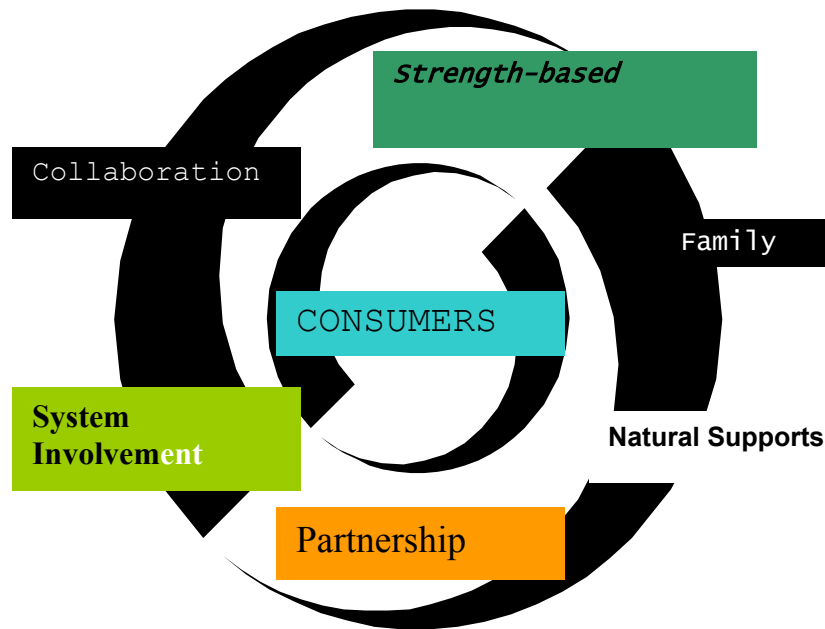


The Single Coordinated Care Plan Process Guide

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Developed by
The Management Group, Inc. (TMG)



Under Contract with

***The Milwaukee County Department of Human Services,
Division of Behavioral Health***

Through the

***Wisconsin Department of Health and Family Services,
Division of Supportive Living,
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NOTE: CURRENT VERSIONS OF THE INITIAL AND FOLLOW-UP CONSENT FORMS, THE BLANK SCCP, AND THE SCCP CONTACT LIST ARE AVAILABLE AT WWW.TMG-WIS.COM. CLICK ON THE SCCP LINK AT THE WEBSITE.

SECTION 1. INTRODUCTION

The Single Coordinated Care Process (SCCP) Guide has been developed to provide practical information and guidance to people involved in the single coordinated care planning process. This guide is intended for:

- Consumers,
- Family members and other people important in consumers' lives,
- Case managers and other workers from social services agencies, and
- Treatment providers.

The Process Guide includes:

- Background on the SCCP – what it is and why it's important,
- Key concepts behind the SCCP,
- How the SCCP process works,
- Frequently Asked Questions (FAQs), and
- Useful Material to support the SCCP process.

SECTION 2. BACKGROUND

The idea for the SCCP came out of the Milwaukee Family Services Coordination Initiative (1999-2000). This project focused on working with representatives from W2, child welfare, AODA, mental health, corrections agencies, and consumers involved in these systems, to identify the problems and barriers consumers faced as they tried to meet their goals. The barriers the consumers identified during the MFSC Initiative are described below.

- **Barrier category #1:**
Consumers are involved in multiple systems, each with separate goals, timelines and expectations. Systems often do not coordinate and communicate with one another. Consumers are subject to multiple, conflicting requirements.
- **Barrier category #2:**
Systems lack consumer focus. Consumers are often viewed as recipients of discrete services, rather than as whole people with families, needs and preferences, who have strengths and natural supports upon which they can build. There is lack of trust and understanding between consumers and the systems staff with whom they interact. Lack of consumer focus results in fragmented, inappropriate service plans and service delivery that does not effectively address consumer needs or build upon consumer strengths.
- **Barrier category #3:**
The approach to services for this population sometimes reflects societal stigmas towards people with mental health and substance abuse issues. There is a lack of knowledge and sensitivity about the needs of these families and how best to meet those needs.

- **Barrier category #4:**

The assessment and treatment system is not designed to adequately meet the needs of women who have complex mental health and substance abuse issues. Assessment may be inadequate, and referrals may be to services that are not designed to meet the consumer's needs. Since treatment duration is determined by funding streams rather than consumer needs, treatment often does not last long enough. There is little or no post-treatment follow-up.

- **Barrier category #5:**

Funding source structure and administration do not support consumer focus and achievement of outcomes.

Based on these issues, a set of recommendations was developed. One of the key recommendations was to create a single coordinated plan of care. Bringing multiple systems together with the consumer in a coordinated, strength-based planning process would help address many of the identified barriers.

In response to this recommendation, the Milwaukee County Department of Human Services (DHS) sponsored a project to develop the SCCP.

DHS asked The Management Group, Inc (TMG) to support the development of the plan and create a process that would help consumers in multiple systems better meet their needs. A SCCP Committee was formed with consumers, community representatives, and workers from each social services system, including AODA, Child Welfare, Corrections, Mental Health, W2, and Medicaid HMOs.

The SCCP Committee developed the SCCP based on the core values of the Milwaukee Family Services Coordination Initiative. These values include focusing on consumers' strengths and needs and building on support from family, friends, and the consumer's community. Other values include making the consumer not only a participant but also an active partner in care plan development. The same expectations are held for workers in each of the systems.

SECTION 3. KEY CONCEPTS AND APPROACHES

The SCCP is unique because it puts the consumer, the family and natural supports at the center of planning care. In many systems the provider of care, like the doctor, case worker, or counselor, decides what the consumer needs without finding out from the consumer what is most important to him/her. The SCCP plan is built using the goals and strengths of the consumer and him/her family as the main focus.

The SCCP builds on the Wraparound approach to meeting the consumers' and families' needs. The Wraparound approach brings the consumer, the family, and other support people together with different service providers. Together they develop a plan of care that is based on what the consumer needs, and one that builds on the consumer's strengths. The care is "wrapped around" the consumer in a cooperative way by agencies that provide a variety of services, as well as

informal supports. Agencies may include AODA and mental health providers, Child Welfare agencies, W-2 agencies, Department of Corrections, and other community organizations. Informal supports may include family, neighbors, friends, church members, or others.

The SCCP brings everyone together at the same time. The consumer and the people from all the agencies involved know what the consumer's goals are and what each agency is doing with the consumer. This way, there is less chance that services are duplicated or missed, financial resources can be shared, and communication is improved between all the people involved.

Core Values

There are basic values or beliefs everyone who uses the SCCP must share to make it work well. See Section 7. Attachment A for a detailed description of the core values associated with the SCCP. Brief summaries of each value are provided below:

- **Family-Centered**: Consumers and their family members work together to identify and meet the needs of the family as a whole and support each other as they move toward self-sufficiency.
- **Consumer Involvement**: The consumer and family are full partners in planning care and making decisions about their service plans.
- **Builds on Natural and Community Supports**: Relatives, neighbors, friends, members of the faith community, or others the family thinks would help support the care plan are encouraged to take part in this approach. Being part of a supportive community helps consumers continue to meet their goals.
- **Strength-Based**: The strengths, qualities, skills, and abilities of families are identified and supported by the members of the care planning team. The service providers offer their strengths to help consumers and families build strategies to move toward independence.
- **Unconditional Care**: The team adapts to the changing needs of the family. If difficulties arise services and supports change to meet the family's needs.
- **Collaboration Across Systems**: Everyone on the care planning team thinks of solutions to the consumer's needs and goals. The different agencies and systems understand each other's programs and work together to help the family.
- **Team Approach Across Agencies**: The different agencies and programs share responsibility for working with each other and the family to meet the consumer's goals.
- **Ensuring Safety**: When child protective services are involved, the team will maintain a focus on child safety. When safety concerns are present, a primary goal of the team is the protection of citizens from crime and the fear of crime.
- **Gender/Age/Culturally Responsive Treatment**: Services reflect an understanding and acceptance of people's cultural and lifestyle differences and respect these issues when planning services.

