

## 8 KEY COMPONENTS OF COLLABORATIVE SYSTEMS OF CARE 2008

As a part of their annual reporting requirements, sites with CST and ISP are asked to complete a self-report measuring how well they met the eight key process and outcome areas that are important in maintaining a successful collaborative system of care (outlined below). In completing this report, sites are asked to gather information from Project Coordinators, Service Coordinators, families, and Coordinating Committee members. Once completed, each site creates a "Program Development Plan" targeting specific areas to be improved in the coming year.

### The Eight Key Components of Collaborative Systems of Care:

1. Parents/caregivers are involved as full partners at every level of activity
2. An inclusive interagency group (Coordinating Committee) serving children and families has agreed upon the Core Values and Guiding Principles of Collaborative Systems of Care, which are outlined in an Interagency Agreement
3. Collaborative family teams create and implement individualized support and service Plans of Care for families
4. Significant collaborative funding is available to meet the financial needs identified in the Plan of Care
5. Advocacy is provided for each family
6. Ongoing training is provided to all participants
7. Functional goals are monitored and measured, emphasizing participant satisfaction
8. Adolescents are ensured a planned transition to adult life

Following is a summary of the responses of 25 sites that completed the report in 2008. For most indicators, sites were asked to choose a response from a Likert scale; responses that differ (e.g. "yes/no" responses) are noted.

<b>1. Parents* are involved as full partners at every level of activity</b> (*The term "parent" represents all caregivers)				
Indicators	4 – Always	3 – Often	2 – Seldom	1 - Never
<b>Team Participation</b>				
1. Parents may request meetings.	100%	0%	0%	0%
2. Parents are present at team meetings. Children are present whenever possible and appropriate.	88%	12%	0%	0%
3. Parents' needs are considered in scheduling meetings.	96%	4%	0%	0%
4. Parents are involved in selection of team members.	92%	8%	0%	0%
<b>Coordinating Committee Participation</b>				
1. Parents on Coordinating Committee and appropriate subcommittees	88% - YES			12% - NO
2. Parents attend at least 75% of scheduled Coordinating Committee meetings.	56%	20%	16%	8%
3. Parents feel they are listened to by other committee members and that they have an important role on the committee.	44%	28%	20%	8%
Comments:				
<ul style="list-style-type: none"> <li>• Consistency is lacking.</li> <li>• We are nominating new members to revive the group. With one less Supervisor; Mentor and</li> </ul>				

Service Coordinator we will need to fully utilize the Coordinating Committee members especially until the position are filled.

- Recommendations: To increase our parent representation on the coordinating committee.
- In 2008 we did have two parents who agreed to be on the coordinating committee. One parent came on one occasion. We continue to ask parents to come to the committee meeting. We are also looking for adults with mental health issues to be on our committee. We have discussed looking into giving parents mileage to attend the meetings.
- Children's Resource Project (CRP) has renewed their own Coordinating Committee meeting quarterly. One consumer has joined the committee and has; thus far; been very active and open as to the family's experience with CRP.
- Many of the caregivers of the children we work with have significant emotional issues of their own. Advocating for these caregivers in the Team environment is a strong component of our programs.
- Parental attendance has been an issue. We are looking at increasing the number of parents on our committee.
- Parents stated that they feel they are being listened to more and they appreciate feeling supported. We would still like to see more participation from a variety of parents who have been through the CST/ISP process and who have experience with children with severe disabilities and mental health issues.
- We have one parent on the coordinating committee and will add at least one more as more families are involved with the program.
- The parents that participate on the Coordinating Committee have grown during their involvement with the Committee and appear to have benefited from their participation. One parent gave a presentation to the Committee on training she attended related to special needs; she has offered to be a resource to other families; and she has made referrals to the ISP Program. The other parent has been excited to be able to attend some trainings and obtain information on additional resources. She has expressed an interest in someday providing respite care to families who have children with special needs.
- It is the intention of Dunn County ISP to increase parental involvement on the coordinating committee. Dunn County did not receive feedback from the parents that were involved during 2008 in order to capture accurate information (explanation for answers to #7 & #8).
- Give parents voice by having each committee member bring a parent with them to the next meeting and let them know that they are key to sustaining and improving this process.
- Parent involvement needs improvement.
- We have not had a Coordinating Committee specifically for our ISP for some time. We have one for our Comprehensive Community Services Program but have had primarily adult consumers attend and not parents of the adolescents that are involved.
- We have changed the location of our Coordinating Committee to a central location to better meet the needs of our families to participate. Parents receive all correspondence to the coordinating committee when they cannot be present. We use our monthly family support meetings for questions regarding improving the process and how the family teams are doing.
- The coordinating committee has agreed it is important to continue to increase parent membership and participation on the committee.
- We continue to have strong parental involvement at both the team level and the Coordinating Committee level. We are at the point of probably recruiting one more parent for the Coordinating Committee.
- Expect to have an increased number in consumer representatives by 2010.

