

DRAFT_Interagency Data Report Form AH

Interagency Review Team

Data Team,

Thank you for reviewing this survey! Most items are preceded by a text explanation of the question (in purple) or a specific request for feedback (in orange). Please use the text to guide you through the survey and please respond to the specific feedback. In general, we are seeking to have the easiest to use survey for workers in our field while attaining information that is critical for the policy decisions we recommend at the statewide level. *Do not hesitate to tell us what is missing or if you believe something should change!*

I look forward to your feedback.

DRAFT_Interagency Data Report Form AH

Review Team Meeting Information

1. Interagency Review Team Leader Contact Information

Name

Agency

Email Address

Phone Number

Logic is applied to this question. If the user selects Local Review Team they will be asked which circuit they represent. If the user selects Regional Review Team they will be asked which DCF region they represent.

2. Is this report for a Local Review Team or a Regional Review Team?

DRAFT_Interagency Data Report Form AH

Review Team Meeting Information

Logic applied.

3. Please select the Local Review Team's circuit?

DRAFT_Interagency Data Report Form AH

Review Team Meeting Information

Logic applied.

4. Please select the Regional Review Team's region.

DRAFT_Interagency Data Report Form AH

Review Team Meeting Information

5. Please indicate the **date of the meeting.**

Date / Time

MM	DD	YYYY
<input type="text"/>	<input type="text"/>	<input type="text"/>

Assessing how many cases were formally addressed at each meeting.

6. How many **cases did you staff** at your Review Team meeting?

The following three questions will help us assess how productive the teams are. We will be able to gauge if they have not addressed all the cases they were referred.

7. How many cases were **referred to** your Review Team?

8. How many cases were **resolved** by your Review Team?

9. How many cases are you **referring up** to the next Review Team level?

DRAFT_Interagency Data Report Form AH

Review Team Meeting Information

Please review the agency and partner list below and suggest any additions, subtractions, combinations or other changes. Please comment on how you believe the answer choices should be categorized or presented. Please make comments on the "other" box instructions. Please review general clarity, order, spelling and organization.

10. Which agencies were represented at this meeting? (Select all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Agency for Health Care Administration (AHCA) | <input type="checkbox"/> Local Mental Health Care Provider |
| <input type="checkbox"/> Agency for Person's with Disabilities (APD) | <input type="checkbox"/> DJJ Residential Provider |
| <input type="checkbox"/> Department of Children and Families-Child Welfare (DCF-CW) | <input type="checkbox"/> DCF Residential Provider |
| <input type="checkbox"/> Department of Children and Families-Substance Abuse and Mental Health (DCF-SAMH) | <input type="checkbox"/> SIPP Provider |
| <input type="checkbox"/> Department of Children and Families-Other (DCF-Other) | <input type="checkbox"/> CINS/FINS |
| <input type="checkbox"/> Department of Juvenile Justice (DJJ) | <input type="checkbox"/> SEDNET |
| <input type="checkbox"/> Department of Education (DOE) | <input type="checkbox"/> Care Management Organization (CMO) |
| <input type="checkbox"/> Department of Health (DOH) | <input type="checkbox"/> Community Action Team (CAT) |
| <input type="checkbox"/> Guardian Ad Litem (GAL) | <input type="checkbox"/> Local Substance Abuse Care Provider |
| <input type="checkbox"/> Florida Office of Early Learning (FOEL) | <input type="checkbox"/> Local Behavior Health Care Provider |
| <input type="checkbox"/> Community Based Care (CBC) | <input type="checkbox"/> Children's Legal Services (DCF) |
| <input type="checkbox"/> Managing Entity (ME) | <input type="checkbox"/> Child Protection Team |
| <input type="checkbox"/> Local School Representative | <input type="checkbox"/> Office of State Attorney |
| <input type="checkbox"/> Local Health Care Provider | <input type="checkbox"/> Office of the Public Defender |
| <input type="checkbox"/> Other/Provider (Please specify additional providers or stakeholders' organization names. Please separate responses by a semicolon, ";") | |

DRAFT_Interagency Data Report Form AH

#1. Youth Information

Please respond to the following prompts for the FIRST youth your review team staffed.