- Self-sufficiency: Families will be supported by the team to achieve life goals in the areas of safety, housing, employment, finance, education, psychological and emotional health, and spirituality.
- Education and Work Focus: The team is dedicated to positive, immediate, and consistent education, employment, and /or employment-related activities to improve quality of life for the consumer, family, and the community.
- Belief in Growth, Learning, and Recovery: Team members believe that every family desires change and can take steps toward attaining a productive and self-sufficient life. Healing is based on hope and grounded in practical everyday steps to move consumers and families toward improvement, growth, learning, and recovery.
- Outcome-oriented: Goals are identified and agreed-upon by all team members. Legal, education, employment, child-safety, and other mandates are considered in developing outcomes, progress is monitored, and each team member participates in defining success.

SECTION 4. THE PROCESS OF DEVELOPING THE SCCP

Guideposts for Developing the SCCP

The following principles guide Single Coordinated Care Plan development:

- The consumer is central to the process. The SCCP focuses on the consumer's needs while simultaneously addressing the requirements and mandates of each system.
- The SCCP builds on the consumer's vision and strengths. It is designed to help the consumer meet his/her needs, as he/she defines them.
- The consumer, service systems, family, friends and community members work together to help the consumer meet his/her needs. The SCCP should be built around available natural supports as much as possible. Support from service systems should fill in the gaps where consumers' family, friends, neighborhoods, and faith communities cannot meet consumer needs.
- Everyone on the SCCP team is accountable for doing his or her part.
- An important goal of the SCCP is to help the consumer achieve self-sufficiency in meeting life goals.

Specific Steps in the Process

This section explains how the SCCP is developed to assure that these principles are met. See Section 7. Attachments B, C and D for brief descriptions of the process for team members and consumers.

Step 1: Meeting between the consumer and the facilitator

The consumer meets with the person who will be the team facilitator. The facilitator is someone who is trained and experienced in Wraparound facilitation. At this meeting, the consumer and the facilitator get to know each another and begin planning for the first team meeting.

At the beginning of the meeting, the facilitator explains the process and tells the consumer what he/she can expect through the SCCP. The facilitator reviews Consent for Release Form #1 with the consumer, and the consumer signs it. The signed Consent for Release Form #1 is needed for the SCCP process to begin. See Section 5 for discussion of consumer confidentiality and consent forms. See Section 7. Attachments E, F, and G for copies of the consent forms, instructions, and Prohibition on Redisclosure.

At this meeting, the consumer identifies his/her *vision*. The consumer and the facilitator work together to identify the consumer's *functional strengths*. In addition, the consumer begins to identify his/her *needs*.

- **Consumer Vision** – The consumer vision describes how the consumer wants his/her life to be. It should be a short statement in the consumer's actual words. For example, a consumer's vision may be: "To have a happy, sober, and safe home with my children," or "To remain sober and get a good job."
- **Functional Strengths of the Consumer** – Every consumer has strengths that will help him/her meet his/her needs. The consumer and the facilitator work together to develop a list of these strengths. Strengths include the consumer's skills, talents, positive relationships, and strong personal qualities. Strengths can include things such as being well organized, having good friends or family, having a high school diploma or GED, having work experience, or having strong spiritual beliefs. The list may also include strengths of the consumer's family and community, if these strengths will help the consumer meet his/her needs.
- **Consumer Needs** – At the first meeting, the consumer and the facilitator start working on a list of areas where the consumer needs assistance. The list is discussed and items may be added during the first meeting with the full SCCP team. Consumer needs may include such things as finding affordable housing, getting good childcare, getting transportation to a job, managing finances, securing a job, meeting requirements from W2, Child Welfare, Corrections, and other systems, and achieving and maintaining sobriety. Consumer needs should not be confused with strategies. For example, "Learn how to deal patiently with my children" is a need, while "Attend parenting classes" is a strategy to meet that need.

The consumer and the facilitator make a list of people who will be invited to be on the consumer's SCCP team. In addition to the consumer and the facilitator, this list may include:

- Family or friends of the consumer
- Clergy or other members of the community
- Representatives of the various systems with which the consumer is involved. These may include:
 - Child welfare worker
 - W-2 FEP
 - Mental health case manager
 - Probation and parole officer
 - Other systems workers with whom the consumer (or in some cases for the consumer's family) is involved

It is important for the consumer and the facilitator to take time to discuss who should be on the consumer's team. If a consumer voices concern about one of his/her workers and chooses not to invite him/her to join the team, it is the facilitator's job to help the consumer understand the consequences—both negative and positive—of this decision. The consumer may not like the worker or feel particularly comfortable with him/her, but it may be helpful to the consumer to improve this relationship and begin working more closely with the worker to better meet his/her needs.

Talking these details through is an important part of the initial conversation between the facilitator and consumer, and this should be revisited as often as necessary to create the best team possible for the consumer.

Step 2: Scheduling the first SCCP team meeting

The consumer and the facilitator decide who will call people to invite them to the first meeting. Sometimes the facilitator does the calling, sometimes the consumer calls, and sometimes the consumer and the facilitator share the calling between them.

If the facilitator and consumer are having a difficult time tracking down a worker or getting him or her to respond to calls, use the SCCP Contact List to contact other staff at the worker's agency or ask for assistance from the worker's supervisor. (The SCCP contact list may be accessed at www.tmg-wis.com. Link to the SCCP section of the website.)

The consumer and the facilitator decide on a place for the SCCP team meeting. The meeting should be in a setting that is comfortable for the consumer, with sufficient space and privacy for the meeting to take place, and with a convenient location.

When a date is scheduled, the facilitator sends a written confirmation to all team members. The confirmation letter should include the date, place and time for the meeting. It should also explain the purpose of the SCCP and how it works. See Section 7. Attachment G for a suggested meeting confirmation letter.

Step 3: The first SCCP team meeting

At the first SCCP team meeting, the following things occur:

- **Consumer reviews and signs Consent for Release Form #2.**¹ See Section 5. Confidentiality and Consumer Consent for an explanation of this form. Copies of the consent forms are included in Section 7 (Attachments E & F).
- **Facilitator hands out the Prohibition on Redislosure Form** to team members. See Section 7 (Attachment F) for a copy of this form.
- **Introductions**—Team members introduce themselves to other team members, noting their relationship to the consumer.
- **Brief review of the SCCP plan and process**—The facilitator briefly describes the SCCP plan and process, handing out a blank copy of the plan for team members to review. The facilitator makes sure everyone understands that this is the consumer’s plan to help meet his/her needs and achieve his/her vision.
- **Review of consumer vision and strengths**—The consumer and the facilitator review with the rest of the team the consumer vision and strengths that they developed at their initial meeting. Team members may wish to add strengths to the list based on their knowledge of the consumer.
- **Review and discussion of consumer needs**—The consumer and the facilitator review with the rest of the team the list of consumer needs that they began developing at their initial meeting. Team members may volunteer other needs that they believe the consumer may have. For example, a consumer may be under court order to do certain things, or the consumer may be required to do certain things to meet a W-2 work requirement. The list of needs may change over time. The consumer should take the lead in ranking the needs, with the most important needs first and the least important needs later. Generally, needs felt most strongly by the consumer and requirements based on court orders or other system mandates should be ranked first.
- **Strategy development**—The team decides on specific strategies to help the consumer meet his/her needs. In developing strategies, the team looks at the consumer’s strengths and at his/her natural supports. What can the consumer and his/her support network do to help meet his/her needs? Then the team looks at the services and supports available from the systems involved in the consumer’s life. How could those systems contribute to meeting the consumer’s needs? From this discussion, a comprehensive list of strategies is created to help the consumer meet his/her needs and move toward self-sufficiency. The list of strategies usually will include formal services, informal supports from family and friends, and things that the consumer will do himself/herself.

