The Coordinated Services Team Initiative
Service Coordination and the Team Process

Peter Christensen Health Center
Lac du Flambeau, WI
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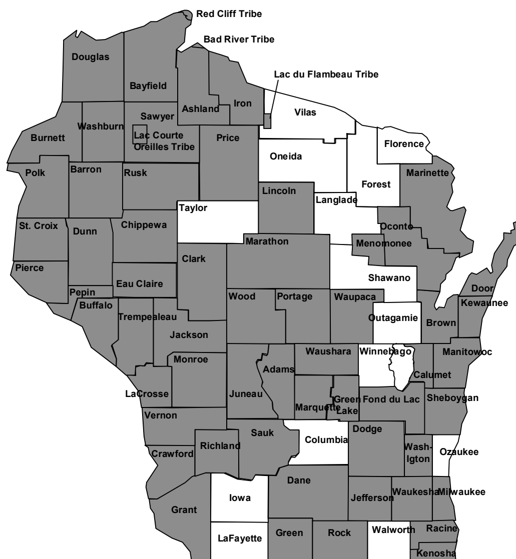
The Importance of Partnership

- No single agency has the staff or resources to serve all individuals with complex needs. Drawing on the expertise and energy of many agencies and individuals working together can increase resources.
- Successfully meeting the needs of participants, families, and team partners, requires a close collaborative relationship with the participant. The participant must be actively involved in the planning, implementation, and evaluation of services.

Why Collaborate?

- Share limited resources
- Share information
- Achieve mutual goals
- Reduce conflict
- Best use of group members' expertise
- Nice people to meet with

Wisconsin's Collaborative Systems of Care
Serving Children & Families
(Updated July 2009)

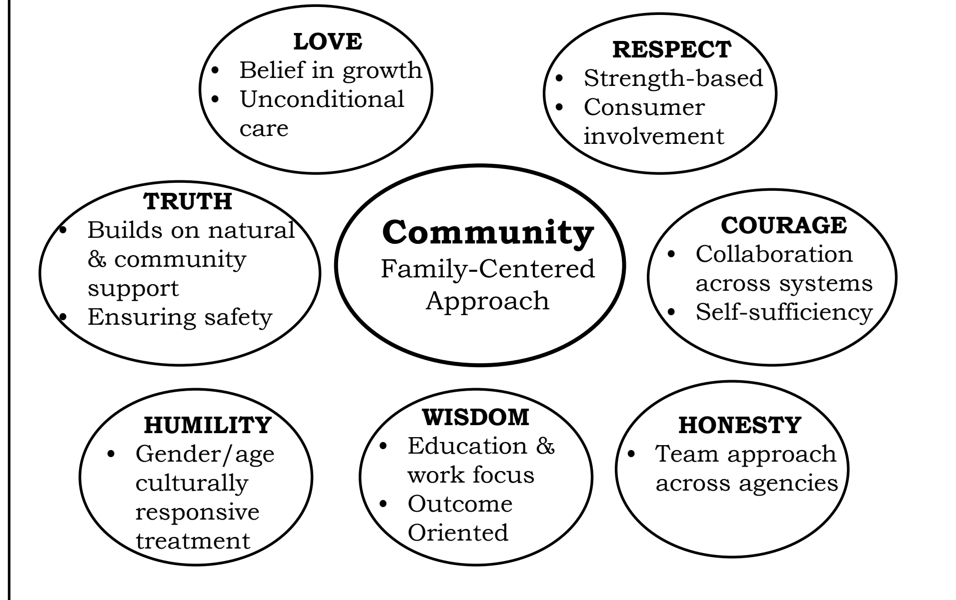


Practicing by the Principles

- Participant Involvement
  - Participant is involved in the planning at all times
  - Participant has voice, access and ownership
- Collaborative/Team Practice
  - Participant and community supports, and service providers working together to establish one plan
  - Unconditional care in all systems involvement
- Individualized Plans
  - Plans that are strength based, needs driven, individualized, culturally competent and community based