For the unique identifier questions we are hoping to use FSFN to match but we have included JJIS as well to cover our bases. Is there a better way we can ask this question. Should we require one or the other or just include one identifier?

11. When was the case **referred to your review team?**

Date

MM	DD	YYYY
<input type="text"/>	<input type="text"/>	<input type="text"/>

12. Please insert the Youth's unique identifier (FSFN Case ID).

13. Please insert the Youth's unique identifier (JJIS).

14. If the youth does not have FSFN or JJIS number please insert an alternative unique identifier. If no alternate identifier exists, please indicate the youth's first initial, last initial, and six digit date of birth mmddyy. (example Jim Morris born September 16, 1994= JM091694).

15. Please indicate the Youth's date of birth.

Date

MM	DD	YYYY
<input type="text"/>	<input type="text"/>	<input type="text"/>

We would like to assess how much work has already be done for staffing this case. Should we add any more teams or ask the question differently?

16. Which team(s) previously staffed this case? (Please select all that apply)

- Not Previously Staffed
- Multidisciplinary Team (MDT)
- Local Review Team
- Regional Review Team
- Informally Staffed
- Other (please specify)

We believe DOB will give us the most specific information. We want to ask for DOB in case the case spans over a youth's birthday.

Are these issues appropriate? Should we add, delete, change answer choices? Does the column categorization make sense? Is there a better way to organize these answer choices. Please suggest better wording, organization and clarity.

17. What issues were involved in this youth's case? (Select all that apply)

	Youth Issue	Current Caregiver Issue	Family Issue (biological, non-biological, or other non-caregiver adult)
Residential Placement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In Home Supports Needed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavioral Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical/Health Issue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Youth Age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parental Issue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abuse-Victimization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abuse- Perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Domestic Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Education Issue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adoption	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual/Developmental Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Homelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Human Trafficking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LGBTQ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incompetent to Proceed (ITP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abandonment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Problematic Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immigrant/Refugee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Language Barrier	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Failed Adoption	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Youth Issue	Current Caregiver Issue	Family Issue (biological, non-biological, or other non-caregiver adult)
Cross State Jurisdiction/Interstate Compact for Juveniles (ICJ)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Law Violations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School Discipline	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Truancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Special Education (504 and/or IEP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other (please specify)

We split out agency/system issues from the previous question. Are these issues appropriate? Should we add, delete, change answer choices? Does the column categorization make sense? Is there a better way to organize these answer choices. Please suggest better wording, **organization** and clarity.

18. What system issues were involved in this Youth's case? (Select all that apply)

- Funding Not Available
- Protocol Inconsistency
- Services Not Available
- Placement
- Cost Sharing
- Other (please specify)
- Transition (independent living)
- Transition (out of or into another system)
- Cross County/Circuit
- Multi-agency Cooperation
- Improper Services/Supports

This item needs some help. How should we capture how the case was resolved? What answer choices should we include?

19. How was the case resolved? (Select all that apply)

- Residential Placement Identified (DJJ)
- Residential Placement Identified (DCF)
- Services Provided
- In Home Supports Provided
- Funding Obtained
- Not Yet Resolved
- Other (please specify)

Please suggest better ways to assess the funding question. What are we really asking here? How can we best ask it?

20. Please identify and describe any funding sources utilized in this case.

The following three questions will help us assess how long cases are active and what their current status' are. Current status can be: referred, resolved, pending. Pending means it is unresolved but will stay at the current review team level. We hope this will add some accountability to the team meetings.

21. What is was the outcome of the review team case staffing?

▼

22. When was the case **resolved or referred**? (Please leave blank if the case is still pending.)

Date / Time MM DD YYYY

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23. Please leave additional information about this case below.

Logic applied. If the user selects yes then they will be sent to a new identical page for youth #2 and can continue up to 20 cases. If the user is finished reporting they are sent to the final question on general feedback for the state review team.

24. Do you have an additional case staffing to report?

- Yes, I need to report on another staffing for this review team meeting.
- No, I am finished reporting.

DRAFT_Interagency Data Report Form AH

Follow up with the State Review Team.

Please take the opportunity to communicate with the State Review Team.

This question allows a direct and open line of communication from the field to the state level review team.

25. Please share any best practices, recommendations and/or comments that you want the State Review Team to be aware of below.