The list of strategies, like the consumer’s needs, will change from meeting to meeting as the consumer gains new strengths and tools to manage his/her life. Some services and

¹ Depending on the agency, Consent Form #2 might be completed at the end of the first meeting. However, this form must be completed before the second meeting.

supports will be used for short periods of time, while others will be needed for longer stretches. The team is responsible for developing strategies to meet the consumer's needs, even if those needs are unusual or outside traditional services provided by systems represented on the consumer's team. The team should be creative and innovative in brainstorming ways to meet these needs.

If systems have requirements that the consumer must meet (for example, court-ordered conditions for regaining child custody or work requirements under W-2), these requirements should be included as strategies in the SCCP. Note that there will not necessarily be a strategy for every identified need. The team may decide to prioritize certain critical needs and focus, at least initially on strategies for meeting those needs.

The team should:

- Describe the strategy for meeting a need. What specifically will be done?
 - Who is responsible for doing it?
 - Where will it be done?
 - When will it be started? When will it be completed?
 - How many hours per week will it require? (This is needed for W-2 work requirements)
 - If there is a cost involved with the strategy, what is the funding source?
- ***Summarizing the meeting results and completing the signature page***—When the team has completed its discussion, the facilitator briefly reviews the consumer vision, strengths, needs, and strategies agreed to during the meeting. Team members sign the signature page of the plan, showing their understanding and agreement with the plan. When the facilitator gets the plan written up, the signature page is attached.
 - ***Scheduling the next meeting***. Each meeting concludes with an agreement on when and where the next meeting will be held. There is no fixed schedule for SCCP meetings. Team members should agree when the next meeting should be held, based on the consumer's needs.

Step 4: Completing the plan

The lead facilitator will take responsibility for completing, updating, and distributing the SCCP to team members. Some agencies may have an electronic version of the SCCP and complete the plan on computer. Other agencies will complete the plan by hand. For a copy of blank SCCP and an example of a completed plan, see Section 7. Attachments H & I.

Regardless of format, completing the SCCP in the right way is a central part of an effective care plan. Before completing the initial SCCP, be sure to have the consumer complete the required Confidentiality Release Form. Instructions for completing the plan can be found on the following page.

Instructions for Completing the SCCP	
1	Consumer Name – Print the consumer’s first and last name. Enter the consumer’s name in the header on the second page of the plan.
2	Lead Facilitator – Print the facilitator’s first and last name
3	Date of Initial SCCP – Enter the date of the first SCCP team meeting
4	Dates of SCCP Revisions – Enter the dates of follow-up SCCP meeting dates. This list should provide a running tally of when each follow-up meeting occurred.
5	Consumer Vision – In the consumer’s words, enter his/her vision for how s/he wants life to be. This statement should capture the consumer’s self-described goals and is usually one or two sentences long. Enter the consumer’s vision in header on the second page of the document.
6	<p>Functional Strengths of Consumers and Team Members – List the consumer’s functional strengths, those that will help him/her work toward his/her vision.</p> <p>Strengths can include a variety of things including accomplishments (earned GED or associates degree); personal qualities (articulate, honest, self aware); informal relationships (family, community, church); and skills (excellent cook, sense of humor, good parenting skills).</p> <p>This section also provides space to enter the strengths of team members, which might include things like strong advocacy, being well connected to community resources, compassion, and responsiveness.</p> <p>Strengths can be added at any time and will be the driving force behind developing strategies for helping the consumer achieve his or her goals.</p> <p>Feel free to use number or bullet points when listing strengths.</p>
7	<p>Consumer Need – This section provides space to describe consumer needs. Each need is numbered and should include the date the need is addressed by the team. Needs are identified by the consumer and the SCCP team members. Priority needs are likely to be addressed first. These might include needs related to shelter, food, and sobriety.</p> <p>Other needs, including mandates from the court system, are also prioritized. Longer-term needs or goals are addressed over time or as they become increasingly important to the consumer.</p> <p>It is important to note that <u>needs are different from services</u>. This section should not consist of a list of services that are available to consumers (parenting classes, bus passes, food stamps). For example, a consumer needs to become a more responsible parent; he or she does not need parenting classes. Parenting class is a service that may help the consumer improve his/her parenting relationship, but it is not a need.</p>

Instructions for Completing the SCCP	
8	<p>Strategies to Meet Needs – The strategy section describes how the consumer and his/her team members are going to meet the needs described above in #7. Strategies should be creative. Available services may be part of the strategy, but the team should come up with as many options as possible, including those that are informal and free.</p> <p>When a strategy for meeting a need is decided, it is important that the team include very specific information about the strategy including:</p> <ul style="list-style-type: none"> • A description of the strategy (or strategies) • Person or people responsible • Where it will occur? • Timeframe – how long will it take to complete and when will it be done? • Location – where is this going to occur? • Funding source – who is going to pay for the service or support? <p>Some of these questions may not apply to each strategy, but it is critical that as much relevant information as possible is included so that expectations and roles are clear.</p> <p>There may be more than one strategy for meeting each need. If this is the case, facilitators may choose to use numbers or bullets to outline each strategy.</p>
9	<p>Updates – This section is directly linked to the strategy section in #8. For every strategy listed, there should be an update on what happened:</p> <ul style="list-style-type: none"> • Who did what? • Was it a success? • Was it completed and accomplished? • Were there barriers to completing the strategy? What didn't work? • What are the next steps? <p>This section provides an opportunity to check in with team members, rethink strategies if necessary, celebrate successes, and provide some accountability to the consumer and team members, ensuring that people are invested and getting things done.</p> <p>If there is more than one strategy listed in #8, then the updates should include information on what's happening with each strategy. Facilitators may choose to add numbers or bullets to make the connection between strategies and updates.</p> <p>Please add dates for each entry. This will help facilitators track when strategies were revised, if they were successful, or if they were discontinued. Where applicable, provide the dates when goals are accomplished.</p> <p>You may need to add more boxes as your needs and strategies grow. To do this: simply copy the needs/strategies/updates box from your template and paste it into the case plan you're working on.</p>

Instructions for Completing the SCCP	
10	Notes – Enter any miscellaneous notes that do not reflect specific needs, strategies, or updates. This section can include information about team dynamics, ongoing barriers, and consumer circumstances – anything that is relevant and important to the success of the consumer. Be sure to include the date for each entry in the space provided.
11	Follow-up Meeting Date and Location – At the end of every SCCP meeting, the facilitator and team members should agree on the date and location of every meeting. This information should be included in the space provided.
12	Signature of Consumer and Date – When the plan has been completed and there is agreement among the team members about the strategies, the consumer should provide his/her signature and the date in the spaces provided.
13	Signature of Facilitator and Date – When the plan has been completed and there is agreement among the team members about the strategies, the facilitator should provide his/her signature and the date in the space provided.
14	Facilitator Phone – Enter the facilitator’s phone number
15	<p>Team Members’ Names and Signatures – Have team members print their names and addresses legibly in the space provided. Then ask that they sign their names after each SCCP meeting. Their signatures signify that they understand the plan, agree with the strategies for meeting needs, and take responsibility for completing assigned tasks. Also ask that they include their addresses. This will allow team members to stay in touch.</p> <p>This section also includes three columns that identify the team members’ roles. They include:</p> <ul style="list-style-type: none"> • Formal or Informal – Are you a friend, family member, pastor, or other community support (informal)? Or are you a professional representing an agency (formal)? • Organization or Relationship – Enter the organization you represent or describe the family/friend/community relationship. • Contact Numbers – List phone numbers and faxes if available. <p>Facilitators should ask team members to complete these columns at each meeting.</p>
16	Team Members Invited But Not in Attendance – Enter the names of team members invited but not able to attend the meeting. This helps keep track of who attends which meetings and provides some degree of accountability for the team. It may also identify barriers for team members who would like to come but, for some reason, can’t.
17	Prohibition on Redisclosure – At every SCCP meeting, facilitators should read the Prohibition on Redisclosure statement and remind team members that they are responsible for maintaining consumer confidentiality outside SCCP meetings.

