the process of organizing a collaborative, members are encouraged to report regularly to their parent organization on the process and planning of the collaborative.

### **Form a Structure**

Successful collaborations organize themselves as efficiently as possible. They develop methods to organize the way people exchange information, make decisions, and allocate resources. Two structures are popular: in one, *all* of the participants gather together to make the necessary decisions; in another model, one or more small groups take independent actions to further the collaborative’s goals — functioning much like committees or task forces — while another group has the responsibility to coordinate information and activities among the independently operating groups, functioning like an executive or oversight committee.

## Create Policies Regarding Conflict

Conflict is to be expected throughout the life of the collaboration. Conflict may be related to power struggles, low trust, vague vision, or lack of clear authority, to mention just a few sources. Addressing conflict requires that the group decide *who* will facilitate the process to resolve the conflict and *what* the process will be. Some groups use the assistance of an outside neutral party with conflict resolution or mediation skills when impartiality is essential to the process. And, since participants must continue working together during and after the conflict, they must agree to ongoing processes to promote trust and mutual understanding.

## Hire Staff

Participants must decide whether or not to hire staff. Staff could be used to fulfill routine administrative functions, such as sending out notices about meeting dates, arranging for meeting rooms, and disseminating minutes. In addition, some collaboratives hire professional or facilitative staff such as consultants skilled in collaboration and group process. Most collaboratives are staffed voluntarily, although this can be difficult to sustain.

## Identify Sustainable Resources

Collaborations have two types of resources: operating and project. Resources can be dollars, staff, technology, training, information, and/or contacts. Members can pool or exchange the resources they contribute. Resource exchange can have a profound effect on collaboration.

Sustainability is critical to the success of collaborations. Structural and operational mechanisms are necessary to build capacity to support the effort over time. Participants must incorporate collaborative objectives into their own institutional mandates and budgets and earmark the permanent flow of adequate resources to keep joint efforts going.

## Develop a Communication Plan

Clear communication holds collaboratives together and supports the members. Open communication builds mutual respect, understanding, and trust. Interpersonal communication relies on informal person-to-person interaction with an emphasis on listening. Formal and inter-organization communication relies on systems to ensure all members are informed — specifically, to identify who receives what types of communications and who is responsible to make sure two-way communication happens.



*“Clear communication holds collaboratives together and supports the members.”*




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*“A collaboration must hold itself and the organizations it represents accountable for meeting goals.”*

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## Step Five: Monitor Success

How will you know whether or not your collaboration is successful?

A collaboration must hold itself and the organizations it represents accountable for meeting goals. Successful collaborations are evaluated in at least three ways. On one level, a collaboration may be evaluated in terms of its ability to improve outcomes. On another level, evaluation strategies should include ongoing mechanisms to track and report on the implementation of collaborative action steps. This helps the team recognize whether it is implementing the action steps as planned and whether those activities are having the “desired outcomes.” In addition to evaluating outcomes and action steps, a successful collaborative also evaluates itself — including the operational structure and team member relationships and involvement.

### Encourage Full Participation

Throughout the evaluation process, collaborative leaders should encourage all members of the collaborative to participate. Ray and Winer identify several questions to facilitate evaluation (Ray and Winer, p. 109). At regular intervals, leaders can ask all members to discuss:

- Whether the effort is effective.
- Whether the effort is adequate.
- Whether the effort is efficient.
- What lessons they have learned.

Members of the collaborative must see the evaluation information as useful to improving and sustaining the collaborative. Based on the findings, the group may revise desired outcomes and action steps. In addition, successful collaboratives provide feedback on the results of the evaluation to all members of the collaborative and their parent organizations.

Collaborative evaluation is a newly emerging field, and the availability of evaluation tools is increasing. Appendixes 5 and 6 contain a list of questions that collaboratives can use to review the team’s priorities, assess membership involvement, and evaluate the outcomes and impact of team activities.




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*“Successful collaboratives celebrate their progress.”*

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### Celebrate Progress

Successful collaboratives celebrate their progress. Celebrations offer an opportunity to acknowledge all collaborative members, to reward active members, and to thank those who may be leaving the collaborative. A collaborative need not wait to reach significant milestones to celebrate: celebrating short-term successes with publicity or awards is a useful tool to keep collaboratives vital.

## SECTION II:

## How to Ensure Success: Ten Best Practices

A successful collaboration is a process to achieve an outcome. Simply following the steps to organize a collaborative (see Section I) will not necessarily result in a *successful* collaboration. A truly successful collaboration involves numerous qualitative characteristics that, together, constitute the “best” way to “practice” collaborative action — or best practices for successful collaborations.

Are some factors more important and some less important? Can a collaborative succeed if it has most, but not all, of the factors? There are no simple answers to these questions. Yet the research reported in literature and the experts agree that nurturing the collaborative spirit in all participants deserves careful attention.

Experts also agree that the process of collaboration and the resulting outcomes will occur if organizational leaders and staff members believe that collaboration is not only important but *essential*. Collaboration requires a different attitude and perspective beyond how organizations mutually plan, provide, and evaluate services. It requires powerful commitments within the system and the individuals. Further, the interpersonal, problem-solving skills required in collaboration will be skills many collaborators have not previously used in their work, so make sure to build training and support into the collaborative process.

The following quick-reference matrix shows the ten best practices for successful collaboratives.




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*“Nurturing the collaborative spirit in all participants deserves careful attention.”*

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*“Collaboration requires a different attitude and perspective beyond how organizations mutually plan, provide, and evaluate services. It requires powerful commitments within the system and the individuals.”*

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## TEN BEST PRACTICES

# Successful Collaboratives...

1

*Have a Clear Purpose.*

People need a reason to participate in the process. A common understanding of the issues supports the development of a clear purpose for the group.

2

*Invite All Appropriate Interested Parties to Participate in the Collaborative.*

Ensure that all members of the collaborative have an interest in the issue and come to the table in good faith, committed to full participation — which includes sticking with the effort until the issues are resolved. Encourage participants to commit to respectful conversation and accept diverse values and interests. Early on, encourage stakeholders to acknowledge where the past has created distrust and to commit to going beyond it. Encourage stakeholders to obtain the executive support of their agency or organization so that they can implement the group's decisions. And make sure participants agree to communication processes that ensure their accountability to the constituencies they represent.

3

*Support the Activities and Passion of the Champions.*

Collaboratives thrive when top-level leaders of the participating organizations champion achievement of the collaborative's goals by being visibly involved and encouraging collaborative practices. True champions tend to be individuals who are passionate about the collaborative's purpose and goals — people who by virtue of their own passion and commitment will not rest until the collaborative successfully achieves its goals. Look for the impassioned champions among the leaders in your collaborative, and be ready to follow their lead.

4

*Share Leadership and Responsibility for Attaining Goals.*

Recruit leaders with skills to build trust and organize. Make sure the group has at least one participant, and preferably more, with skills to facilitate joint problem solving and shared decision making.

5

*Develop Policies and Procedures in Support of the Collaborative.*

Let the collaborative design the organizational structure and related policies and procedures. Embrace group processes such as consensus building, shared decision making and conflict resolution. Importantly, make sure the decision-making process is clear — agreement on the process ensures that all participants accept how the group will operate. Further, it empowers stakeholders to take charge and make decisions.