Core Values

- Participant-centered approach
- Participant involvement throughout the process
- Building resources on natural and community supports
- Strength-based approach
- Providing unconditional care
- Collaborating across systems
- Using a team approach across agencies
- Ensuring Safety
- Being gender/age/and culturally responsive
- Promoting self-sufficiency
- Focus on education and employment where appropriate
- A belief in growth, learning and recovery
- Being oriented to meaningful outcomes



Traditional Services vs. Wraparound

Traditional Services	Wraparound
The service provider is the expert	Participants have insight into their own needs and strengths
Participants have little input in or ownership of plans concerning them	Participants have input and ownership of plans concerning them and their family
Focus of treatment is problem saturated	Focus is strength-based
Participants are often seen as the cause of the problem	Blame is not placed on the participant; care is unconditional
Relatives and other non-service providers are not utilized in treatment	Relatives and other non-service providers are key to the plan
Participant is left with little support following treatment	Participant is left with long-lasting support

Collaboration with Participants

- Voice: Participants are listened to as active team members throughout the process
- Access: Participants have valid formal and informal options. Categorical service issues are addressed by the team.
- Ownership: The Participant helps develop, understands, agrees with and commits to any plan concerning them.

Target Group

- Involvement in two or more direct services
- Other interventions have not been successful over time; persistent obstacles to service access exist; and/or there is a need for service coordination
- Placement in or at risk of a restrictive living placement
- Willingness to be involved in the wraparound process

The Referral Process

- Referring person discusses referral to wraparound as an option with the participant
- Referring person discusses potential referral with project staff
- Referring person and participant complete Referral Form
- Project staff reviews referral
- Referring person and project staff organize the screening process, if necessary

The Screening Process

- Confirm eligibility
- Determine if wraparound is the best way to meet needs
- Answer/clarify questions
- Affirm commitment
- Involvement in wraparound or referral to other supports

Engagement Phase Tasks

- Meet and begin building a relationship with the consumer
- Explain the collaborative team process
- Address safety and immediate needs
- Gather perspectives on strengths and needs
- Begin Initial Assessment Summary of Strengths and Needs
- Begin to identify an emerging sense of mission
- Identify, invite and orient wraparound members
- Arrange initial wraparound meeting

Individual and Family Culture

- Culture is defined as "the unique values, ideas, customs, skills, arts, of a family or a people that are transferred, communicated and passed along"
- "Culture" refers to the unique way an individual or family operates and functions, including habits, characteristics, preferences, roles, values, traditions etc.
- Sometimes we have difficulty identifying individual and family culture or reflecting it in Plans of Care. Culture is much more than race, language or food preferences. Without a quality and thorough discovery of family culture, and without reflecting that culture in the work of the team, plans are less likely to be successful.

Core Conditions in Engagement

- Genuineness
  - Being you
  - Being consistent in what you say and do
  - Communicating trustworthiness and acceptance
- Empathy
  - Communicate an understanding of and compassion for the person's experience
- Respect
  - Believing in the value of each person and the potential within them
  - Your ability to communicate respect in observable ways

Explaining the CST Process to a Consumer

- Planning Process
- Strengths-based and needs driven
- Consumer and team based
- Assures that all parties are on the same page
- Comprehensive stabilization is provided

Qualifications for Team Involvement

To qualify for team involvement, individuals should:

- Have a role in the lives of the participant
- Be supportive of the participant
- Be supported for membership by the participant
- Be committed to participate in the process – including regular team meeting attendance
- Participate in discussions
- Be involved in the Plan of Care

Team Development
Informal/Natural Supports as Team Members

- Emphasize the importance of natural supports as team members with the participant at time of referral and screening
- Help the consumer or family identify their natural supports
  - Who is the first person you call in a crisis?
  - Who do you trust?
  - Who has been helpful to you in the past?
  - Do you have neighbors who could help?
- Make natural support recruitment an ongoing team goal
- Don’t give up – it may take months and require creative planning

Team Development
Getting Natural Supports on Teams

- Make personal contact, initiated by someone who has a trusting relationship with the person
- Eliminate barriers
  - Childcare
  - Transportation
  - Time & location of meeting
- Help ensure an active role
  - Encourage active participation
  - Explain the reciprocal supportive role of the team
- Provide orientation and ongoing support