**2. An inclusive interagency group (Coordinating Committee) serving children and families has agreed upon the core values and guiding principles of Collaborative Systems of Care which are outlined in an Interagency Agreement.**

Indicators	4 – Always	3 – Often	2 – Seldom	1 - Never
1. Agreement incorporates all the members and components listed under State Statute 46.56 (3) (5).	96% - YES			4% - NO
2. The Coordinating Committee reviews interagency agreements at least every three years.	96% - YES			4% - NO
3. Coordinating Committee meets at least quarterly.	92% - YES			8% - NO
4. Conflict resolution policies are clearly written and reviewed at least annually.	92% - YES			8% - NO
5. Conflict resolution policies are followed when disagreements arise.	96% - YES			4% - NO
6. The Coordinating Committee assures that the core values and guiding principles are evident in the operation of the integrated services system of care.	76%	20%	0%	4%
7. Collaborating agencies are satisfied with process.	32%	64%	0%	4%

**Comments:**

- A school district still expresses some concerns about the program and if they will be served adequately. Discussions will continue with them.
- As stated earlier we continue to struggle with getting parents on our committee. We have a general conflict resolution policy in place in accordance with our grievance procedure. This is one area that will be looked at; written and developed in 2009. Collaborating agencies seem to be happy with our services however are disappointed more kids and families can't get into the program.
- Conflict did not arise this year to require the utilization of the conflict resolution policy. Collaborating agencies have expressed some concern related to the wait list that is currently in place for ISP. There are consultation services offered and information regarding community resources while families are on the wait list.
- Collaborating agencies continue to state that more children need services than Racine County is currently providing.
- Due to the lack of our ISP Coordinating Committee I answered no/never to all of these above questions. However; just because we don't have this group meeting and everything spelled out on paper doesn't mean that the collaboration isn't happening. Being a contracted agency; we have many different venues to meet and staff cases as well as to talk about our integrated service system of care. The meetings include or Case Planning and Reviews ; Transition Team Meetings; and Service Review Team just to name a few. Conflict Resolution is always met by talking things out in these collaborative forums.
- Invite collaborating agencies to ISP Coordinating Committee meetings to constructively evaluate how working together has been effective or not. Look to gaining valuable input on how to make things better. What is working and what is not working.
- Our community SOCCC is about to start a pilot project demonstrating the collaborative CST method with 8 children/families coming from 4 different school districts. If the outcomes are favorable; the SOCCC plans expansion of partners and families participating.
- Our Coordinating Committee of 2008 has been the most consistent and strong since program inception. We have had regular attendance by most members and now have two strong parent voices on the CC. Partners are dedicated to system change and efficacy of the services.
- Recommendation made to continue efforts to get Coordinating Committee representation from new local agencies as well as to increase Tribal representation. Continue to educate agencies on the CST/ISP process.

- Suggestions offered by the collaborating agencies included: to be more involved in the planning of crisis plans. A local school Principal stated they feel the school is always involved in the development and use of the crisis plans. All agencies present stated they are very satisfied in working with ISP.
- The Coordinating Committee lacks ownership of the System of Care.
- The Coordinating Committee reviews the Interagency agreements yearly and meets quarterly to discuss the program needs and case related concerns; when needed. The minutes of these meetings are sent to Nancy Marz.
- The coordinating committee takes an active role with the outcomes and evaluation of the Wraparound process. We are fortunate to have a strong commitment from school districts throughout the county. We also have a strong commitment from service providers. We need to improve our representation from law enforcement and the spiritual community.
- The coordinating committee will continue to encourage collaborating agency participation; including that of school representation.
- There is always a need for checks and balances within and among all partners to make sure that we all stay true to the philosophy and core values and principles of CST. A plan to remedy getting back to core values and principles.
- We are having difficulty getting our coordination committee to meet often enough; and meet with a quorum. One possible solution is to have a CST subcommittee that is separate from our co-CST/CCS committee that can meet as our needs dictate.
- We have conflict resolution policies; but need to remember to review them yearly. While our partners are increasingly satisfied with the process; there are times they think something should happen; usually placement; that we (DHS) don't. We are continuing to try to resolve these differences through conversation and education.
- We make volunteer and professional service coordination available for all integrated services program teams.