Step 5: Distributing the plan

As soon as possible after the meeting, the facilitator writes up the plan reflecting the agreements reached at the meeting, attaches the signature page, and distributes the plan to all team members. It is important that the facilitator write up the plan exactly as the team members agreed it to. The facilitator will also want to send a Follow-up Meeting Confirmation notice with the plan. See Section 7. Attachment J for a sample Follow-Up Meeting Confirmation Notice.

Step 6: Follow-up meetings

Follow-up meetings should start by having the facilitator hand out the Prohibition on Redislosure Forms to team members, reminding them of the consumer's right to confidentiality (See Section 7. Attachment F for a copy of this form). Team members should then review the strategies agreed to at the previous meeting and determine whether they have been carried out. If a strategy has not been completed according to schedule, it will be important for the team to find out from the person responsible why the strategy was not completed. Either a new due date should be set, or the strategy or person-in-charge should be changed to assure that it will be carried out.

Once the current status of the plan has been determined, the team should make decisions about next steps. Given what has been achieved, what new strategies should be added? What strategies can be removed from the plan if goals have been met? What strategies should be changed? As the plan changes over time, it is important to remember that it should always reflect the consumer's vision, functional strengths, and needs. The consumer should continue to be at the center of the process.

Responsibilities of the Facilitator

The facilitator is a key person in the SCCP process. The facilitator is the person responsible for the care coordination and the care plan. The facilitator is also responsible for support services for the family, conducting family driven support teams, and handling related documentation. Facilitators' responsibilities include:

- Getting to know the consumer and helping him/her identify his/her vision, strengths, and needs.
- Making sure that team meetings are scheduled and that people important in the consumer's life are at the table.
- Explaining the SCCP process and goals to team members.
- Making sure that team meetings focus on the consumer's vision, functional strengths, and needs, and that the consumer is at the center of the process.
- Making sure everyone on the team has an opportunity to be heard and team members interact in a respectful manner.
- Writing and distributing the plan
- Assuring that all team members understand and respect consumer confidentiality and that the consumer signs the needed releases.
- Making sure the plan is being carried out and organizes the team if problems arise.

When a Team Ends

Every team has a different life span. How long a team continues to meet depends on whether the consumer wants continued support to meet his/her life vision. In some case, consumers will meet some or all of their goals and still want the support of the team to maintain the quality of their lives. In other cases, a consumer will choose not to continue on the team whether needs have been met or not. In these cases, it is important for team members to offer their support and express willingness to continue to work with the consumer. This may require rethinking the vision, revisiting the consumer's strengths, and working more efficiently to address the consumer's short and long-term goals.

SECTION 5. CONFIDENTIALITY AND CONSUMER CONSENT

Importance of Confidentiality

Confidentiality is central to the SCCP process. Federal law (42 CFR, Part 2) has very detailed and extensive requirements to protect the confidentiality of people with drug or alcohol abuse issues. It includes criminal penalties for violation of AODA confidentiality.

Professionals involved in the SCCP process are responsible for telling consumers about their right to confidentiality and consent. It is the job of professionals to make sure consumers understand these rights. It is their job to uphold these rights throughout the care planning process.

Protecting the consumer's confidentiality reduces the stigma related to AODA. This is one reason federal regulations are so strict in this area. Confidentiality increases the likelihood of treatment and supports consumers to be selective about what and to whom personal information is shared.

To ensure confidentiality and consent for consumers, the SCCP committee created two consent forms that meet the federal guidelines. The first consent form is completed generally at the initial meeting between the consumer and the facilitator. The second consent form is completed at the beginning or end of the first team meeting according to agency policy.

These forms and instructions are included in the Section 7. Attachments E & F.

Differences in AODA Consents and Other Consents

When using the new consent forms, agencies will notice several differences between AODA consent forms and other consent forms. These include:

- Selecting the people with whom information is shared
- Limiting redisclosure
- Specifying information to be shared

Selecting People With Whom Information Is Shared

When completing this section of the consent form, consumers identify members of their team by agency and location, if necessary. They also consent to allow team members to talk with each other about the consumer's plan. This sharing among the team only applies to specific information identified by the consumer.

Limiting Redislosure

Redislosure or sharing information with people who are not on the team is prohibited without the consumer's written consent. A team member at the meetings cannot give any AODA treatment information to anyone who is not listed on the consent, with a few exceptions.

- The consumer can identify other people to whom specific information can be released and includes their names on the consent form.
- Team members can disclose information within their specific department if it is necessary to the consumer's care. However, if they are in a large agency and have contracts with private agencies or there are other sub-departments who have no need for this information, legally they are not to redisclose verbally or through databases.

The Prohibition on Redislosure Form (See Section 7. Attachment F) should always be given out and explained at the initial meeting and at each follow-up meeting. This is important even though the Prohibition is printed on the SCCP; team members won't get copies of the SCCP for a week or so after the meeting.

Specifying Information to Share

The consent form lists specific types of information that could be discussed. Consumers have the right to limit what information is shared with team members. By initialing specific information on the consent form, the consumer indicates what information the team can discuss. Explanations of each item are on the instructions.

Other Key Points

- The consumer's *written consent* is mandatory, including signature and date.
- The consumer must be offered a copy of the consent form and can ask to see a copy of the information disclosed at any time.
- Consent forms must include the date or event (end of treatment) when the consumer's consent expires.

HIPAA Notes Update

The Wisconsin State Department of Health and Family Services recommends two changes to the SCCP Consent for Release of Confidential Information forms due to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations. Both are contained in the paragraph at the bottom of the form before the expiration date.

1. One sentence has been revised and one added to read: "The information that I authorize to be released may be redisclosed by the recipient of the records only if allowed by law. If information is redisclosed, the recipient of the redisclosed information may be controlled by different laws."
2. There is a new phrase, "I may revoke this consent in writing" because HIPAA requires a consent to be revoked in writing now instead of verbally as it was before HIPAA. The client could write a statement stating he/she revokes the consent, sign and date it right on the consent form.

SECTION 6. FREQUENTLY ASKED QUESTIONS (FAQs)

FAQs from Team Members

As a team member will it be my responsibility to maintain and update the coordinated care plan?

Unless you are the lead facilitator organizing the meetings with the consumer, you will not have to create, update, or distribute the plan for the rest of the team. This is one of the many advantages of being part of this process: you have someone leading the team and doing the groundwork so that you can focus your energy on getting to know the consumer and meeting his/her needs in the best way possible. Please note: All team members are still responsible for any plans specific to their agency.

I am concerned that the team won't focus on the things in the consumer's life that are important to my agency. How can I be assured that our requirements are met?

While the consumer's vision, strengths, and needs are central to the care planning, the team members recognize the importance of meeting system requirements. Workers from various agencies may have specific and, in some cases, court-ordered requirements; it's imperative that these get included on the plan. It's even more important that the team come up with ways to help consumers meet these system requirements while working toward their vision.