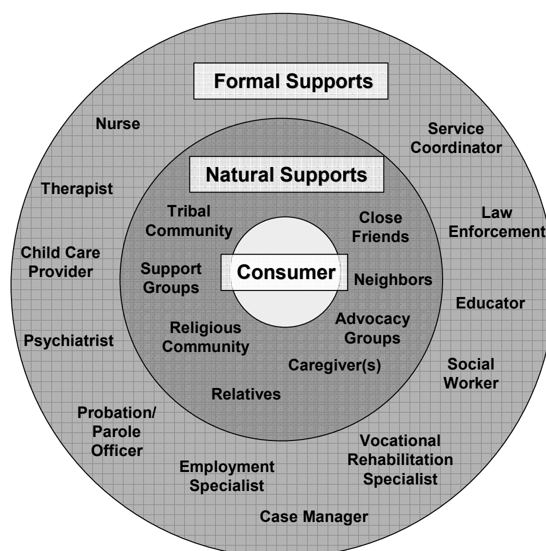
Team Development
Children as Team Members

- Age
- Nature of the child's disability
- Ability to contribute
- Child's schedule

Team Development
The Role of Advocacy

- Reinforce Coordinated Services Team process
- Use their experience to support the participant
- Attend & participate in team meetings
- Encourage balanced participation
- Clarify communication
- Ensure team members are being heard
- Encourage active listening

Develop Your Team



Service Provider Orientation

- Explanation of the CST Process
- Role and Vision for the Participant
- Perceived Needs
- Perceived Strengths
- Perception of What Works

The Role of a Service Coordinator

Role:

- “Expert” on the Collaborative Team Process
- Assure Team Completes the Assessment and Plan of Care
- Ensure the Plan of Care is Monitored
- Ensure Reassessment and Plan of Care Updates
- Share Outcomes

Not Role:

- Sole decision-maker
- Person who does all the work
- The only person team members call
- To dictate what should be done, to infringe on, or be a substitute for the policies and procedures of other agencies

Service Coordination: Abilities for Effective Team Facilitation

- Ability to accurately listen
- Ability to communicate clearly
- Ability to develop trust of team members
- Ability to understand multiple perspectives
- Ability to intervene on ineffective behavior
- Ability to accept feedback without reacting defensively
- Ability to provide support and encouragement
- Ability to maintain and demonstrate patience

Preparing for a Team Meeting

- Ensure all team members are aware of meeting time and location – address possible barriers to attendance
- Reserve meeting room
- Prepare materials
- Follow-through on commitments

Source: The Team Handbook, Second Edition; Scholtes, Peter; Joiner, Brian; and Streibel, Barbara. 1996, Joiner Associates, Inc.

Team Facilitation: Important Details

- Hold meetings when & where it is best for most
- Conduct regularly scheduled meetings
- Establish meeting time and end as planned
- Establish and follow an agenda
- Ensure that someone is responsible for taking and distributing meeting minutes

Using Agendas

- Discuss & record end time
- Develop “skeleton” agenda, including carry-over items from the last meeting
- Solicit additional items from team members
- Include scheduling of next meeting(s)

Source: The Team Handbook, Second Edition; Scholtes, Peter; Joiner, Brian; and Streibel, Barbara. 1996, Joiner Associates, Inc.

Facilitating a Team Through the Agenda

- Cover one agenda item at a time
- Manage discussions
- Maintain focus and pace
- Address and work through conflicts

Source: The Team Handbook, Second Edition; Scholtes, Peter; Joiner, Brian; and Streibel, Barbara. 1996, Joiner Associates, Inc.