<b>3. Collaborative family teams create and implement individualized support and service Plans of Care for families</b>				
<b>Indicators</b>	<b>4 – Always</b>	<b>3 – Often</b>	<b>2 – Seldom</b>	<b>1 - Never</b>
1. Orientation is provided to all team members.	100% - YES			0% - NO
2. Team facilitator and/or service coordinator receive training and support.	96%	4%	0%	0%
3. Collaborative family team includes membership from home, school and community.	64%	36%	0%	0%
4. Team composition is consistent with family culture and preferences.	68%	32%	0%	0%
5. Family is satisfied with its team.	16%	84%	0%	0%
6. Family is satisfied with the team process.	16%	84%	0%	0%
7. Process is a collaborative team effort that begins with an individualized strengths and needs based assessment.	100%	0%	0%	0%
8. Plan of Care flows from assessment.	96%	4%	0%	0%
9. Plan of Care incorporates strengths of child, family and team.	100%	0%	0%	0%
10. The Plan of Care includes specific actions to meet identified needs, including who is responsible (including parents) for completing the action and the plan is being followed.	84%	16%	0%	0%
11. Family and other team members sign the Plan of Care.	92% - YES			8% - NO

12. Transition is addressed for major life changes.	60%	40%	0%	0%
<p>Comments:</p> <ul style="list-style-type: none"> <li>• Signatures need to be obtained with consistency.</li> <li>• As a new program; we have limited experiences so far.</li> <li>• As with our partners; some families are not always satisfied with the process. This is primarily with our court-ordered; more resistant families. It is hoped that as we work to decrease staff turnover and increase worker skills that this outcome will improve.</li> <li>• Currently Racine Unified School District (RUSD) has become an ally to CCF children and has shown a dramatic interest in participating in the development of POC's and attending meetings to address each child's specific needs. The major reason stated by social workers and teachers was their participation in the CCF mini conference; April 2008; here in Racine. Dan Naylor's presentation on wraparound and THE ARC's presentation of constructing FBA's correctly were stated as the catalyst to their new found interest in the wraparound process.</li> <li>• Development and involvement of informal supports is an ongoing challenge for families and service coordinators. The Coordinating Committee will address this ongoing need during 2009.</li> <li>• Need to orient to team process and roles more consistently. Continued sporadic attendance by key team members at times due to scheduling conflicts when meeting family needs/time. Recommendation made to continue efforts to ensure transition planning is put on the plan of care and that it is a top priority for every child age 14 and over.</li> <li>• Service Coordinators receive ongoing training through team supervision. We attended conferences throughout the state and attend teleconferences. We receive positive feedback through service provider surveys. Eight-five percent of our family teams have informal supports. This is an area we continue to develop working on family relationships. Schools and communities are very active with the family teams.</li> <li>• Team development is good within our program. We always start by asking the client and family who their supports are and who they would like to be a part of the team. Sometimes we may make some suggestions and point out why it would be beneficial to have a particular person on a team. The entire "Teaming" concept is growing within our community. People are seeing the benefits of teaming and are starting to do it within their own agencies; programs; and schools. We are doing teams with our CLTS waiver clients and of course with our CCS clients as well.</li> <li>• Teaming allows for communication to increase across the services involved with the family. The schools are very active in the transition for children when applicable. Dunn County ISP is implementing changes to the referral and orientation process to provide more of a one-on-one system of delivery.</li> <li>• The families have went through losing two mentors this year as well as a service coordinator. Some families are disenchanted with CCSN. That is why "Often" was checked above. Many of Ilah's families are being closed successfully as they are ready for transition and received as much care and guidance from the team process as possible.</li> <li>• To help parents identify the impact of their actions and follow-through or lack of follow-through in the overall outcome of their child's success. This is such a valuable concept but difficult to have parents truly understand their impact on their children.</li> <li>• To strengthen our program; CRP has joined with another well-established wrap around program; Comprehensive Community Services (CCS) designed to meet the needs of adults and children in the community with on-going mental health and substance abuse issues.</li> <li>• Transition begins for many children at school. For others; the team seeks agency help to provide for children after integrated services end.</li> <li>• Transition from CAFAS to CANS has been a positive.</li> <li>• We are working with our local and regional Transition Advisory Councils to help build our transition resources for consumers.</li> <li>• We have not yet had to address any major life transitions; however; any transition will be addressed during the team process.</li> <li>• We need to bridge the gap of services to the 18-25 year-old population. We will be doing that via CCS; ADRC's and IRIS.</li> </ul>				