Make sure participants understand the needs, concerns, and aspirations of all other members of the group. From this understanding, groups will develop creative solutions that address the needs of many, not just a few. Mutually agreed-upon information is a powerful tool, and clear information is a keystone of success. Therefore, throughout the process, make sure that all information is equally available to all participants. Develop communication systems to support implementation of decisions made by the group, and continuously document agreements. Balance short- and long-term actions that members of the collaborative can actively support.

*Create Workable Solutions and Implement Them.*

6

Make sure you have the funding, staff time, physical space, contacts, and other necessary resources to gather information on which to base collaborative decisions and to implement work plans. Pool resources for long-term activities that are managed by the collaborative structure. Share resources among members of the collaborative, as appropriate.

*Ensure Adequate Resources.*

7

Acknowledge that the process of collaboration does not happen overnight. Allow the process of collaboration to evolve. Be patient.

*Take Time.*

8

On the surface, collaboration is about bringing together *resources* to work toward a common purpose. However, it is collaborative *relationships* that make collaboratives work — relationships based on openness, trust, and an understanding that complex issues require a common vision, joint activities, and a commitment to resolving the issues.

*Foster a Collaborative Spirit.*

9

Collaboration is a *process* to achieve an *outcome*. Often, just being engaged in the process of moving closer to your goal is important progress — even if you haven't achieved your goal yet. Regularly share and celebrate that progress by acknowledging incremental successes and contributions by all stakeholders and by building on your successes.

*Do Something, Celebrate, Do Something Else, and Celebrate Again.*

10



## SECTION III:

## What Successful Collaboration Looks Like

### Five Case Studies

The process to select the case studies for inclusion in this manual focused on California's 21 nonprofit regional centers. Regional centers are part of the State of California's commitment to provide services and support to individuals with developmental disabilities throughout their lifetime. The centers have offices throughout California and serve as a local resource to help find and access the services and support systems available to individuals with developmental disabilities and their families.

Since regional center staff and consumers are primary audiences for the manual, staff from the California Department of Developmental Services (DDS) requested nominations of successful collaboratives from regional center clinical directors. The response to this call for nominations was impressive. The final case study selections were made based on the following criteria: region of California represented; model of collaboration; stage in the collaborative process; issues addressed by collaboration; performance; and the best practices illustrated by the collaborative. DDS staff picked five different efforts. The manual includes case studies of the following collaboratives:

- Autism Connection — Valley Mountain Regional Center
- Autism Community Team (ACT) — North Bay Regional Center
- Regional Center of Orange County and CalOptima
- The Anchor Project — Golden Gate Regional Center
- Frank D. Lanterman Regional Center and UCLA Neuropsychiatric Institute

Members of each collaborative reviewed their own case study for accuracy. The members felt strongly that their collaborations demonstrated many, if not all, of the ten best practices presented in this manual. Consequently, comments about best practices in each case study bring the ten best practices to life.



# Autism Connection



## A S N A P S H O T

**Goal:** To establish a broad-based coalition of key stakeholders to develop, plan, and monitor programs for children with ASD in the Central Valley of California.

**Catalyst:** In 1990, three families from the Central Valley, staff from Valley Mountain Regional Center (VMRC), and a private practice behavior analyst attended a lecture on a research-based, intensive, in-home treatment program for ASD designed by O. Ivar Lovaas from the University of California, Los Angeles (UCLA). As a result, these families began working closely with the behavior analyst and VMRC staff to gain access to a similar program in the Central Valley. At the same time, many school-related professionals were growing weary of the emotional and fiscal costs of fair hearings that challenged decisions regarding treatment. The environment was conducive to large-scale change.

**Results:** Over the past decade, Autism Connection has:

- Developed a range of programs for ASD in the Central Valley including in-home programs modeled after the Lovaas model.
- Facilitated the development of a core group of highly trained, well-supervised professional staff who provide services at the research and clinical replication site of the UCLA Young Autism Project (YAP). (Today, Central Valley Autism Project, Inc., a private company, is the replication site.)
- Established autism clinics to provide screening and diagnosis of ASD and link families with other families who provide support and guidance throughout the program planning process.
- Developed an operational structure — the collaborative — to discuss program planning needs of children with ASD in the region and assure ongoing communication and policy formulation in support of services.
- Implemented a policy of “shared responsibility” in which schools and the regional center share expenses, administrative functions, and program administration for intervention services.



**Issue:** Parents and providers of services to young children with autistic spectrum disorders (ASD) are often frustrated by obstacles to accessing effective interventions for their children and/or unavailability of services. These frustrations translate into strained communication — even conflict and/or litigation — and parents working in isolation.



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*“In the late 1980s research suggested that early intensive behavioral interventions could improve functioning for many children with ASD; therefore, parental demand for these services began to accelerate.”*

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## B A C K G R O U N D

The convergence of several forces and strong leadership resulted in the development of Autism Connection:

- **Parent Advocacy.** Growth of parent advocacy groups — both in the number and size of the groups and their ability to influence policy.
- **Interested Behavior Analyst.** The willingness of a San Joaquin Valley behavior analyst to be educated regarding core competencies that were central to Lovaas’ Young Autism Project (YAP) and her success in replicating the model with a small group of children.
- **Committed Regional Center.** The willingness of Valley Mountain Regional Center to support the work of the behavior analyst, which led to the creation of a research and clinical replication site of the Young Autism Project in 1994.
- **Conflict.** The emotional and financial impact of several fair hearing processes on Special Education Local Planning Area (SELPA) directors and VMRC staff.
- **SELPA Leadership.** The willingness of several Special Education Local Planning Area (SELPA) directors and VMRC to investigate co-funding the new home-centered YAP model (Central Valley Autism Project, Inc.).

In the late 1980s research suggested that early intensive behavioral interventions could improve functioning for many children with ASD; therefore, parental demand for these services began to accelerate.

At that same time, several Central Valley families learned about the research-based early intensive behavioral intervention program — the Young Autism Project (YAP) — designed by a UCLA professor and researcher, Dr. O. I. Lovaas. The Central Valley had no specialized early educational programs at the time for children with ASD, yet, Lovaas’ program promised improvement for some children with ASD. As a result a group of parents got together with a local behavior analyst and staff of Valley Mountain Regional Center and hired a YAP consultant to conduct a workshop for them. Based on this training, they subsequently began to provide the program to their children. Little by little the informal network of parents seeking improved and expanded services for their children grew. Gradually, through persuasion and litigation, a few parents received support for enrolling their children in the intensive in-home treatment program with Central Valley Autism Project, Inc. At the same time, the informal parent network developed into a formal advocacy group, Central Valley Families for Effective Autism Treatment (FEAT).





Throughout this process, the late Dr. Howard Cohen, Clinical Director of Valley Mountain Regional Center (VMRC), gathered information on YAP and met with Dr. Lovaas. These activities were instrumental in Dr. Cohen's decision to support the fledgling efforts of the behavior analyst and parents working to replicate the Lovaas model in the Central Valley. From the beginning, both Dr. Cohen and the VMRC staff advocated for strong parental involvement in the program.

Dr. Cohen and his VMRC staff made a profound policy decision: that VMRC would share the program costs with the schools. Staff from VMRC began to meet with Special Education Local Planning Area (SELPA) directors who coordinate special education services for clusters of school districts. The desire to avoid costly litigation and the strong support of parents for the Young Autism Project (YAP) motivated school personnel and regional center staff to find common ground on issues related to public funding. Regional center staff, SELPA directors, the behavior analyst, and parent groups met regularly to discuss early intervention treatment for children with ASD. And, as a result, two Central Valley SELPA directors (San Joaquin and Stanislaus) decided to take a risk and approve the use of the new home-centered program for some of their students.

