EIGHT KEY COMPONENTS FOR COLLABORATIVE SYSTEMS OF CARE

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

Key Component I. Parents* are involved as full partners at every level of activity. **The term "parent" represents the primary caregiver(s).*	
7. Parents may request team meetings that are convenient to them.	☐4 ☐3 ☐2 ☐1
8. Parents are present at team meetings.	☐4 ☐3 ☐2 ☐1
9. On child/family teams, the child/youth is present whenever possible and appropriate.	☐4 ☐3 ☐2 ☐1
10. Parents are involved in the selection of team members.	☐4 ☐3 ☐2 ☐1
11. Parents represent at least 25% of the membership on the Coordinating Committee and appropriate subcommittees.	☐4 ☐3 ☐2 ☐1
12. Parents attend at least 75% of scheduled Coordinating Committee meetings.	☐4 ☐3 ☐2 ☐1
13. Parents feel they are listened to by other committee members and they have an important role on the committee.	☐4 ☐3 ☐2 ☐1

Key Component II. An inclusive interagency group (Coordinating Committee) serving children and families has agreed upon the core values which are in the Interagency Agreement.	
14. The Coordinating Committee reviews interagency agreements at least annually.	☐Yes ☐No
15. Processes for referral, service coordination, intake, assessment, plan of care development, and transition are established.	☐Yes ☐No
16. The Coordinating Committee meets at least quarterly.	☐Yes ☐No
17. Conflict resolution policies are clearly written and reviewed at least annually.	☐Yes ☐No
18. The Coordinating Committee assures that the core values are evident in the operation of the collaborative system of care.	☐Yes ☐No
19. The Provider Satisfaction Survey is utilized to monitor the satisfaction of collaborating agencies with the process.	☐Yes ☐No

Key Component III. Collaborative family teams create and implement individualized support and plans of care for families.	
20. Orientation to the team process is provided to all team members.	☐4 ☐3 ☐2 ☐1
21. The team approach is used to identify and develop needed informal and formal supports and services.	☐4 ☐3 ☐2 ☐1
22. There are enough service coordinators to serve the needs of all families screened for enrollment.	☐4 ☐3 ☐2 ☐1
23. The team composition is consistent with family culture and preferences.	☐4 ☐3 ☐2 ☐1
24. Process is a collaborative team effort that begins with an individualized assessment of strengths and needs.	☐4 ☐3 ☐2 ☐1
25. A single Plan of Care which guides the team process is developed for each child and family team.	☐4 ☐3 ☐2 ☐1
26. 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
27. Plans of Care include specific actions to meet identified needs, including who is responsible for completing the action.	☐4 ☐3 ☐2 ☐1
28. Family and other team members sign the Plans of Care.	☐4 ☐3 ☐2 ☐1
29. 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
30. If challenging behaviors persist, teams still continue with a wraparound Plan of Care until they agree it is no longer required for a child and family.	☐4 ☐3 ☐2 ☐1

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

Key Component IV. Significant collaborative funding is available to meet the financial needs identified in the Plan of Care.	
31. Partner agencies contribute resources such as staff and other in-kind support for the collaborative team process.	☐4 ☐3 ☐2 ☐1
32. Partner agencies contribute financial resources to support the collaborative team process.	☐4 ☐3 ☐2 ☐1
33. Child and family teams use funding flexibly to support individualized service.	☐4 ☐3 ☐2 ☐1
34. Child and family teams access informal community resources.	☐4 ☐3 ☐2 ☐1

Key Component V. Advocacy is provided for each family.	
35. Parent 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 options to enrolled families, and may participate as team members.	☐4 ☐3 ☐2 ☐1
36. Team members, including the service coordinator, advocate for families.	☐4 ☐3 ☐2 ☐1
37. Families are provided the option to attend formal training on how to become better advocates for their children.	☐4 ☐3 ☐2 ☐1

Key Component VI. Ongoing training is provided to all participants	
38. The Coordinating Committee and Project Coordinator identify training needs on an ongoing basis.	☐Yes ☐No
39. Annual local training opportunities are made available to families, staff, and all others involved with the CST process.	☐Yes ☐No
40. Team facilitators and/or service coordinators receive training and ongoing support.	☐Yes ☐No
41. Service coordinators have been trained and are certified to utilize the Child and Adolescent Needs and Strengths (CANS) tool.	☐Yes ☐No
42. A representative of the CST attends annual statewide and regional project directors meetings.	☐Yes ☐No

Key Component VII. Functional goals are monitored and measured, emphasizing participant satisfaction	
43. Our CST participates in the statewide evaluation process reporting required child and family data.	☐4 ☐3 ☐2 ☐1
44. Plans of Care include measureable goals.	☐4 ☐3 ☐2 ☐1
45. Child/family teams review and modify Plans of Care at least every 3 months based on progress toward goals.	☐4 ☐3 ☐2 ☐1
46. Families are satisfied with the team process.	☐4 ☐3 ☐2 ☐1
47. Families are satisfied with the outcomes.	☐4 ☐3 ☐2 ☐1
48. Providers are satisfied with the team process.	☐4 ☐3 ☐2 ☐1
49. Providers are satisfied with the outcomes.	☐4 ☐3 ☐2 ☐1
50. Families have a voice in the decisions that are made, access to needed supports and services, and ownership of their plan of care.	☐4 ☐3 ☐2 ☐1
51. Families evidence the ability to provide for the ongoing safety of all family members.	☐4 ☐3 ☐2 ☐1

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

Key Component VIII. Adolescents are ensured a planned transition to adult life.	
52. A process is in place to identify children ages 14 and older who have long-term treatment needs and who will require services beyond age 18.	☐Yes ☐No
53. For children ages 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 3: SYSTEM AND PROCESS OUTCOMES

System Outcomes	
54. 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 a planning process that involves families, natural supports, and all key service providers.	☐4 ☐3 ☐2 ☐1
55. Are there cost savings to your county as a result of CST?	☐Yes ☐No ☐Don't Know
56. Any realized savings from the 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.	☐4 ☐3 ☐2 ☐1
57. Please explain why you believe your program does or does not have cost savings for your county or tribe. If you have specific numbers regarding cost savings, please provide them (this type of information is very valuable). If you don't know, please explain what information you are missing that you would need to make a determination or why the information you have is unclear.	

Process Outcomes	
58. The administering agency is able to document a reduction in the number of children entering out-of-home care.	☐Yes ☐No
59. The administering agency is able to document that the length of time children spend in out-of-home care is reduced.	☐Yes ☐No
60. The administering agency is able to document there is a reduction in the number of children re-entering out-of-home care.	☐Yes ☐No
61. The administering agency is able to document a reduction in the rate of recurrence of child maltreatment.	☐Yes ☐No
62. A process evaluation procedure is established.	☐Yes ☐No

PART 4: COORDINATING COMMITTEE RECOMMENDATIONS

63. What consultation and training do you need in 2015 for your CST?
64. What other recommendations does the Coordinating Committee have to improve your local CST process?

65. Please record the name of the person responsible for the completion of this survey who could be contacted with questions if necessary.

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66. Please record the phone number of the person responsible for the completion of this survey.

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