<b>4. Significant collaborative funding is available to meet the financial needs identified in the Plan of Care</b>				
<b>Indicators</b>	<b>4 – Always</b>	<b>3 – Often</b>	<b>2 – Seldom</b>	<b>1 - Never</b>
1. Agencies contribute resources and funding to meet the needs of families.	48%	44%	4%	4%
2. Child and family teams use funding flexibly to support individualized service.	40%	48%	8%	4%
3. Child and family teams utilize informal community resources.	52%	48%	0%	0%

Comments:

- As family team facilitators we will educate teams about strength based approaches; tools and resources that are available for children and families to be successful and self-sufficient in their community.1. Develop resource list2. Use strength based approach handouts3. Use roles; strengths; goals and mission statement exercise as a learning tool for team members4. Through the team process
- Budget cuts for schools; this Dept. and the overall economic situation is challenging most professional partners and impacting funding and resources. Goal and recommendation is to have team continue to work to access informal and community resources.
- Development and involvement of informal supports is an ongoing challenge for families and service coordinators. The Coordinating Committee will address this ongoing need during 2009.
- Money plays an important role in the amount of resources that can be provided. Our county has diversified resources that we utilize. Creativity is a vital component in seeking new and viable resources.
- Other funding sources always looked at; but due to agency budget cuts/constraints is sometimes difficult to access. Flexible funding/revolving loan continues to be used based on family's needs and availability of other resources. Informal supports are always looked at first.
- Some families involved have few if any natural supports in place and sometimes these take some time to be able to develop. We really make an effort to make sure that families have access to informal community resources and even training if desired.
- Teaming and other meetings/contacts increase the exchange of resources; we hope to improve on this through the continued recruitment of community members for the coordinating committee.
- The service providers in our community are always willing to provide services as they are able. Funding has become an issue due to the current economic times.
- The state should do as much as it can to help local community service providers with funding to make this possible in the future for additional children and families.
- This year funding was denied to CCF families for training and wraparound requests; such as utility bills; Christmas gifts; food.
- We are fortunate to be in a community rich with services and supports. We have a large number of contracted agencies that provide numerous home; school; and community services for the youth that we serve. Most providers are willing to be involved in our team and help in any way they can. One thing that we are lacking however; is good child psychiatrists that accept MA.
- We continue to be extremely creative for funding needs.
- We continue to have an excellent working relationship with the Family Center; who provides a wide variety of programs and support for children and their families. We also assist families with their connection to the YMCA and local recreation departments.
- We have been able to find funding for most family/Team needs. This year; our ISP and one of our school districts contributed a large sum toward successful completion of a plan of care when Medical Assistance funding ran out. We are also beginning to utilize the Children's Waiver more frequently.
- We have limited experience so far. Flex funds are available to families but have not had to be used/been requested yet. Future agency contributions are troublesome as IV-E monies which were used for the program will expire and other state funding is flat or decreasing. Increased county tax dollars to supplant these funds are unlikely. This will be a major challenge in 2010.
- We have not yet had to access funding for CST as we are a new site still developing.

<b>5. Advocacy is provided for each family</b>				
<b>Indicators</b>	<b>4 – Always</b>	<b>3 – Often</b>	<b>2 – Seldom</b>	<b>1 - Never</b>
1. Family advocacy information and options are provided.	92% - YES			8% - NO
2. Advocates participate as team members as requested by the family.	100% - YES			0% - NO
3. Service Coordinators advocate for families	88%	12%	0%	0%
<p>Comments:</p> <ul style="list-style-type: none"> <li>• A huge strength.</li> <li>• Advocacy is available but has not had to be used so far.</li> <li>• Advocacy is provided by service coordinators or by outside sources or families who are welcome to have their advocate on the team.</li> <li>• Advocates from Wi Family Ties; Disability Rights of Wi and our local CESA 10 office are involved in teams as needed and requested.</li> <li>• All of the case managers advocate for their families. We are also very fortunate to have Ginger Fobart from Wisconsin Family Ties working with us. Ginger sits on our screening committee; she is a member of some of our child and family teams; and she runs a monthly parent support group that many of our parents attend.</li> <li>• As of yet; we have no formal advocates; but the service coordinator does act as an advocate for the family.</li> <li>• Continued lack of family advocates--either volunteer or paid. When available; they always participate as team members. Recommendation made to meet with local family advocate through CESA #12.</li> <li>• More impartial advocacy service are needed. Training will be fundamental in implementing knowledgeable advocates.</li> <li>• none at this time</li> <li>• Our Service Coordinators view advocacy as one of their primary roles. Agency Management is also supportive. When families have other formal or informal advocates; they are welcomed to the Team.</li> <li>• Service Coordinators work hard to ensure that families' needs and wishes are met and respected. With the involvement of our Family Advocate through Wisconsin Family Ties we are able to receive added advocacy for families at the team level and on an individual basis.</li> <li>• Strong area for us. Recommendation is to simply continue to appropriately advocate for families as well to increase our funding and use of the new Family Ties Advocate.</li> <li>• THE ARC has been an excellent and reliable advocate resource for CCF kids and has responded to requests for IEP advocacy with less than 24 hour notice.</li> <li>• Validating family concerns and understanding the need for advocacy are vital in building trusting relationships.</li> </ul>				