Today, all SELPA directors have agreed to participate in the in-home program, and VMRC and the SELPA directors continue to jointly fund Early Intensive Behavioral Treatment (EIBT) programs as directed by the child's Individual Education Program (IEP). In this way, parents enjoy treatment options for their child, with smooth transitions at age three, without the need to change programs and/or providers or to pursue due process litigation in order to continue with the EIBT program. Importantly, Valley Mountain Regional Center is not required by law to provide financial support to educational programs for children over age three; they fund these programs as an investment in the child's future.

The SELPA directors, regional center staff, the behavior analyst, and parents who collaborated to develop a funding mechanism for the YAP replication site evolved into the Autism Connection, which meets monthly and sponsors an annual ASD Collaborative Forum. This collaborative has mentored other collaboratives across the state by giving presentations at conferences and responding individually to requests for assistance (see case study on ACT, p. 29).



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*“The desire to avoid costly litigation and the strong support of parents for the Young Autism Project (YAP) motivated school personnel and regional center staff to find common ground on issues related to public funding.”*

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## S U C C E S S F A C T O R S

The Autism Connection employed many, if not all, of the ten best practices for a successful collaboration. Collaborative members felt that two best practices stood out in making a difference.

### **Support the Activities and Passion of the Champions.**

Howard Cohen, PhD, late Clinical Director of Valley Mountain Regional Center, wrote about the creation of Autism Connection in “Pyramid Building: Partnership as an Alternative to Litigation,” a chapter of O. I. Lovaas’ book, *Teaching Individuals with Developmental Delays* (2003). In this chapter, Dr. Cohen pointed to leadership as one of the contributors to the success of this collaboration — leadership of parent organizations, leadership from Valley Mountain Regional Center, leadership from vendors, and leadership from the SELPAs. The characteristics of these leaders were many: good listener, good communicator, ability to think outside the box, ability to reach consensus and confidence to take calculated risks.

In fact, it was the leadership of Dr. Cohen that helped to ensure the success of Autism Connection. Modest to the core, Dr. Cohen himself was an ideal example of a “champion” and impassioned leader. His passion and commitment to delivering to children the best services possible in the most efficient and compassionate way and at the earliest possible stage are the very definition of the champion among leaders that each collaborative must have to achieve buy-in and success. Dr. Cohen was a role model for many. Because of his profound influence and support of the process of collaboration, this manual is dedicated to him (see p. i).

### **Create Workable Solutions and Implement Them.**

The collaborative has written two detailed documents, *Collaborative Early Intensive Autism Treatment Program Handbook*, which addresses policy, procedures, and implementation issues, and *Early Intensive Behavioral Treatment Program Procedures and Guidelines*, to communicate the vision for EIBT and delineate the roles and responsibilities of each participant in an EIBT program.

***For More Information Contact:*** Sandee Kludt, EdD, Assistant Superintendent Special Education and SELPA Director, San Joaquin County Office of Education, [skludt@sjcoe.net](mailto:skludt@sjcoe.net).

# Autism Community Team (ACT)



Napa, Sonoma, Solano

## A S N A P S H O T

**Goal:** Establish a clinic where staff from North Bay Regional Center and the school systems work together to diagnose autistic spectrum disorders and coordinate services for children and their families and, ultimately, start treatment earlier.

**Catalyst:** The education systems and regional center serving Napa, Sonoma, and Solano counties had their own processes and standards for diagnosing children with autistic spectrum disorders (ASD). As a result, both diagnosis and treatment were delayed for some children. This was an ongoing concern of parents and professionals in the community. In 2002, new best practice guidelines for screening and diagnosis of ASD recommended that the diagnosis of ASD be made as soon as possible to allow services to start early for children. Armed with the new information, a core group of educators, regional center staff, and families came together to ask themselves how they could diagnose ASD in children at an earlier age and how they could improve the process of getting children diagnosed and referred for services.

**Results:** The Autism Community Team (ACT), a coordinated group of parents, school system professionals, and staff of North Bay Regional Center, whose collaborative efforts produced major outcomes:

- A four-month reduction in the average age of ASD diagnosis during the first year of the collaborative.
- One-stop Collaborative Autism Diagnostic (CAD) clinics to diagnose autistic spectrum disorders in Napa, Solano, and Sonoma counties using diagnostic processes based on the publication, *Autistic Spectrum Disorders: Best Practice Guidelines for Screening, Diagnosis, and Assessment* (DDS, 2002).
- Use of the learning collaborative model to bring regional center, school-based, and private practice clinicians together and educate them about the *Guidelines* and train clinicians on the use of standardized diagnostic tools and methods.
- A funding mechanism whereby the regional center pays county offices of education for assessments on a fee-for-service basis as part of the CAD clinic.



**Issue:** Education systems and regional center systems each have their own processes and procedures to diagnose children with autistic spectrum disorders (ASD). The duplication and inconsistency of services can result in delayed diagnoses and delayed treatment for many children.



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*“Parents expressed concern that diagnoses were not made in a consistent manner using the same diagnostic tools and methods to assure accuracy of the diagnosis.”*

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## B A C K G R O U N D

For decades, families and professionals in California have observed increases in the number of children diagnosed with autistic spectrum disorders (ASD). As the number of children with ASD increased, frustration with fragmented services has intensified among families of these children and the professionals serving them. In addition, parents expressed concern that diagnoses were not made in a consistent manner using the same diagnostic tools and methods to assure accuracy of the diagnosis.

Responding to this concern, in 2002 the California Department of Developmental Services and its key partners developed a document, *Autistic Spectrum Disorders: Best Practice Guidelines for Screening, Diagnosis and Assessment*. The *Guidelines* provide recommendations based on published research and clinical experience for screening, evaluating, and assessing persons suspected of having ASD. The medical consultant for North Bay Regional Center was one of an experienced group of professionals who assisted in the development of this document. As the findings were shared with the public in Napa, Sonoma, and Solano counties, several of the *Guidelines*' recommendations immediately caught the attention of local educators, families of persons with ASD, and staff at North Bay Regional Center. Specifically, this core group of individuals met to ask each other how the diagnosis of ASD could be made earlier.

The core group reached out to other stakeholders to get their input on the need for change. The first meeting of the expanded group included several local special education administrators, Special Education Local Planning Area (SELPA) directors, families of persons with ASD, regional center staff (including the regional center's executive director), and representatives from organizations that provide ASD-related services. At that meeting, the participants demonstrated wide-spread consensus on the need to change the processes by which children were diagnosed for ASD. A collaboration was launched.

Through his work on the development of the *Guidelines*, the regional center's medical director was aware of the success of another ASD-related collaborative — Autism Connection, located in the Central Valley. As a result, the North Bay group invited stakeholders from Autism Connection to share their experiences and lessons learned about how to set up and sustain a collaborative. Of specific interest to the North Bay group was how Autism Connection established a one-stop ASD diagnostic clinic.

Subsequent meetings of the North Bay collaborative finalized the purpose of the group: to provide families of persons with ASD and local agencies and organizations that provide services to children with ASD a vehicle





through which they can exchange ideas and monitor progress on their commitment to coordination of services.

