

Annual System of Care Review for Coordinated Services Team (CST) Initiatives and Integrated Services Projects (ISP)

County/Tribe _____

Date _____

Contact Person: _____

Completion Instructions:

This system review should be completed annually by your site's Coordinating Committee, your Project Coordinator and (if applicable) with your site's CST Consultant.

Parts A and C should be completed by both ISP and CST sites. Part B should be completed by CST sites only.

Sites that receive funding for both ISP and CST should complete one single "Annual System of Care Review" to reflect all of the children served by your ISP/CST.

Submitting Results:

Sites with CST (including sites with both ISP and CST), please complete and send a copy of this review by January 30th to:

White Pine Consulting Service
N3000 Rusch Road
Waupaca, WI 54981
(715) 258-5430
whitepine@mwwb.net

Sites with ISP Grants (that don't receive CST funding), please complete and send a copy of this review by January 30th to your State Liaison:

Nancy Marz
Bureau of Prevention, Treatment and Recovery
DMHSAS/DHS
1 W Wilson Street Room 951
Madison, WI 53703
(608) 261-6746
nancy.marz@wisconsin.gov

George Hulick
Bureau of Prevention, Treatment, and Recovery
DMHSAS/DHS
1 W Wilson Street Room 951
Madison, WI 53703
(608) 266-0907
george.hulick@wisconsin.gov

Western Regional Partnership Grant (RPG) Sites: please submit a copy of this review by January 30th to White Pine Consulting Service (address above). If you are also receiving ISP funding, please also submit your completed review to the appropriate State Liaison (see above)

PART A: Eight Key Components of Collaborative Systems of Care

To be completed by ISP and CST sites

Please use the following rating scale: 4 – Always 3 – Often 2 – Seldom 1 – Never

Indicators	Rating
1. Parents* are involved as full partners at every level of activity *The term “parent” represents the primary caregiver(s)	
1. Parents may request team meetings.	4 3 2 1
2. Parents are present at team meetings.	4 3 2 1
3. On child/family teams, the identified child/youth is present whenever possible and appropriate.	4 3 2 1
4. Parents’ needs are considered in scheduling meetings.	4 3 2 1
5. Parents are involved in selection of team members.	4 3 2 1
6. Parents represent at least 25% of the membership on the Coordinating Committee. and appropriate subcommittees	Yes No
7. Parents attend at least 75% of scheduled Coordinating Committee meetings.	4 3 2 1
8. Parents feel they are listened to by other committee members and that they have an important role on the committee.	4 3 2 1
2. An inclusive interagency group (Coordinating Committee) serving children and families has agreed upon the Core Values and Guiding Principles which are in the Interagency Agreement	
1. The Coordinating Committee reviews interagency agreements annually.	Yes No
2. Processes for referral, service coordination, intake, assessment, plan of care development, and transition are established.	Yes No
3. Coordinating Committee meets at least quarterly.	Yes No
4. Conflict resolution policies are clearly written and reviewed at least annually.	Yes No
5. The Coordinating Committee assures that the core values and guiding principles are evident in the operation of the integrated services system of care.	4 3 2 1
6. The Provider Satisfaction Survey is utilized to monitor the satisfaction of collaborating agencies with the process.	4 3 2 1
3. Collaborative family teams create and implement individualized support and service plans of care for families	
1. Orientation to the team process is provided to all team members.	Yes No
2. The team approach is used to identify and develop needed informal and formal supports and services	4 3 2 1
3. There are enough service coordinators to serve the needs of all families screened for enrollment.	4 3 2 1
4. Team composition is consistent with family culture and preferences.	4 3 2 1
5. Process is a collaborative team effort that begins with an individualized strengths- and needs-based assessment.	4 3 2 1
6. A single Plan of Care which guides the team process is developed for each child and family team.	4 3 2 1
7. Plans of care incorporate strengths of the child, family and team as identified in the Assessment Summary of Strengths and Needs	4 3 2 1
8. Plans of care include specific actions to meet identified needs, including who is responsible for completing the action.	4 3 2 1