**6. Ongoing training is provided to all participants**

Indicators		
1. Coordinating Committee and Project Coordinator identify training needs on an ongoing basis.	100% - YES	0% - NO
2. Annual local training opportunities are made available to families, staff, and all others involved with the ISP and/or CST process.	92% - YES	8% - NO

Comments:

- Confusion about funding for training dollars for families prevented them from attending the CCF conference and other trainings offered within the community.
- CRP staff attend regional and state CST/ISWP meetings that offer education and training opportunities.
- During the committee meetings were also have a time to share updates on trainings and meetings that would be of interest to other committee members.
- Families are definitely made aware of training opportunities. Accessibility is often an issue. Child care; funding etc. Often stand in the way of families participating in trainings. Staff training is maximized.
- In Question #40; there are always trainings that pertain to ISP however these trainings are not always facilitated by the Dept. or other collaborative agencies. Families are made aware of what is available in the local community.
- Information on local/state trainings is sent to families on an ongoing basis and is distributed at committee meetings. A parent website is currently in development which will aide with the distribution of resources and information to parents. Continued discussions regarding identifying training needs within committee meetings was recommended.
- It is Dunn County's intention to increase the awareness of and opportunity to attend trainings for families and other staff involved in the program.
- Local workshops; classes; and educational opportunities are available through county agencies and extension offices; etc.
- Our outside training opportunities were limited due to budgetary reasons this year. However; staff were able to attend numerous in house trainings and they also do a lot of research on new topics and diagnosis as they arise.
- Training is an initial commitment and ongoing process. The committee discusses this at most meetings.
- Training is currently being provided for area group home where some of the clients are placed short-term.
- Training needs are sometimes identified by the Coordinating Committee and there is always information shared regarding resources or upcoming training opportunities. Sheboygan County has utilized resources to provide several families with opportunities to attend training both locally and statewide.
- Trainings are offered to our interagency partners; committee members; and to families and team members.
- We continue with ongoing training in the mental health area for service coordinators. We provide trainings to families through our family support group in the areas families identified.
- We have tried to get training information to families and our partners; but need to improve in this area. The Coordinating Committee is in the process of first assessing training needs and will then develop a training plan for the community regarding CST.
- We shine. We are proud to advocate for our children and families and will continue to do so.
- White Pines consulting has done a great job of helping our community with training needs with SOC and CST.

**7. Functional goals are monitored and measured, emphasizing participant satisfaction**

Indicators	4 – Always	3 – Often	2 – Seldom	1 - Never
1. Generally, Outcomes show: <ul style="list-style-type: none"> <li>• Decrease in police contact/recidivism rates</li> <li>• Maintenance or decrease in level of restrictiveness of living environment</li> <li>• Improvement in grades</li> <li>• Improvement in attendance</li> <li>• Decrease in problem behaviors</li> </ul>	96% - YES			4% - NO
2. Plan reviews are held at least every six months.	100% - YES			0% - NO
3. Family is satisfied with process.	16%	84%	0%	0%
4. Family is satisfied with outcomes.	8%	92%	0%	0%
5. Providers are satisfied with process.	36%	%64	0%	0%
6. Providers are satisfied with outcomes.	24%	%76	0%	0%

Comments:

- A provider survey was completed in 2008. The survey identified areas of strength and areas for improvement; the overall outcome and success of the project was rated very high. At the time of enrollment we had three children placed in the foster care system that were transitioned to their home. After a six month review these children remained in their home.
- Families and providers are generally happy with the outcomes and progress that the child and families have made. There are times when some families still struggle even with the wraparound process in place.
- Families and Providers voice a strong satisfaction with the process and outcomes of CCF. Obviously not all can be pleased all the time as personal agendas vary. Our Service Coordinators work diligently at reviewing goals and expected outcomes of Team members and formulating plans that address the concerns/strengths of all involved.
- It was suggested to our program by a school Principal to develop a better system of engagement with parents to fully explain the program in the initial phase of the process. Other suggestions included quotes made by parents in the program to be available to other parents.
- none at this time
- Outcomes can be situational and fluctuate due to environmental and/or medical changes. Reminder to look at and celebrate all small changes/outcomes.
- Service providers have been diligent in helping with this process.
- Since we have just started we have limited experience to adequately assess these areas.
- The Team process works very well. I think overall; most are satisfied with the process and the outcomes that result from it. Oftentimes families are in crisis when we first get them so we may need to jump ahead to getting services in prior to doing the assessment or developing the Plan of Care. We also go back and complete that process however. We have not received the results of the 2008 family satisfaction survey yet; and look forward to that; however my guess is that most families would rate the process and the service they received favorably.
- There is a constant review of how things are progressing while working with families. The more formal reviews to sit down and specifically go through the entire plan of care occur but we will focus on doing this more frequently. The results of the Family Satisfaction Surveys have more detail regarding the families' opinions on this program.
- This is generally hard to judge as we are a new site. However; feedback has been positive thus far; and there have been no complaints on our CST program.
- This is in flux all the time. Our deep-end families have been entrenched for a very long time and sometimes as we move forward a step we move back two steps. The providers and families are understanding and accepting this ebb and flow as a reality. Some families are strong enough to run with their plans. Others need support over a greater period of time.
- We are working to increase and improve the use of satisfaction surveys and team observation. This will help us know which team facilitation areas need attention to increase team and provider satisfaction.

**8. Adolescents are ensured a planned transition to adult life**

Indicators	4 – Always	3 – Often	2 – Seldom	1 - Never
1. A mechanism is in place to identify children age 14 and older who have long-term treatment needs and who will require services beyond age 18.	92% - YES			9% - NO
2. Plans of care reflect collaborative transitional planning for children age 14 and older identified as needing services beyond age 18.	88% - YES			12% - NO
3. For the most seriously ill adolescents, within one year of transition to adult living:				
• Action steps are clearly defined	44%	44%	8%	4%
• Needed referrals have been made	60%	36%	0%	4%
• Future collaborators are invited to team meetings	56%	%	0%	4%

**Comments:**

- Brown county does have an m-team process to transition cases with adult system supervisors and staff.
- Children with long-term support needs are identified and screened for CLTS. We are currently in the process of adding additional children to the CLTS Waiver. Social worker for adult long-term support attends team meetings for identified 14-18 year olds.
- Continues to be a weak area for us. Due to long-term care reform; our Dept. recently developed an MOU with the ADRC that spells out how we will transition youth requiring long-term care to adult services. The plan will be piloted and if necessary; we will suggest changes.
- Early identification.
- for question number 51; 2008 families did not warrant any seriously ill adolescents within a year of transition to adult living.
- In regards to transition I think that 14 years old is a little young to start looking at that and we probably do not really start planning until a child is at least 16 or 17. Since having DCFS worker Chris Hribal; as the Special Needs Coordinator working with us; I feel that we have a much clearer understanding and plan for transitioning kids over in to the adult world for services. We have a format to follow to refer to Family Care; and have always worked well with the Kenosha Unified School District as well as well as Kenosha Human Development Services.
- Our plan and expectations call for this to be done but our limited experiences have not had us face these situations yet.
- Problem...little money for this population. We are hopeful that a CCS grant; the ADRC's family care and IRIS will aid us with this.
- The families receiving services from ISP have children under the age of twelve therefore questions 49-51 are marked no and never because they do not pertain.
- The move to combine CRP with CCS programming is going to make any transition from adolescent to adult services even more seamless than before.
- The team always starts discussing what is needed for the transition of child and family early so a very defined plan is started so the child and family know what to expect when the child reaches eighteen. This has been more important recently due to long term care reform.
- The Wraparound Project is collaborating with CCS and the mental health team to better meet the needs of these adolescents. Proper referrals are made for success and the individual to live in the least restrictive environment.
- We are making consistent improvements in this area.
- We are still learning what actions steps should be taken.
- We have not had to transition any client into adulthood yet. However; there is a recently started team that will address transition as its major goal.