The group selected a name for the collaborative — Autism Community Team (ACT) — partly because the acronym symbolized its desire to move quickly to coordinate the implementation of services. One specific goal of the group was agreed upon: to establish county-specific, one-stop clinics where staff from the regional center and school system would work together to perform comprehensive diagnostic evaluations and coordinate services. Importantly, the clinics would follow the DDS *Guidelines* to assure accuracy of the diagnosis and research-based practice. ACT members agreed to a financing policy for the clinics, with regional centers paying for assessments as part of the CAD clinic.

As subsequent meetings of ACT were held, members recognized that the large geographic area covered by the collaborative necessitated extensive driving by members to attend the meetings. In addition, some of the needs of the Napa community differed from those in Sonoma and Solano. Therefore, the group divided itself into two parts: ACT I and ACT II. ACT I represents Sonoma and ACT II represents Napa and Solano counties. Both groups meet together quarterly to evaluate the effectiveness of their clinics and develop strategies to continue to provide coordinated services.

The ACT collaborative has developed an extensive track record. For example, over the past four years the collaborative has:

- Reduced the average age of ASD diagnosis by four months, an accomplishment made during ACT's first year in existence.
- Developed a single intake health history form that is used by the regional center and schools in all three counties.
- Developed and disseminated to local pediatricians, family practitioners, and other professionals a screening tool to identify persons possibly on the autism spectrum, to educate providers about common symptoms of autism, and encourage referral to the CAD clinic, as appropriate.
- Established two clinics to diagnose autistic spectrum disorders — one in Napa at North Bay Regional Center and one in Santa Rosa at a Sonoma County Office of Education school.
- Provided several staff training sessions on standardized diagnostic tools using the learning collaborative model.
- Developed a parent handbook — a resource highlighting service options for children up to five years of age who live in Napa, Sonoma, or Solano counties. (To obtain a copy of the publication, refer to the contact information at the end of this case study.)
- Hired a CAD clinic coordinator.



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*“The group selected a name for the collaborative — Autism Community Team (ACT) — partly because the acronym symbolized its desire to move quickly to coordinate the implementation of services.”*

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## S U C C E S S F A C T O R S

ACT employed many, if not all, of the ten best practices for a successful collaboration. Collaborative members identified three they felt were responsible for the group's profound success.

### **Support the Activities and Passion of the Champions.**

High-level regional center leaders championed the use of collaborative practices and were highly visible in this process.

### **Create Workable Solutions and Implement Them.**

- The project list serve notifies everyone about the meetings — dates, times, location — and is useful as a tool to disseminate minutes and other related information.
- The clinic coordinator is the point person for scheduling clinic appointments and coordinating services among staff and agencies.

### **Foster a Collaborative Spirit.**

Support and education from another community-based collaborative with a similar goal, the Autism Connection, helped build ACT's capacity.

***For More Information Contact:*** *Patrick Maher, MD, Medical Consultant at North Bay Regional Center, patrickm@nbrc.net.*

# Collaboration Between Regional Center of Orange County and CalOptima, a Managed Care Organization



## A S N A P S H O T

**Goals:** To decrease confrontation between Regional Center of Orange County (RCOC) consumers and health plans; to provide seamless and integrated healthcare services for RCOC consumers.

**Catalyst:** In 1995, the local Area Board threatened to bring a lawsuit against CalOptima on behalf of Regional Center of Orange County consumers. As a result of the pending suit, a series of meetings were held involving the director of the Area Board, RCOC's executive director, and CalOptima's CEO, and a decision was made to improve access to healthcare services.

**Results:** The collaboration between RCOC and CalOptima, Orange County's managed healthcare program, resulted in the following system changes:

- A metamorphosis in the processes used to problem solve healthcare issues for Medi-Cal eligible people with developmental disabilities from confrontation and threatened litigation to one of facilitated decision making among regional center staff, its consumers, and the health plans.
- The co-location, since August 1997, of a CalOptima liaison at one of four RCOC offices. In 2007, the liaison position was shared by two CalOptima staff members — allowing one of the liaisons to deal solely with issues related to the implementation of Early Start.
- The ability of the CalOptima liaisons to resolve day-to-day problems and respond quickly to requests for healthcare services, thanks to the co-location of CalOptima's liaison at RCOC and communication systems established between RCOC service coordinators and the liaisons.
- Improved communication between RCOC and CalOptima regarding the resources each needs to serve its clientele. RCOC provides input to CalOptima on the specialized services that health plans must have to meet the needs of persons with developmental disabilities. And CalOptima staff are available to advise regional center consumers on which health plans have the primary care providers and medical specialists that may best meet their needs.



**Issue:** Health plans unfamiliar with the needs of persons with developmental disabilities may have difficulty in providing services for regional center consumers, resulting in conflict between the health plans and the regional centers.



*“The executive director of Regional Center of Orange County was motivated to develop a managed care system in Orange County that was responsive to the healthcare needs of his consumers. CalOptima’s chief executive officer was motivated to prevent a lawsuit and move forward with the transition to managed care in the county.”*

- Improved healthcare services for RCOC consumers. Liaisons enhance services by acting as advocates for members, ensuring that members receive appropriate and timely referrals.
- Coordinated, efficient, and effective communication between CalOptima and RCOC that results in children receiving medical and early intervention services as quickly as possible. As appropriate, RCOC notifies CalOptima of all CalOptima member infants and toddlers from birth to 36 months of age whose parents contact RCOC to seek an evaluation of a developmental delay as part of the Department of Developmental Services (DDS) Early Start Program. As a result, a letter is immediately sent directly to the consumer’s primary care provider to notify him or her of the assessment being conducted by the regional center and to ask the provider to initiate a complete physical exam and make referrals as needed.

## B A C K G R O U N D

In 1995, Medi-Cal eligible persons with developmental disabilities began to transition into CalOptima, Orange County’s managed healthcare program.<sup>1</sup> While members moving from Medi-Cal’s fee-for-service system to a system of coordinated care could benefit from a guaranteed network of providers and the measurement of quality of care, the transition was challenging.

Prior to the actual transition, advocates for persons with developmental disabilities grew concerned about how the change would potentially affect the health of this population. Advocates had several reasons to worry: some of the health plans were less familiar with the diverse healthcare needs of persons with developmental disabilities. (For example, because of conditions associated with disabilities, certain types of specialist care are needed more often. Similarly, persons with disabilities may have higher utilization rates for healthcare services than the general population. Also, communication challenges often arise while providing healthcare services for persons with developmental disabilities.)

These concerns and frustrations grew. In 1995, the local Area Board threatened to bring suit against CalOptima on behalf of RCOC consumers. The lawsuit became the catalyst for change. The Area Board sought quality healthcare for persons with developmental disabilities. The executive director of Regional Center of Orange County was motivated to develop a managed care system in Orange County that was responsive to the healthcare needs of his consumers. CalOptima’s chief executive officer was motivated to prevent a lawsuit and move forward with the transition to managed care in the county. Thus, an historic meeting between the director of the Area Board,

<sup>1</sup> Orange County has no fee-for-service Medi-Cal option. A waiver directs all Medi-Cal eligibles to join a CalOptima health plan or CalOptima Direct.





RCOC's executive director and CalOptima's CEO was initiated and a joint decision was made to improve access to healthcare services.

The cornerstone of the proposed systems change was the creation of a CalOptima liaison to the Regional Center of Orange County. In this way, the regional center maintained a role in the coordination of healthcare services for its consumers, and the managed care organization became more responsive to the needs of persons with developmental disabilities. The liaison has been co-located at one of the offices of RCOC since August 1997. As a result, day-to-day problems are resolved quickly.