My caseload is pretty heavy, and I don't have lots of time to spend with each consumer. Will this team approach take more time and add to my work?

The frequency and length of team meetings vary from consumer to consumer and may take longer in the early part of the team's development, but it's likely that your participation will not take more time or add to your work. In fact, you'll have the advantage of working with other agencies to help the consumer. You'll have a team of people to rely on, other eyes and ears to help you track the consumer's progress and keep things moving in positive and progressive ways. You'll also be able to speak with the consumer and other caseworkers directly, reducing the need for time consuming phone calls.

I am new to this process, how can I best prepare for these meetings?

The consumer invited you to attend the team meeting because he/she sees you as someone who can help. Coming prepared and willing to participate sends a strong message to the consumer that you're ready to work together. Here are some tips to help you prepare:

- *Know what's expected.* As a team member you will be expected to listen to the consumer and help them articulate their vision, strengths, and needs. You will be expected to contribute your own thoughts and concerns and ensure that the requirements of the system you represent are met. You will also be expected to respect the needs of the other systems at the table and support all team members, especially the consumer, to feel part of the care planning process. This process asks team members to recognize that the needs of the consumer and the team as a whole are equally important to the needs of any one service system.
- *Be prepared to offer suggestions* and services to meet consumer needs, even those that fall outside your agency's service focus. The consumer and your team members rely on your expertise and community connections to support the SCCP.
- *Before the first meeting, make sure you gather and review material* related to the consumer. This could include case notes, court orders, treatment, care, or employment plans, progress to date, and current concerns.
- *Take a few minutes to think about the consumer's strengths.* Look beyond the consumer's needs to see his or her potential for success. You will be asked to share these at the first meeting, so take the time to jot your thoughts down.
- *Ask the facilitator* to send you an agenda and any other relevant material so that you can plan accordingly. Be sure you know where you'll be meeting and plan to be on time. This sends a strong message to the consumer and other teams members that you are committed to the process.

As you attend more meetings, you'll recognize that your role will vary from consumer to consumer and meeting to meeting. With each encounter, you'll gain new skills and knowledge about working collaboratively to support consumers.

Some of the team members and I seem to disagree about issues in the consumer's life. Understandably we are all coming at this from different directions, but what can I do to work better with my team members?

It's normal and natural that team members have disagreements. And in most cases, this is a sign that the team is dynamic and working hard. The important thing to remember is that disagreements among team members must be handled respectfully. Keep in mind the goal of each meeting: supporting consumers to achieve their goals. All efforts should be focused towards this end.

I've been working with consumers for years, and new case planning approaches have come and gone. What are the advantages of this approach, and how will it help me do my job better?

There are several advantages to this approach that will make your job easier. Participating in the SCCP meetings supports workers to

- Gain insight into multiple aspects of the consumer's life and focus on the whole person.
- Work in collaboration with other systems so that information is shared freely and new community contacts are made among agencies.
- Benefit from the built-in, ongoing monitoring system. Because teams check in regularly and talk about progress and barriers to meeting needs, there are people consistently focused on the consumer, supporting him/her to work toward his/her stated vision.

FAQs from Consumers

How will the SCCP help me get my life on track?

The SCCP will help you simplify and organize the different things you have going on in your life. Workers from the different agencies you deal with will be coming together to create one care plan that meets your needs. The people you invite to join your team will help you describe your goals, listen to and understand the different things you need in your life, and think of ways to help.

I've never been on a team before. What can I expect at these meetings and how can I get ready for them?

The lead facilitator will help you prepare for the meeting. He or she will describe how the meeting works and help you to come up with a list of people to be on your team. You can invite friends, family, neighbors, or people from your church, mosque or synagogue—people who know and support you. Your facilitator will help you list your strengths, a vision for your life, and your needs. You will decide what things the team knows about you and what things you want kept private. Team members will respect these limits. Remember: they are there to help you improve your life and meet your goals.

I don't get along with one of my case managers. Do I have to invite all workers to team meetings?

No. You don't have to invite all of your workers. However, these may be the people you are struggling the most with. Inviting them to join your team may help improve your working relationship and move things in a positive direction. In the end, though, you decide who attends the team meetings. By being on the team, a worker may better understand your situation and be better able to help you.

There are some things in my life that I don't like talking about. Do I get to decide what gets said at these meetings?

Yes. You get to decide what information is shared with your team members and others. Before and after your first team meeting the facilitator will give you two consent forms to fill out. These forms must be completed before you meet with team members. On them you will be able to list people that are allowed to be part of your team and discuss your personal issues. You will be able to limit or stop workers from sharing information about you with others. You will also be able to pick and choose what things about your life you want shared.

I would prefer having my team meetings at my house. Is this going to be a problem?

As much as possible, team meetings will be held in places selected by the consumer. Some people prefer having meetings in their own homes; others decide to meet at an agency. Feel free to talk about the possibilities with your facilitator and team members.

I have so many appointments each week with different agencies, how am I going to find the time to make it to these meetings?

The SCCP should reduce the number of appointments you have, especially if your team meetings are scheduled regularly and your workers attend. Also, if staying organized and keeping on top of things is difficult for you, then you and your team should identify this as a need and think of different ways to help you manage this better.

I have a pretty good sense of what my limits are, but some of my team members are pushing me to do things I'm not ready to do. How can I get them to listen to me and respect my opinion?

You are the driving force of your care planning team and need to let people know when you are feeling overwhelmed. If there are things that you aren't handling well or need help with, let your facilitator know. If emergencies arise and you don't know where to turn, or if you are not able to make one of your commitments, contact your facilitator and get his/her input and help. Remember: your team members are there to help you succeed.

SECTION 7. USEFUL SCCP MATERIALS

This section provides material that may be useful to you in preparing to conduct or attend a single coordinated care plan meeting. With the exception of the Consent Forms, which must be completed before the team meetings occur, use of these tools is entirely optional. They are provided to educate people about the SCCP and support consistency in the process.

Tools include the following:

- Attachment A. Core Values Memo
- Attachment B. Description of the SCCP for Team Members
- Attachment C. Expectations for Team Members
- Attachment D. Description of the SCCP for Consumers
- Attachment E. Initial and Follow-up Consent Forms and Instructions
- Attachment F. Prohibition on Redislosure
- Attachment G. SCCP Meeting Confirmation Letter
- Attachment H. Blank SCCP
- Attachment I. Completed Sample SCCP
- Attachment J. Follow-up Meeting Confirmation Letter
- Attachment K. Agency Contact List for SCCP Teams

ATTACHMENT A

DEPARTMENT OF HEALTH AND FAMILY SERVICES COORDINATED SERVICES TEAM INITIATIVE

Concept Paper – July 14, 2003

Vision

To implement a practice change and system transformation in Wisconsin by having a strength-based coordinated system of care, driven by a shared set of core values, that is reflected and measured in the way we interact with and deliver supports and services for families who require substance abuse, mental health, and child welfare services.