Team Facilitation: Promoting Participation

- Clarify team members' roles, strengths, and goals
- Establish team guidelines
- Assure active and sincere participation by all team member
- Identify "hidden agendas" and get them on the table
- Recognize and reward creativity, flexibility, and volunteerism by team members
- Evaluate team member satisfaction with the process at the end of meetings

When to Use Different Decision-Making Methods

Consensus	Voting
• Use with small groups (10 or less) • When decisions are important or affect a lot of people • The group is informed and individual members feel a similar level of investment	• When it is known that consensus is highly unlikely in the time allowed • Members are equally informed on the subject matter and understand each others' viewpoints • Have a plan for how to keep those who "lose" from becoming defensive
Subgroup	**One Person**
• When the whole group is truly comfortable delegating their authority • When the subgroup has the necessary information and expertise to make the decision	• When it's an emergency • One person has all of the relevant information • One person is especially trusted to make a good decision • The outcome only impacts the decision-maker

Adapted from The Team Handbook; Sholtes, 1996

Facilitating The Meeting Process: Closing the Meeting

- Summarize Decisions
- Review action items and discuss "homework"
- Schedule next meeting(s)
- Evaluate the meeting
- Thank team members

Source: The Team Handbook, Second Edition; Scholtes, Peter; Joiner, Brian; and Streibel, Barbara. 1996, Joiner Associates, Inc.

Facilitating the Meeting Process: Follow Up

- Distribute meeting notes promptly
- File agendas, notes, and other documents
- Follow-through on activities

Source: The Team Handbook, Second Edition; Scholtes, Peter; Joiner, Brian; and Streibel, Barbara. 1996, Joiner Associates, Inc.

Goals of First Team Meeting

- Build Relationships
- Team members understand “the process”
- Team members understand each others’ roles
- Team members feel invested
- Consensus on a common team goal

Assessment Summary of Strengths & Needs

- Living situations
- Basic needs and financial status
- Participant & family situation
- Mental health
- Social interaction
- Access to community resources
- Cultural involvement
- Spiritual status
- Educational/vocational status
- Legal involvement
- Medical status
- AODA status
- Crisis response

Strength-Based Assessment

- Strength-based does not mean difficulties and needs are ignored
- Strengths and needs are identified in the context of the participant's life
- Everyone has strengths – one of the skills of a good service coordinator is to ask the right questions
- Strengths can be found in interests, relationships, hobbies, activities and personal traits
- The Roles, Strengths & Goals exercise can also help identify strengths

Summary of Strengths & Needs Assessment

Living Situation

0 = No Problems -------------------- No action needed
1 = Mild Problems --------- Let's watch, try to prevent
2 = Moderate Problems ---------------- Help is needed
3 = Severe Problems ------------ Help is needed now

	Strength?	0 1 2 3
Describe your family's current living situation…Does your home provide enough space, privacy, and comfort?	**Strength?**	**0 1 2 3**
Mom's perspective: Family (mother, son, and 2 younger sisters) lives in a 2-bedroom single-level apartment. Mom feels the situation isn't ideal (she and 2 girls share a bedroom; her son has own room), but it's "good for now".		
Several team members are concerned that Mom doesn't have a place for herself.		
Are there barriers to living in your current home long-term?	**Strength?**	**0 1 2 3**
No current barriers; although the family wouldn't be able to afford their apartment if Mom had to cut her hours at work.		
Are there any safety concerns?	**Strength?**	**0 1 2 3**
Mom/family currently don't have any concerns.		
Neighbor concerned about busy traffic. Kids play area is on the same side of the house as the street.		
Social worker noticed bare wires sticking out of an outlet in the living room…		

Other Strengths:	***Other Needs:***
Mom has supported her family in their current home for the past 2 years.	Address possible safety concerns if the plan is for the children to walk to school.
Apartment is close to school – children can walk	

Assessment to Plan of Care

- Review of Summary of Strengths & Needs Assessment
- Determine top 3 areas of need
- Prioritize

Strength-Based Planning

- Strength-based planning means
  - Clearly identifying the consumer & team’s unique needs
  - Using the resources of the team to meet needs
  - Considering interests, relationships, hobbies, activities and personal traits of the participant and team members

The First Step in Successful Planning

Clearly identify the need

Needs are not services or places. Services and places may be a way to meet needs.

Clearly Identifying Needs

- Peel away the onion
- Ask questions
  - Why is this happening/not happening?
  - Was this ever not a problem in the past?
  - What would it look like if this weren't a problem anymore?

Need or Service?