During the first year of the collaboration, staff members from both organizations struggled to construct a memorandum of understanding (MOU) that outlined the roles and responsibilities of both parties; however, during this challenging process, the organizations got to know one another. Regional center staff learned how managed care works. Similarly, staff from CalOptima learned about the needs of persons with developmental disabilities, as well as the statutes guiding the responsibilities of regional centers in California. Slowly, trust began to develop among the participants. Importantly, staff from each organization demonstrated a willingness to listen to one another and to change their practices. The MOU was finalized in 1996 and is updated periodically.

The organizations initiated regular periodic meetings to ensure communication among key groups providing services to persons with developmental disabilities. Staff from the regional center, CalOptima, California Children's Services (CCS), and Department of Health Services In-Home Operations (IHO) meet twice a year to monitor progress. In addition, regional center and CalOptima staff members meet quarterly.

A recent experience in which an RCOC consumer required dental care with general anesthesia highlights some of the positive outcomes that have resulted from the collaboration between the regional center and CalOptima. In this case, a regional center nurse was concerned about how to access dental care with general anesthesia for a consumer in pain. She contacted the CalOptima liaison and explained the need for the specific consumer to find an authorized anesthesiologist in an authorized surgery center or hospital to get the needed dental care under general anesthesia. CalOptima helped to find and authorize the anesthesiologist and appropriate venue to expedite dental care for the consumer.



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*“The cornerstone of the proposed systems change was the creation of a CalOptima liaison to the Regional Center of Orange County.”*

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## S U C C E S S F A C T O R S

This collaboration employed many, if not all, of the ten best practices for a successful collaboration. Collaborative members felt that three best practices stood out in making a difference.

**Create Workable Solutions and Implement Them.** RCOC staff, adult day program staff, and residential care providers appreciate CalOptima staff's presence at meetings to share updates and hear concerns. Interagency meetings are important and have interesting dynamics. RCOC usually has specific concerns and questions — often about specific cases. CalOptima personnel provide input on new systems and policies. Despite these differences, the meetings continue and both parties find them effective.

**Ensure Adequate Resources.** In addition to locating staff at one of the regional center locations, CalOptima has assumed the responsibility to organize meetings and record and disseminate minutes from the meetings. This has been a valuable resource and critical to the continuation of quarterly meetings for the past decade. RCOC and CalOptima staff members regularly communicate with one another and often initiate several means of communication concurrently — written, verbal, e-mail, meetings — all of which demand considerable amounts of staff time from both organizations.

**Foster a Collaborative Spirit.** In the process of developing a Memorandum of Understanding, RCOC and CalOptima leaders grew to know and trust each other and were willing to speak frankly about concerns. They share a commitment to the process of collaboration as a means to improve services for persons with developmental disabilities. Collaborative leaders communicate both formally and informally — with the intention of solving problems and improving services.

**For More Information Contact:** *Bill Bowman, Executive Director, Regional Center of Orange County, [bbowman@rcocdd.com](mailto:bbowman@rcocdd.com).*

# The Anchor Project



## A S N A P S H O T

**Goal:** To decrease the number of unnecessary visits of Golden Gate Regional Center consumers to local emergency rooms and improve management of behavioral and mental health conditions for these individuals.

**Catalyst:** In 1996, San Francisco police officers observed an increase in calls from members of the community complaining and concerned about residents with developmental disabilities who were demonstrating extreme and erratic behaviors, including angry outbursts and violence. Following established procedure, the police transported these persons to San Francisco General Hospital Emergency Room for care. Discussions between police and emergency room staff uncovered the fact that many of the individuals were clients of Golden Gate Regional Center (GGRC). Concerned about the well-being of these clients and their need for comprehensive mental health services, the police contacted the executive director of the regional center and asked for his assistance in providing services. At the same time, executive staff of San Francisco County Community Mental Health Services (SFCCMHS)<sup>1</sup> became aware of and concerned about the increase in the number of unnecessary hospital admissions of GGRC clients to San Francisco General subsequent to their arrival at the emergency room.

**Results:** The Anchor Project produced these major outcomes:

- Decreased the rate of unnecessary visits of GGRC consumers to San Francisco General Hospital by at least 65 percent.
- Provided the structure for GGRC staff to co-facilitate, with staff of SFCCMHS, group therapy to clients of GGRC.
- Provided specialized therapy and targeted behavioral interventions to select GGRC clients to prevent decompensation of mental health symptoms.
- Provided GGRC clients who met entry criteria for county-sponsored mental health services with improved medication evaluation and monitoring.
- Stabilized the living situations for GGRC clients with mental health conditions.
- Replicated the project in Marin and San Mateo counties.



**Issue:** The unnecessary use of emergency room care by regional center consumers with mental health conditions is a concern of mental health advocates and regional center staff members.

<sup>1</sup> Over the past 10 years, the name associated with mental health services housed within San Francisco's Department of Public Health has changed. In 1997 it was called San Francisco County Community Mental Health Services (SFCCMHS). Today the name is San Francisco Community Behavioral Health Services (SFCBHS).



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*“The Anchor project is named for its intention to provide an “anchor” for persons with developmental disabilities to stabilize their mental health conditions, and allow them to live their lives more fully.”*

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## B A C K G R O U N D

In 1996, a group of Golden Gate Regional Center staff and mental health professionals from San Francisco County Community Mental Health Services (SFCCMHS) met to address a community need for better mental health services for persons with a developmental disability who live in San Francisco. They created the Anchor Project, named for its intention to provide an “anchor” for persons with developmental disabilities to stabilize their mental health conditions, and allow them to live their lives more fully.

Golden Gate Regional Center (GGRC) is one of 21 regional centers in California. Like the general population, many clients of GGRC are subject to a range of psychiatric illnesses. The incidence of mental disorders among people with developmental disabilities is estimated to be at least two to three times that of the general population.

Treatment is often based upon a combination of psychopharmacology, behavior modification, psychotherapy, cognitive therapy, and social skills training. Unfortunately, as a result of their disability, these individuals may not always comply with prescribed therapies, sometimes resulting in erratic behaviors that cause concern to the person as well as to those around him or her. In such cases the police are often called to help. San Francisco General Hospital Emergency Room serves as a point of entry and triage for services for many people from San Francisco’s underserved urban setting; therefore, the police often transport disturbed persons to that emergency room.

During the late 1980s and into the early 1990s, community advocates were concerned that persons with developmental disabilities were underserved in the county’s mental health system and raised these issues in several community forums. Consequently, in 1996, as police learned from emergency room staff that many patients who presented severe mental health problems were clients of Golden Gate Regional Center, the police contacted the executive director of GGRC and asked him to assist in obtaining appropriate care for these consumers. The executive director convened a small group of GGRC clinical staff to discuss the problem and reached out to the director of the San Francisco County Community Mental Health Services Department (SFCCMHS) for input.

The Developmental Disabilities Community Advisory Board (DDCAB), including staff from SFCCMHS and GGRC, met regularly and established the Anchor Project to streamline entry into the city’s mental health system for GGRC clients who met entry criteria. During the project’s start up, GGRC hired a behavioral psychologist who was interested in mental health issues in persons with developmental disabilities. He was designated as the project’s clinical psychologist and assigned to provide therapeutic services





on the GGRC site. Similarly, SFCCMHS allocated a full-time therapist to the project to provide services and serve as a liaison to the county's public health department. In addition, SFCCMHS provided access to a psychiatrist to assist in the prescribing of medications.