Core Values Guiding This Initiative

- Family-Centered: A family-centered approach means that families are a family of choice defined by the consumers themselves. Families are responsible for their children and are respected and listened to as we support them in meeting their needs, reducing system barriers, and promoting changes that can be sustained overtime. The goal of a family-centered team and system is to move away from the focus of a single client represented in systems, to a focus on the functioning, safety, and well being of the family as a whole.
- Consumer Involvement: The family's involvement in the process is empowering and increases the likelihood of cooperation, ownership, and success. Families are viewed as full and meaningful partners in all aspects of the decision making process affecting their lives including decisions made about their service plans.
- Builds on Natural and Community Supports: Recognizes and utilizes all resources in our communities creatively and flexibly, including formal and informal supports and service systems. Every attempt should be made to include the families' relatives, neighbors, friends, faith community, co-workers or anyone the family would like to include in the team process. Ultimately families will be empowered and have developed a network of informal, natural, and community supports so that formal system involvement is reduced or not needed at all.
- Strength-Based: Strength-based planning builds on the family's unique qualities and identified strengths that can then be used to support strategies to meet the families needs. Strengths should also be found in the family's environment through their informal support networks as well as in attitudes, values, skills, abilities, preferences and aspirations. Strengths are expected to emerge, be clarified and change over time as the family's initial needs are met and new needs emerge with strategies discussed and implemented.
- Unconditional Care: Means that we care for the family, not that we will care "if." It means that it is the responsibility of the service team to adapt to the needs of the family - not of the family to adapt to the needs of a program. We will coordinate services and supports for the family that we would hope are done for us. If difficulties arise, the individualized services and supports change to meet the family's needs.
- Collaboration Across Systems: An interactive process in which people with diverse expertise, along with families, generate solutions to mutually defined needs and goals building on identified strengths. All systems working with the family have an understanding of each

other's programs and a commitment and willingness to work together to assist the family in obtaining their goals. The substance abuse, mental health, child welfare, and other identified systems collaborate and coordinate a single system of care for families involved within their services.

- Team Approach Across Agencies: Planning, decision-making, and strategies rely on the strengths, skills, mutual respect, creative, and flexible resources of a diversified, committed team. Team member strengths, skills, experience, and resources are utilized to select strategies that will support the family in meeting their needs. All family, formal, and informal team members share responsibility, accountability, authority, and understand and respect each other's strengths, roles, and limitations.
- Ensuring Safety: When child protective services are involved, the team will maintain a focus on child safety. Consideration will be given to whether the identified threats to safety are still in effect, whether the child is being kept safe by the least intrusive means possible, and whether the safety services in place are effectively controlling those threats. When safety concerns are present, a primary goal of the family team is the protection of citizens from crime and the fear of crime. The presence of individuals who are potentially dangerous requires that protection and supervision be sufficiently effective to dispel the fears of the public.
- Gender/Age/Culturally Responsive Treatment: Services reflect an understanding of the issues specific to gender, age, disability, race, ethnicity, and sexual orientation and reflect support, acceptance, and understanding of cultural and lifestyle diversity.
- Self-sufficiency: Families will be supported, resources shared, and team members held responsible in achieving self-sufficiency in essential life domains. (Domains include but are not limited to, safety, housing, employment, financial, educational, psychological, emotional, and spiritual.)
- Education and Work Focus: Dedication to positive, immediate, and consistent education, employment, and/or employment-related activities which results in resiliency and self-sufficiency, improved quality of life for self, family, and the community.
- Belief in Growth, Learning and Recovery: Family improvement begins by integrating formal and informal supports that instill hope and are dedicated to interacting with individuals with compassion, dignity, and respect. Team members operate from a belief that every family desires change and can take steps toward attaining a productive and self-sufficient life.
- Outcome-oriented: From the onset of the family team meetings, levels of personal responsibility and accountability for all team members, both formal and informal supports are discussed, agreed-upon, and maintained. Identified outcomes are understood and shared by all team members. Legal, education, employment, child-safety, and other applicable mandates are considered in developing outcomes, progress is monitored and each team member participates in defining success. Selected outcomes are standardized, measurable, based on the life of the family and its individual members.

ATTACHMENT B

SINGLE COORDINATED CARE PLANNING

A Brief Description

You may have been contacted about participating on a *Single Coordinated Care Planning team* for one of your clients. This memo briefly explains the Single Coordinated Care Plan process and what you can expect.

What is a Single Coordinated Care Plan?

Currently, consumers who are involved in multiple systems (for example, W-2, AODA, Child Welfare and Corrections) have separate care plans for each system. The large number of separate, uncoordinated plans can result in needless *duplication* of services. In addition, because expectations and requirements are not coordinated among plans, they may collectively impose *unrealistic expectations* on consumers. Finally, the plans are often less effective than they could be because they do not build on the *consumers' strengths, informal support systems, or priorities*.

In response, The Milwaukee AODA/TANF Services System, a consortium of Milwaukee County and 40 AODA services providers, has initiated **Single Coordinated Care Planning**. This approach has been developed through a joint effort involving AODA agencies, W-2 agencies, Child Welfare Agencies, Mental Health Providers, Corrections, Medicaid HMOs, consumers and community representatives.

- The Single Coordinated Care Plan will apply to consumers who are receiving TANF-funded AODA services and who also are involved in one or more other systems.
- The plan will be developed by a "Planning Team" consisting of the consumer, his or her family members or informal supports, and representatives of all systems with which the consumer is involved. You may be asked to participate on a Planning Team for a consumer who is being served by your agency.
- The plan will be developed using the Wraparound approach. This approach is consumer-focused and builds on the consumers' goals and strengths. At the same time, it recognizes the necessity of complying with system mandates, such as court orders.
- The planning meetings will be led by facilitators who are trained in Wraparound facilitation. The facilitators will contact you about scheduling the meetings.
- The planning team will hold an initial meeting to develop the plan. Follow-up meetings will be held periodically to review progress and modify the plan as needed.

Benefits of Single Coordinated Care Planning

First and foremost, coordinated care planning will benefit the consumer by providing him/her with a single plan that builds on his/her strengths, addresses his/her needs and reflects the expectations and requirements of all systems with which he/she is involved.

Coordinated care planning will also benefit you, as a caseworker. It will give you an opportunity to discuss goals and strategies with everyone involved with the consumer, helping to assure efficient and cost-effective use of resources. Since you'll meet the consumer's other caseworkers face-to-face, the coordinated care planning process should vastly reduce the amount of "phone tag" you currently encounter trying to contact and coordinate with other systems.

In addition, the Single Coordinated Care Planning Process has many other benefits:

- It encourages creative approaches to achieving consumers' goals.
- It promotes accountability and shared responsibility.
- It provides systems representatives with information that is not always available or accessible.
- It generates a more permanent support system for consumers before and after system involvement.

Questions

If you have questions about the team you've been asked to participate on or about the Single Coordinated Care Plan in general, feel free to call your team's lead facilitator.

It is also important that you talk to your supervisor to let him/her know that you've been invited to participate on an SCCP team. Many people have played a part in the development and implementation of this process, so your supervisor may have helpful information about what you can expect as a team member.

ATTACHMENT C

SCCP EXPECTATIONS FOR TEAM MEMBERS

As a member of a single coordinated care planning team, you play an important role in helping consumers get the support they need to meet their goals. Your primary job will be to work with the consumer and other agency representatives to plan and coordinate different formal services and natural supports so that consumers can meet the demands of each system and, at the same time, move toward achieving their personal goals.

Your contributions as a team member cannot be overstated. To help you feel better prepared to participate in the team meetings, the following guidelines have been provided.

- Be on time and ready to stay for the duration of the meeting. Nothing can be more distracting or disappointing to a consumer than having team members come late and leave early.
- Be prepared to talk about your relationship and experience with the consumer, focusing on his or her strengths and on issues that need attention and resolution. Your insight and experience working with the consumer may help the team develop different strategies to meet his/her needs.
- Be a good listener. Even if you disagree with a team member or think something is being mischaracterized, focus on what people are saying. On any team, there are bound to be differences of opinion, especially as people sort out priorities and brainstorm different strategies. Keep an open mind and respect each team member equally.
- Think beyond the requirements of the agency you come from and look at consumer as a person with diverse needs and strengths. Whether you are from a W2 agency or from Child Welfare, your focus should be on getting to know the consumer and the circumstances of his/her life. You should strive to come to a better understanding of who the consumer is and what possibilities lay ahead for him/her. While specific concerns like W2 eligibility limits and weekly urinalysis testing are important and should be addressed on the plan, it's essential that you see your role as supporting the person to move beyond these agencies and gain self-sufficiency.
- Exercise your creativity. Great care plans are created when they're individualized to meet the consumer's needs. As much as possible, think of things in the consumer's life that could be used to support their success. Family, friends, neighbors, and faith communities—all could offer an array of built in support. Don't hesitate to think aloud and be creative about your approach to care planning.
- Follow through on what you've committed to do. If you've agreed to do something on the care plan, be sure that you do everything in your power to follow through. Your team members are counting on you!
- Respect consumer confidentiality and make sure you uphold the federal regulations.