9. Family and other team members sign the Plans of Care.	Yes No
10. On child/family teams, transition is addressed for major life changes (e.g. transition to different living environments, educational environments, etc.)	4 3 2 1
4. Significant collaborative funding is available to meet the financial needs identified in the Plan of Care	
1. Partner agencies contribute resources such as staff and other in-kind to support the collaborative team process	4 3 2 1
2. Partner agencies contribute financial resources to support the collaborative team process	4 3 2 1
3. Child and family teams use funding flexibly to support individualized service.	4 3 2 1
4. Child and family teams access informal community resources.	4 3 2 1
5. Advocacy is provided for each family	
1. Peer support (other parents with children who have multiple needs) and an advocate (someone who has been trained to support families involved in the team process) are offered as an option to enrolled families	4 3 2 1
2. Families are provided the option to have peer support specialists participate as team members.	4 3 2 1
3. Team members (including the service coordinator) advocate for families	4 3 2 1
4. Families are provided the option to attend formal training on how to become better advocates for their children	4 3 2 1
6. Ongoing training is provided to all participants	
1. Coordinating Committee and Project Coordinator identify training needs on an ongoing basis.	Yes No
2. Annual local training opportunities are made available to families, staff, and all others involved with the ISP process.	Yes No
3. Team facilitator and/or service coordinator receive training and ongoing support	4 3 2 1
4. Service coordinators have been trained and are certified to utilize the Child and Adolescent Needs and Strengths (CANS) tool.	4 3 2 1
5. A representative of the ISP/CST attends annual statewide and regional project directors meetings.	4 3 2 1
7. Functional goals are monitored and measured, emphasizing participant satisfaction	
1. Our CST/ISP participates in the statewide evaluation process, reporting required child and family data, including CANS items, at least every 6 months.	4 3 2 1
2. Plans of Care include measureable goals.	4 3 2 1
3. Child/family teams review and modify Plans of Care at least every six months, based on progress toward goals	4 3 2 1
4. Families are satisfied with the team process.	4 3 2 1
5. Families are satisfied with outcomes.	4 3 2 1
6. Providers are satisfied with process.	4 3 2 1
7. Providers are satisfied with outcomes	4 3 2 1
8. Families have a voice in the decisions that are made, access to needed services, and ownership of their plan of care.	4 3 2 1
9. Families evidence the ability to provide for the ongoing safety of all family members.	4 3 2 1

8. Adolescents are ensured a planned transition to adult life	
1. A process is in place to identify children age 14 and older who have long-term treatment needs and who will require services beyond age 18.	Yes No
2. For children age 14 and older identified as needing services beyond age 18, do their plans of care (within one year of transition to adult living), contain:	
a. Clearly defined action steps	4 3 2 1
b. Documentation that needed referrals have been made	4 3 2 1
c. Notation that future collaborators are invited to team meetings	4 3 2 1

PART B: System of Care and Process Outcomes

To be completed by Coordinated Services Team Initiatives only

System Outcomes	
1. CST core values are implemented across substance abuse, mental health, child welfare, and other identified systems as evidenced by consistent use of family-centered, strength-based plans of care and planning process that involves families and natural supports and all key service providers.	4 3 2 1
2. Any realized savings from substitute care budget are re-invested in the community-based CST process. Savings would be one of the funding sources for future sustainability. Planning for future sustainability begins in year one	Yes No
3. A formal system change evaluation process is established.	Yes No

Process Outcomes	
1. The administering agency is able to document a reduction in the number of children entering out-of-home care	Yes No
2. The administering agency is able to document that the length of time children spend in out-of-home care is reduced	Yes No
3. The administering agency is able to document there is a reduction in the number of children re-entering out-of-home care	Yes No
4. The administering agency is able to document a reduction in the rate of recurrence of child maltreatment	Yes No
5. A process evaluation procedure is established	Yes No

PART C: System of Care and Process Outcomes

To be completed by ISP and CST sites

1. Based on the results of this review, what recommendations does the Coordinating Committee have to improve your local CST/ISP process?
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