As part of the Anchor Project, the county's mental health services are offered through the OMI (Oceanside, Merced Heights, Inglewood District) Family Center, one of four integrated service centers in San Francisco. Regional center social workers who identify a client who may need mental health services confer directly with the county's therapist at OMI who makes arrangements to initiate care, if appropriate. Clients are referred to either the GGRC clinical psychologist or SFCCMHS professional, depending on the client's symptoms and availability of the therapist. Early in the project's development, staff from both agencies co-facilitated groups; however, today the services are primarily provided via individual therapy.

During the first year of the project, staff evaluated all participants to learn whether or not the services had an impact. According to a review of the project conducted in 1998 by the program coordinator, the outcome data indicated that many of the clients showed improvement in the status of their daily activities. Some improvements included clients starting a day program, obtaining a job, and maintaining a job. In the area of housing and family relationships, several clients displayed some improvement in the stability of their situation; for example, some reported moving to a better location, getting better support at the housing complex in which they lived, moving out from a homeless shelter to a residential care home, and getting along better with family members (Amy Greenberg, *Review of The Anchor Project*, SFCCMHS, April 27, 1998). The report concluded that the program was an "enormous value."

Over time, the project has become institutionalized within both GGRC and San Francisco Community Behavioral Health Services (SFCBHS). Daily coordination by phone between staff members of GGRC and SFCBHS has become an established and accepted feature of the project, although combined staff meetings are less frequent.

The success of the project prompted GGRC to replicate it in Marin County as "The Bridge Project," and in San Mateo County as "Puente" ("bridge" in Spanish). Although these projects differ somewhat from the Anchor Project, their goals are similar: to provide comprehensive mental health services to GGRC clients in need.



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*"The success of the project prompted GGRC to replicate it in Marin County as 'The Bridge Project,' and in San Mateo County as 'Puente,' ('bridge' in Spanish)."*

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## S U C C E S S F A C T O R S

The Anchor Project employed many, if not all, of the ten best practices for successful collaboration. Collaborative members felt that three best practices stood out in making a difference.

### **Support the Activities and Passion of the Champions.**

As the Director of Clinical Services at Golden Gate Regional Center (GGRC) sees it, the behavioral psychologist they hired as part of the project was the key to its success. “We (GGRC) did not just appoint a mental health clinician (to the Anchor Project). He is a well trained, well-rounded behaviorist as well. It is the behavioral expertise that he brought to the project that made it work...as well as his dedication to serving those with developmental disabilities. In my opinion it is the absolute key to everything that he did and the success of the program.”

**Ensure Adequate Resources.** The Anchor Project is now financed by GGRC and SFCBHS as part of their regular budgets. As a result, staff salaries are integrated into the budgets of both organizations and the continuation of the project is assured. The regional center was able to initiate the Anchor Project from a Wellness grant from the Department of Developmental Services. It was started with a modest budget with the longer-term goal being sustainability. With the passage of time, the funding was incorporated into the ongoing regional center budget.

**Take Time.** Community advocates discussed and debated issues concerning access to mental health services for persons with developmental disabilities *for at least 10 years* prior to establishing the Anchor Project. During this time, advocates were able to fully consider the needs of GGRC clients as well as the political climate in order to develop an appropriate structure to meet those needs.

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# Lanterman/UCLA Neuropsychiatric Institute Specialty Clinic



## A S N A P S H O T

**Goal:** To provide high quality outpatient assessment, diagnosis, and treatment for psychiatric and behavioral concerns of clients of Lanterman Regional Center (LRC) in order to prevent unnecessary hospitalizations and improve the quality of life for people who receive or should be receiving psychoactive medications.

This goal was to be achieved through the establishment of a Specialty Clinic for people with developmental disabilities at the Neuropsychiatric Institute at UCLA. The clinic not only provides direct services, but also serves to educate Lanterman staff and families about psychiatric conditions and treatment. Families and caregivers are educated by virtue of their involvement in the development and implementation of treatment plans. LRC service coordinators are encouraged to accompany their clients to clinic appointments so they can understand the treatment plan and ensure appropriate follow-up and continuity of care.

**Catalyst:** In 1997, Lanterman Regional Center conducted a comprehensive assessment of the health status of 353 adult clients. Included in the study was a review of the documented behavioral and psychiatric concerns of those clients and psychotropic medications prescribed to treat them. The findings revealed that many of these clients were prescribed multiple psychotropic medications — often four or five different drugs and often in addition to other medications for seizures or chronic health conditions. These combinations were often found to result in side effects that interfered with the individuals' functioning. Medications were often judged to be inappropriate for the diagnosis or inappropriate in combination with other drugs being taken by the individual. Dosages were often sub-therapeutic without an explanation of the rationale for such variation from the recommended amount. Concerned about the apparent overuse and inappropriate use of these medications, the regional center contracted with UCLA's Neuropsychiatric Institute (NPI) to create a resource for the regional center in its attempts to address this problem.



**Issue:** With the increasing use of psychotropic medications by persons with developmental disabilities, appropriate psychiatric care by knowledgeable psychiatrists is needed to assess the need for medications, to prescribe appropriately, and to monitor their effectiveness.



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*“One of the findings of these assessments showed significant inappropriate and overuse of psychoactive medications within this population and lack of adequate monitoring of patients’ response to these medications.”*

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### **Results:**

- Since March 1999, Lanterman Regional Center clients with severe psychiatric and or behavioral conditions have been treated and monitored by four psychiatrists at NPI. To date, these four professionals have provided nearly 2,500 episodes of care.
- An ongoing evaluation of family and caregiver satisfaction indicates overwhelming satisfaction with the clinic services. The regional center has recently begun to evaluate the outcome of clinic services by implementing a standardized clinical measure at intake and follow-up.
- Bryan King, MD, a psychiatrist who encouraged the development of the Specialty Clinic, also wrote a booklet aimed at educating families and care providers about the use of psychoactive medications. This booklet, *Psychotropic Medications in Persons with Developmental Disabilities: An Overview for Families and Other Care Providers*, was published by LRC and is currently available through the center. (See contact information on p. 44.)
- Clinic psychiatrists attempt to work closely with community-based physicians to ensure continued provision of appropriate follow-up care for clients discharged from the clinic.
- Clinic psychiatrists and Lanterman staff have shared lessons learned at statewide conferences, including a yearly conference sponsored by the California Department of Developmental Services (DDS) and UCLA NPI, “Innovative Approaches to Psychiatric Care for Persons with Developmental Disabilities.”

### **B A C K G R O U N D**

In the late 1990s, the Lanterman Act was amended to enhance clinical teams serving people with developmental disabilities through the addition of medical expertise. In response to this change in the law, Lanterman Regional Center initiated an assessment of the health status of adult clients to better evaluate the need for medical resources within the center and the community. The objective of the assessment was to determine the health status of adult clients and evaluate how effectively their physical, dental, reproductive, and behavioral/psychiatric needs were being met.

Clinical professionals from UCLA Schools of Nursing, Medicine, and Public Health and the Neuropsychiatric Institute conducted the health assessments. One of the findings of these assessments showed significant inappropriate and overuse of psychoactive medications within this population and lack of adequate monitoring of patients’ response to these medications.