ATTACHMENT D

SCCP INFORMATION FOR CONSUMERS

The Single Coordinated Care Plan

The SCCP or the Single Coordinated Care Plan is a new way for consumers to work toward achieving personal goals such as:

- Getting a job
- Staying sober and healthy
- Keeping families together
- Living successfully in the community

The SCCP brings together teams of people who work with consumers to help them figure out what they need to live the lives they want. The SCCP teams support consumers while they are working to achieve their goals. SCCP Teams are usually made up of family, friends, and workers from different agencies like W-2, Child Welfare, Corrections, and Drug and Alcohol Abuse services.

Consumers' teams will be different depending on the things they have going on in their lives and the family and friends they rely on for help. No matter who is on the SCCP teams, the goal is the same: to work together to create one plan that prioritizes consumers' needs and describes how these needs are going to be met. Each team member will have a job and a responsibility to the team and, more importantly, to the consumer.

How SCCP Works

Consumers who participate in the SCCP work with a person called the lead facilitator. Lead facilitators work closely with consumers, get to know them, help create a list of strengths and needs, and discuss possible team members. Lead facilitators are the people who organize the team meetings, write the coordinated care plan, follow up with team members and the consumer, and keep an eye on the team's progress.

When the consumer decides what people should be on his/her SCCP team, the lead facilitator and consumer set the time, date and location for the first meeting. This may take some negotiating given people's schedules, but the facilitator will do his/her best to schedule something that meets the consumer's needs.

Before the first meeting, the consumer will write a vision statement describing how he/she would like life to be. This statement will be the team's driving force. With the lead facilitator's help, the consumer will write a list of his/her strengths and needs that will be shared with the team during the first meeting. The remainder of the first meeting

will be spent prioritizing the consumer's needs and coming up with ways to meet these needs.

At the end of the first meeting, the consumer will have a coordinated care plan, one that describes how his/her most important needs will be met, who will be responsible for what, and when things should happen. The facilitator will also schedule a follow-up meeting so that the team can begin to meet regularly to support the consumer, discuss problems, and come up with strategies to make the coordinated care plan work. How often a team meets depends on the consumer and the team members.

If consumers have questions at any time during the SCCP process, they should call their lead facilitators.

Advantages of the SCCP

The SCCP is different from other approaches in several important ways.

- The SCCP builds care plans around consumers. Systems, family, and friends work together to help consumers talk about their needs and provide support for consumers to achieve their goals.
- It brings the key people in consumers' lives together on a regular basis to ask questions, problem solve, and celebrate accomplishments.
- The SCCP provides consumers one-stop-shopping. Team members come to the consumers and provide support, information, resources, and plans of action.
- The SCCP puts the requirements of each system on one plan, instead of two or three different plans.
- The SCCP builds families and other natural supports into consumer plans.

How the SCCP Helps Consumers and Families

The SCCP helps consumers to:

- Address basic and immediate needs (housing, food, clothing, transportation).
- Identify short and long-term needs and goals.
- Pick or prioritize which needs and goals are the most important.
- Think of ways that these goals and needs can be met using their professional knowledge and access to resources.
- Come up with new ways of doing things when others approaches haven't worked.
- Achieve their goals.
- Prevent crises.
- Plan for the future.

ATTACHMENT E

INITIAL AND FOLLOW-UP CONSENT FORMS

A current version of Attachment E
is located in the SCCP Directory
on the TMG website:
<http://www.tmg-wis.com>

ATTACHMENT F

PROHIBITION ON REDISCLOSURE OF INFORMATION CONCERNING CLIENT IN ALCOHOL OR DRUG ABUSE TREATMENT

This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

ATTACHMENT G

SCCP MEETING CONFIRMATION

Date:

To:

Subject: Single Coordinated Care Plan (SCCP) Meeting

You have been invited to participate on a Single Coordinated Care Planning team for **[Consumer's Name]** . The SCCP meeting has been scheduled for **[Date]** at **[Time]** . The meeting will be held at **[Location and address]** .

The purpose of the Single Coordinated Care Plan is to coordinate services and supports for the consumer. This meeting is an opportunity for you to work collaboratively with the consumer and representatives of other service agencies to develop a care plan that helps the consumer meet his/her needs and those of the systems in which he/she is involved.

The meeting will focus on the consumer's vision, strengths and needs. You have been invited to attend because the consumer views you as someone who can help.

I have attached some background information including an agenda, a brief description of the process, and expectations for team members. Please feel free to contact me if you have questions. I look forward to seeing you on the **[Date]** .

Sincerely,

[Name]

[Title]

Enclosure

ATTACHMENT H

Single Coordinated Care Plan (SCCP)

Consumer Name:
Lead Facilitator:
Date of Initial SCCP:
Dates of SCCP Revisions:

Consumer Vision _____

Functional Strengths of Consumers and Team Members	

Single Coordinated Care Plan (SCCP)

1. Consumer Need: <i>(Add Date of Meeting when Need & Strategies were addressed)</i>
Strategies to Meet Needs: (For each strategy include the following: what, who, where, when, how long, funding source, and other relevant information)
Updates: (Progress and accomplishments – Please date each entry and include dates of completion or accomplishments when applicable)

2. Consumer Need: <i>(Add Date of Meeting when Need & Strategies were addressed)</i>
Strategies to Meet Needs: (For each strategy include the following: what, who, where, when, how long, funding source, and other relevant information)
Updates: (Progress and accomplishments – Please date each entry and include dates of completion or accomplishments when applicable)

Single Coordinated Care Plan (SCCP)

3. Consumer Need: <i>(Add Date of Meeting when Need & Strategies were addressed)</i>
Strategies to Meet Needs: (For each strategy include the following: what, who, where, when, how long, funding source, and other relevant information)
Updates: (Progress and accomplishments – Please date each entry and include dates of completion or accomplishments when applicable)

4. Consumer Need: <i>(Add Date of Meeting when Need & Strategies were addressed)</i>
Strategies to Meet Needs: (For each strategy include the following: what, who, where, when, how long, funding source, and other relevant information)
Updates: (Progress and accomplishments – Please date each entry and include dates of completion or accomplishments when applicable)

Single Coordinated Care Plan (SCCP)

5. Consumer Need: <i>(Add Date of Meeting when Need & Strategies were addressed)</i>
Strategies to Meet Needs: (For each strategy include the following: what, who, where, when, how long, funding source, and other relevant information)
Updates: (Progress and accomplishments – Please date each entry and include dates of completion or accomplishments when applicable)

6. Consumer Need: <i>(Add Date of Meeting when Need & Strategies were addressed)</i>
Strategies to Meet Needs: (For each strategy include the following: what, who, where, when, how long, funding source, and other relevant information)
Updates: (Progress and accomplishments – Please date each entry and include dates of completion or accomplishments when applicable)

Single Coordinated Care Plan (SCCP)

Notes	
Date	

Follow-up Meeting Date:	Location:

Single Coordinated Care Plan (SCCP)

Signature of Consumer:
Date:
Signature of Lead Facilitator:
Date:
Facilitator Phone:

Team Members' Names Addresses & Signatures <i>(Please write legibly)</i>	Formal or Informal	Organization or Relationship	Contact Numbers (Phone & Fax)

Single Coordinated Care Plan (SCCP)

Team Members Invited But Not In Attendance	
Date	Members Not in Attendance/Reason

Prohibition on Rediscovery: This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Par 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

ATTACHMENT I

Single Coordinated Care Plan (SCCP) Sample

Consumer Name: Gina Gray – <i>Sample Consumer</i>
Lead Facilitator: Patty Mallone – <i>Sample Facilitator</i>
Date of Initial SCCP: 5/19/03
Dates of SCCP Revisions: 5/28/03, 6/17/03, 7/14/03

Consumer Vision _____
I want to learn how to do deal with life and have a happy and joyous recovery. I want to stop using all drugs and eventually have a career working with elderly people.

Functional Strengths of Consumers and Team Members	
<p>Consumer's Strengths: Open-minded Willing to be honest Willing to give abstinence a try Makes very good first impression and follows through Articulate Takes one day at a time Gets strength from her kids</p> <p>W-2 FEP's Strengths: Good communicator Excellent rapport with consumer Experienced FEP Knows rules and regulations Willing to work with consumer</p> <p>Therapist's Strengths: Experienced T-19 Reimbursable Flexible People person, easy to talk to Down to earth Able to keep it real Non-judgmental</p>	<p>Housing Counselor's Strengths: Effective HAS LIST OF LANDLORDS THAT RENT TO CONSUMERS REGARDLESS OF HOUSING HISTORY</p> <p>TREATMENT COUNSELOR'S STRENGTHS: KNOWLEDGEABLE ABOUT ADDICTIONS AND RECOVERY RESOURCEFUL GOOD SENSE OF HUMOR UNDERSTANDS CONSUMERS Good motivator</p>

Single Coordinated Care Plan (SCCP) Sample

7. **Consumer Need** (5/19/03): Recovery from addictive disorder, cocaine dependence, and mental health issues including depression.

Strategies to Meet Needs:

(For each strategy include the following: what, who, where, when, how long, funding source, and other relevant information)

1. Consumer will attend POWER program at MWC (5444 W. Fond du Lac Avenue). This includes: POWER groups M-Th at 10 am and 12:30 pm; meeting with drug counselor 1x/week in the office or at consumer's home. Activities funded by AODA/TANF.
2. Random urine analysis to be done in house at POWER. This includes a combination of the quick result tests to be paid for by POWER.
3. Consumer will attend Narcotics Anonymous 12 Step Meetings at a frequency to be determined by the consumer; consumer will read NA literature, get sponsor and other support persons, get and use phone numbers of members in recovery. Case manager will accompany consumer to 1st meeting if she cannot find someone to go with her.
4. Consumer will call the emergency number for MWC to get the case manager on call if craving comes up. Consumer will also call her other support persons from her phone list. No payer is required.
5. Consumer will meet with therapist at the MWC clinic on 611 Broadway St. Consumer and therapist will determine the frequency of visits.

Updates:

(Progress and accomplishments – Please date each entry and include dates of completion or accomplishments when applicable)

1. Consumer has goes to POWER on daily basis –attendance and participation is phenomenal.
2. 5/15/03 Consumer has not started meeting with drug counselor yet.
3. 6/17/03 Consumer reports that she has made a plan to start NA meetings this week and will try the 12-Step Club and Friendship Club.
4. Consumer voiced concern about attending family event. She worried about relapse. Case manager talked with consumer about relapse and recovery and how to deal with anxiety. Case manager and consumer talked about a relapse prevention plan including reviewing the on-call emergency phone numbers.
5. 7/07/03 Consumer has attended NA meetings with two friends two weeks in a row.

Single Coordinated Care Plan (SCCP) Sample

2. Consumer Need (5/19/03): Transportation

Strategies to Meet Needs:

(For each strategy include the following: what, who, where, when, how long, funding source, and other relevant information)

1. W2 FEP will attempt to arrange for consumer to pick up her weekly bus pass at the north side site. FEP will let case manager know when the pass is available by Friday, 7/18/03. Consumer will pick up pass in person. Payer is Maximus.
2. Case manager will provide emergency bus passes as the need arises. Payer is AODA/TANF. Consumer will keep in touch with case manager about bus passes.
3. T-19 will provide transportation for doctor's appointments and therapy sessions.

Updates:

(Progress and accomplishments – Please date each entry and include dates of completion or accomplishments when applicable)

1. FEP contacted case manager and consumer picked up bus pass on 7/21/03.

3. Consumer Need (5/19/03): Safe Housing

Strategies to Meet Needs:

(For each strategy include the following: what, who, where, when, how long, funding source, and other relevant information)

1. Consumer would like to move out of the emergency shelter. Consumer wants to meet with housing counselor to assist with housing search.
2. Case manager will fill out referral form and consumer will make an appointment to meet with housing counselor.

Updates:

(Progress and accomplishments – Please date each entry and include dates of completion or accomplishments when applicable)

1. 5/28/03 consumer and housing counselor have found housing
2. Consumer moved into her new apartment on 6/20/03.
3. Case manager phoned building inspector to check on code violations and found none.
4. AODA/TANF grant application was submitted by case manager.
5. Grant received and delivered to landlord by case manager.
6. Consumer and case manager discussed strategies to get rent assistance. Consumer will talk to housing counselor to apply for federal programs.

Single Coordinated Care Plan (SCCP) Sample

Notes	
Date	
5/28/03	Case manager phoned SDC case manager who did not want to continue SCCP process because consumer found housing. SDC will make referral to another agency; no meeting was scheduled.
6/10/03	SCCP process will continue with W-2 FEP. Case manager will attend appointment with consumer at her next W-2 meeting.
6/17/03	Wrap process will no longer include W-2 FEP because consumer is being moved to a new region. No SCCP is being scheduled until a new FEP is assigned.

Follow-up Meeting Date:	Location:
7/14/03 Thursday at 2:30	MWC - 611 Broadway Street

Single Coordinated Care Plan (SCCP) Sample

Signature of Consumer: Gina Gray
Date: 8/14/03
Signature of Lead Facilitator: Patty Mallone
Date: 8/14/03
Facilitator Phone: 222-333-4444

Team Members' Names Addresses & Signatures <i>(Please write legibly)</i>	Formal or Informal	Organization or Relationship	Contact Numbers (Phone & Fax)
Case Manager	Formal	MWC	
W-2 FEP	Formal	Maximus	
Therapist	Formal	MWC	

Single Coordinated Care Plan (SCCP) Sample

Team Members Invited But Not In Attendance	
Date	Members Not in Attendance/Reason

Prohibition on Rediscovery: This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Par 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

ATTACHMENT J

SCCP FOLLOW-UP MEETING CONFIRMATION

Date:

To:

Subject: Follow-up Single Coordinated Care Plan Meeting

Thank you for your participation on **[Consumer's Name]** SCCP team. I have attached the current care plan for your review. Please let me know if you have any questions about the plan.

As we agreed at our last meeting, the next SCCP team meeting for **[Consumer's Name]** will be held on **[Date]** at **[Time]**. The meeting will be held at **[Location and address]**.

Please bring a copy of the current SCCP, as well as any additional material that may be helpful to the team.

Your involvement in these team meetings is important to the consumer. If for any reason you cannot attend the meeting, contact me.

I look forward to seeing you soon.

Sincerely,

[Name]

[Title]

Enclosures

ATTACHMENT K

SCCP CONTACT LIST

A current version of Attachment K
is located in the SCCP Directory
on the TMG website:
<http://www.tmg-wis.com>