Concern over these findings resulted in an agreement between LRC and NPI to establish the Specialty Clinic. LRC employed a psychiatric nurse to coordinate referral and monitoring activities between the two organizations. The Lanterman/UCLA NPI Specialty Clinic saw its first patients in March of 1999.

In determining treatment plans, clinic professionals may go beyond standard medical practice by, for example, making home or school visits to observe clients in those settings.

To support the families, physicians and nurses have given their office phone numbers to family members. In this way, physicians are available to respond quickly to urgent requests for help and information.

Specialty Clinic services are individualized and the assessments are comprehensive, focused on the whole person. For example, one clinic client presented with self-injurious and aggressive behaviors that had precluded her from being medically assessed in the primary care setting. Upon her presentation to the clinic for the initial assessment, the treating psychiatrist concluded that she had a need for urgent medical attention. She was referred immediately to UCLA's urgent care center where she was diagnosed with an upper respiratory infection and oral abscesses. She received treatment for both. Subsequent visits to the Specialty Clinic revealed that the referral behaviors (aggression, self-injury) appeared to have been directly related to the pain and discomfort associated with her medical problems and that, further, she was not in need of psychiatric treatment.

Since its inception, the clinic has operated efficiently and effectively through the cooperation of staff, patients, families, and care givers — without interruptions in service. Clients are reliable in attendance at appointments since their families and care givers receive reminders by mail. In addition, staff arrange transportation for clients who are unable to make their own arrangements. Staff also provide other individualized services, such as intervening to help clients manage anxiety associated with their clinic visits. As a result of this high level of team work, the quality of psychiatric care has improved.



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*“In determining treatment plans, clinic professionals may go beyond standard medical practice by, for example, making home or school visits.”*

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## S U C C E S S F A C T O R S

This collaboration embodies many, if not all, of the ten best practices for a successful collaboration. Collaborative members believe, however, that two best practices have been particularly important to the success of the activity.

### **Share Leadership and Responsibility for Attaining Goals.**

To assess the psychiatric needs of their clients, children as well as adults, Lanterman turned to a well-known organization — UCLA. The knowledge of the staff who made the recommendation to change the way psychiatric services are provided was grounded in science and experience.

By staff members from NPI and Lanterman working collaboratively improved services were developed and implemented.

### **Create Workable Solutions and Implement Them.**

The arrangement with NPI is a “win-win” for Lanterman Regional Center and NPI. The staff members from the respective organizations are committed to the provision of high quality comprehensive psychiatric services to Lanterman clients and this activity gives them a vehicle for realizing this commitment. They also excel at learning from one other and sharing lessons learned with individuals and organizations outside of the collaborative.

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# Appendixes

Appendix 1: Elements of Cooperation, Coordination, and Collaboration	47
Appendix 2: Sample Ground Rules	48
Appendix 3: Visioning Activity	50
Appendix 4: Collaboration Action Plan	51
Appendix 5: Evaluation of Best Practices	52
Appendix 6: Evaluation Questions	54



APPENDIX 1:

# Elements of Cooperation, Coordination, and Collaboration

ESSENTIAL ELEMENTS	COOPERATION	COORDINATION	COLLABORATION
<b>Vision and Relationships</b>	<p>Basis for cooperation is usually between individuals but may be mandated by a third party.</p> <p>Organizational missions and goals are not taken into account.</p> <p>Interaction is on an as-needed basis, may last indefinitely.</p>	<p>Individual relationships are supported by the organizations they represent.</p> <p>Missions and goals of the individual organizations are reviewed for compatibility.</p> <p>Interaction is usually around one specific project or task of definable length.</p>	<p>Commitment of the organizations and their leaders is fully behind their representatives.</p> <p>Common, new mission and goals are created.</p> <p>One or more projects are undertaken for longer-term results.</p>
<b>Structure, Responsibilities, Communication</b>	<p>Relationships are informal; each organization functions separately.</p> <p>No joint planning is required.</p> <p>Information is conveyed as needed.</p>	<p>Organizations involved take on needed roles, but function relatively independent of each other.</p> <p>Some project-specific planning is required.</p> <p>Communication roles are established and definite channels are created for interaction.</p>	<p>New organizational structure and/or clearly defined and interrelated roles that constitute a formal division of labor are created.</p> <p>More comprehensive planning is required that includes developing joint strategies and measuring success in terms of impact on the needs of those served.</p> <p>Beyond communication roles and channels for interaction, many levels of communications are created as clear information is a keystone of success.</p>
<b>Authority and Accountability</b>	<p>Authority rests solely with individual organizations.</p> <p>Leadership is unilateral and control is central.</p> <p>All authority and accountability rests with the individual organization's needs.</p>	<p>Authority rests with the individual organizations, but there is coordination among participants.</p> <p>Some sharing of leadership and control.</p> <p>There is some shared risk, but most of the authority and accountability falls to the individual organizations.</p>	<p>Authority is determined by the collaboration to balance ownership by the individual organizations with expediency to accomplish purpose.</p> <p>Leadership is dispersed, and control is shared and mutual.</p> <p>Equal risk is shared by all organizations in the collaboration.</p>
<b>Resources and Rewards</b>	<p>Resources (staff time dollars, and capabilities) are separate, serving the individual organization's needs.</p>	<p>Resources are acknowledged and can be made available to others for a specific project.</p> <p>Rewards are mutually acknowledged.</p>	<p>Resources are pooled or jointly secured for a longer-term effort that is managed by the collaborative structure.</p> <p>Organizations share in the products; more is accomplished jointly than could have been individually.</p>

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## APPENDIX 2:

## Sample Ground Rules

### Decision-Making Process

1. We will use consensus. Consensus as used here means modified consensus, adhering to the test of “can we live with it and publicly support it?” If not, what needs to be changed so that we can?
2. If we cannot achieve consensus on an item, we will (choose one or more):
  - Not include it in our plan. “When in doubt, leave it out.”
  - Take a vote (by member or by agency).
  - Refer this to the respective heads of the agencies we represent for decisions, providing for them the various perspectives of this team.
  - Decide on an individual basis how best to proceed.
  - Other (specify).
3. Other rules at the team’s discretion.

### Task Focus

1. We will start and end on time.
2. Stay outcome focused — using a “Parking Lot” and flip chart on which to record or “park” good ideas not directly related to stated meeting outcomes ... ideas that might get us off task.
3. Meeting logistics:
  - Regular meeting dates and times.
  - Meeting location.
4. Maximize our time together and between meetings.
5. Other rules at the team’s discretion.

### Attendance

1. Attend team meetings regularly.
2. Missed meeting — contact another member for follow-up.
3. Other rules at the team’s discretion.

**Interactions**

1. Be realistic; respect others' right to say no.
2. Share ideas and air time.
3. All ideas have value...even ones with which we disagree.
4. Honor confidentiality.
5. Other rules at the team's discretion.

**Communicating with Others in Our Agency and Community**

1. With respective agency decision makers regarding team recommendations.
2. With agency decision makers to ensure they are "in the loop," supportive, and not blocking.
3. With line staff for input as we develop, implement, and evaluate our efforts to make sure that any procedures or activities affecting them will be relevant.
4. With families for input as we develop, implement, and evaluate our efforts to make sure that any procedures or activities affecting them will be relevant.
5. With others in the community with an indirect interest in our efforts.

**Orientation of New Members**

1. Identify a team member to orient each new member and to be that person's buddy during the first year on the team.
2. Provide a notebook or file of team orientation materials.
3. Other rules at the team's discretion.

## APPENDIX 3:

## Visioning Activity

### Focus Question

Related to our chosen area(s) of team focus, what is the desired reality we want the team to create in the community? What concrete and doable procedures and/or services do we want to see in place? How are children and families benefiting?

1. Appoint a **facilitator**, **recorder** and **timekeeper**.
2. The **recorder** sets up a story board of two flip chart pages taped side-by-side to the wall, making one large chart with a heading of “Our Vision.” The focus question is written on flip chart paper and posted.
3. Each **team member** identifies three to five answers to the focus questions and uses a member to record one answer per post-it.
4. Each **team member** posts all post-its on chart.
5. The **facilitator** presents the focus question to the team and leads them in merging similar ideas into groups.
6. The **recorder** notes the name and title of each grouping near that grouping. These names and titles become the characteristics describing the vision we want to create.
7. **Timekeeper** helps the team track time.

APPENDIX 4:

# Collaboration Action Plan

TEAM:

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PERIOD COVERED

Generally preferable to have action plans with a time frame of one year or less.

VISION

What you want to see at some point in the future (usually three to five years) as a result of overcoming challenges. In effect, what you are working toward.

CHALLENGE

A problem you are trying to solve that is standing in the way of achieving your vision; for example, staff requiring additional knowledge and skills to perform critical functions.

OBJECTIVE	STRATEGIES/ ACTION STEPS	RESOURCES	PEOPLE	TIMELINE	OUTCOME
Tangible things we want to accomplish to overcome the challenge and move toward the vision; for example, establish parent training and support groups, transition policies and procedures, community resource directory, committee or structure to address interagency issues on an ongoing basis, mechanism for communicating with physicians on a per child and system basis, and so on.	For each objective, list the series of steps that your team will need to take to accomplish that objective.	Identify the resources (money, people, training, materials, and so on) that you will need to implement your action plan. Your strategy column should include steps to access the resources.	Identify who will be responsible for implementing each step in the strategy column.	Identify the time frame for completing each step in the strategy column.	<p>Leave this column blank so that the team can use this planning form to document plan implementation and evaluation. That is, you can make notes here that answer:</p> <p>Did we do what we said we would do?</p> <p>Did the plan produce the results we wanted?</p> <p>What have we learned as a team as a result of plan implementation?</p> <p>What are next steps?</p>

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A P P E N D I X 5 :

# Evaluation of Best Practices

Name of Collaboration Project \_\_\_\_\_

Date \_\_\_/\_\_\_/\_\_\_ Respondent Name \_\_\_\_\_

Organization \_\_\_\_\_

## Statements About Your Collaborative Group

Best Practices		Statements	Strongly Disagree	Neutral	Strongly Agree		
1	<i>Have a Clear Purpose.</i>	What we are trying to accomplish would be hard for any one organization to accomplish by itself.	1	2	3	4	5
		Most members of the collaborative understand its purpose.	1	2	3	4	5
2	<i>Invite All Appropriate Interested Parties to Participate in the Collaborative.</i>	Our collaborative members represent those with a stake in what we want to accomplish.	1	2	3	4	5
		Members of our collaborative trust one another.	1	2	3	4	5
3	<i>Support the Activities and Passion of the Champions.</i>	Our collaborative has a passionate champion.	1	2	3	4	5
		I respect our leader and am willing to follow his/her lead.	1	2	3	4	5
4	<i>Share Leadership and Responsibility for Attaining Goals.</i>	Our collaborative leaders have strong skills working with other people and organizations.	1	2	3	4	5
		Our leaders communicate well with collaborative members.	1	2	3	4	5
5	<i>Develop Policies and Procedures in Support of the Collaborative.</i>	Our collaborative has clear policies regarding decision-making.	1	2	3	4	5
		Collaborative members understand their roles and responsibilities.	1	2	3	4	5



	Best Practices	Statements	Strongly Disagree	Neutral	Strongly Agree		
6	<i>Create Workable Solutions and Implement Them.</i>	I have a clear understanding of what our collaborative is trying to accomplish.	1	2	3	4	5
		The goals for our collaborative are reasonable and attainable.	1	2	3	4	5
7	<i>Ensure Adequate Resources.</i>	Our collaborative has adequate funds to achieve our goals.	1	2	3	4	5
		Our collaborative has members who are willing to give their time and effort.	1	2	3	4	5
8	<i>Take Time.</i>	Our collaborative is working at the right pace.	1	2	3	4	5
		Our collaborative keeps up with the work necessary to achieve our goals.	1	2	3	4	5
9	<i>Foster a Collaborative Spirit.</i>	Everyone who is a member of our collaborative wants the collaborative to succeed.	1	2	3	4	5
		The level of commitment among participants is high.	1	2	3	4	5
10	<i>Do Something, Celebrate, Do Something Else, and Celebrate Again.</i>	We celebrate our accomplishments regularly.	1	2	3	4	5
		We recognize the contributions of members of the collaborative on a regular basis.	1	2	3	4	5

## APPENDIX 6:

# Evaluation Questions

## 1. Review the team's priorities.

- Have priorities been met?
- How well?
- Is working on priorities benefiting both the collaborative team and the participating agencies?
- What priorities remain or are emerging?
- Do previously set priorities continue to be relevant to all members of the team?
- What changes in internal (agency) and external (community, state, federal) environments are likely to impact priorities of this team?

## 2. Assess membership involvement.

- Are all members actively involved? Why or why not?
- What can be done to get active involvement of all members?
- Do activities or membership need to change so that active involvement of all members will be more likely?
- As new individuals or agency members are added to the team, what is done to help them adapt to the team and to help the team adapt to them (for example, orientation or refocusing priorities to address new members' interests)?

## 3. Evaluate the outcomes and impact of team activities.

- Did we do what we said we would do?
- Are these activities helping to achieve the goals set for each of the priorities?
- Are the activities effective?
- Are the activities beneficial enough to warrant the time and other resources allocated to them?
- Can we replace any current activities with other activities that now may be more worthwhile?
- Do members consider these activities a good use of their time considering their individual agency responsibilities?

**4. Consider the team's continued existence.**

- Does the team need to continue to exist?
- Whom does it benefit?
- Given the time and effort involved, is there a return on investment?

If the benefit derived from the team's continued existence is questionable, celebrate accomplishments and bring the team to an end. If the team is determined to be effective, identify next steps for team continuation. This should include reaffirmation or revision of the team's focus and consideration of who needs to be involved as you proceed in your efforts to promote collaboration to benefit children and families in your community.



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Karen Bodenhorn is a healthcare consultant and advocate for improved population health. She has extensive experience working in the content area of developmental disabilities. On this project, she convened the focus groups of collaborative leaders, interviewed selected leaders from each of the case studies, reviewed the literature on collaboration and wrote the manual.

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# Ten Best Practices

In Inter-Organizational  
Collaboration



# Successful Collaboratives...



- 1 *Have a Clear Purpose.*
- 2 *Invite All Appropriate Interested Parties to Participate in the Collaborative.*
- 3 *Support the Activities and Passion of the Champions.*
- 4 *Share Leadership and Responsibility for Attaining Goals.*
- 5 *Develop Policies and Procedures in Support of the Collaborative.*
- 6 *Create Workable Solutions and Implement Them.*
- 7 *Ensure Adequate Resources.*
- 8 *Take Time.*
- 9 *Foster a Collaborative Spirit.*
- 10 *Do Something, Celebrate, Do Something Else, and Celebrate Again.*

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