- Transportation to work
- Parenting class
- Help with math homework
- Foster care
- A telephone
- Family Therapy
- A mentor
- Energy Assistance
- Individual Education Plan
- YMCA membership
- Respite Care

Sharing and Monitoring Responsibility

- Determining tasks:
  - Solicit ideas without judgment – use the board
- Assigning:
  - This is done with the team
  - Look for volunteerism
  - Look for sharing in the work
  - Look for natural assignments
- Monitoring:
  - This is done with the team during meetings through review of the Plan of Care
  - Service coordinator may need to check in with team members individually

When a Team Needs Money

- Identify any non-funded resources that may be available
- Use consumer and community resources first
- Reframe “non-emergency” needs in terms of the process
- Flex funds may/may not be available to your families in your county
- Potential of Revolving Loan Funds

Planning for Transitions

- Transitions to different setting
  - New community
  - New grade in school; different school
- Transitions from school year to summer
  - Summer activities
  - Childcare and/or respite
- Transition to different living environment
  - Foster home
  - Home of parent or caregiver
  - Hospital or Residential Care Center
- Transition to "adulthood"
  - Location of living status
  - Educational/vocational options
- Transition out of the formal team process
  - Voice, Access, and Ownership

Plan of Care Development

- The service coordinator schedules meetings with the team to develop the plan
- The team reviews process principles, and identifies the strengths of the individual and team member.
- The team reviews each domain, identifying strengths, needs, and the participant's current level of functioning.
- The team prioritizes the needs
- The team develops the Plan of Care to include:
  - The participant's present level of functioning
  - The goals, objectives and activities
  - Who will be involved
  - How services will be paid for
  - How outcomes will be evaluated

The Benefits of Crisis Response Planning

- Reduces stress
- Provides safety
- Teaches skills
- Strengthens team
- Controls outcomes

Crisis Response Plans: Before you Begin

Make sure team members understand the purpose of a Crisis Response Plan –

Distinguish between Crisis/Safety issues and "Plan of Care" issues

Crisis Response Plan Development

"A crisis occurs when adults don't know what to do." **– Carl Shick**

- Expect that an individual with multiple needs living in the community will experience crisis.
- Consider the most challenging act(s) that could happen
- Review historical strength-based information regarding strategies that have worked
- Pre-plan interventions with people and/or agencies who may be involved in the safety issue
- Develop a protocol of who will be notified, in what time frame, including responsibilities and communication procedures
- Establish a "blame free" time in which team members cannot fault each other for the crisis
- Develop a process for evaluating the crisis response plan's use within two weeks of the event.

Creating Crisis Response Plans: Brainstorming

- Consider the most challenging situations that have occurred or may occur – distinguish between safety/crisis issues & Plan of Care issues
- Consider strategies/interventions that have worked in the past
- Consider strengths of the participant, family, team & community – brainstorm possible interventions

Creating Crisis Response Plans: Developing the Document

- Include date created/updated
- Begin with brief summary of important information
- Consider results of "brainstorming" – order interventions from least to most restrictive
  - Describe the intervention
  - Clarify who is responsible & for what
  - Include backups
- Don't stop at "contact law enforcement", or "call 911". Develop options through these interventions with agency representatives

Creating Crisis Response Plans: The Final Details

- Discuss a process for evaluation of the Crisis Response Plan
- Get signatures from individuals and agencies involved in the plan's development
- Discuss distribution and release of information

Sample School Crisis Response Plan

Past behaviors/situations considered crises or safety concerns: Usually starts with refusal to comply with a request or to follow routine. Can escalate quickly to swearing, physical aggressiveness, destruction of property, and self-harm.

Mental Health Diagnoses: ADD & Intermittent Explosive Disorder; Mild Developmental Disability

Rx (include name of doctor prescribing: Lithobid, Trazodone, Trileptol, Risperdal; Dr. Bob

Progressive list of interventions to respond to a Crisis/Safety situation:

* If at any time, Billy's behavior escalates to the point of harming himself, someone else, or destroying property, go directly to Step 4

Praise Billy for following requests and routines. Some reinforcers include: verbal praise, tokens, star for his chart, physical contact (e.g. hugs), and edible treats (cottage cheese, cereal, cookies, etc.)

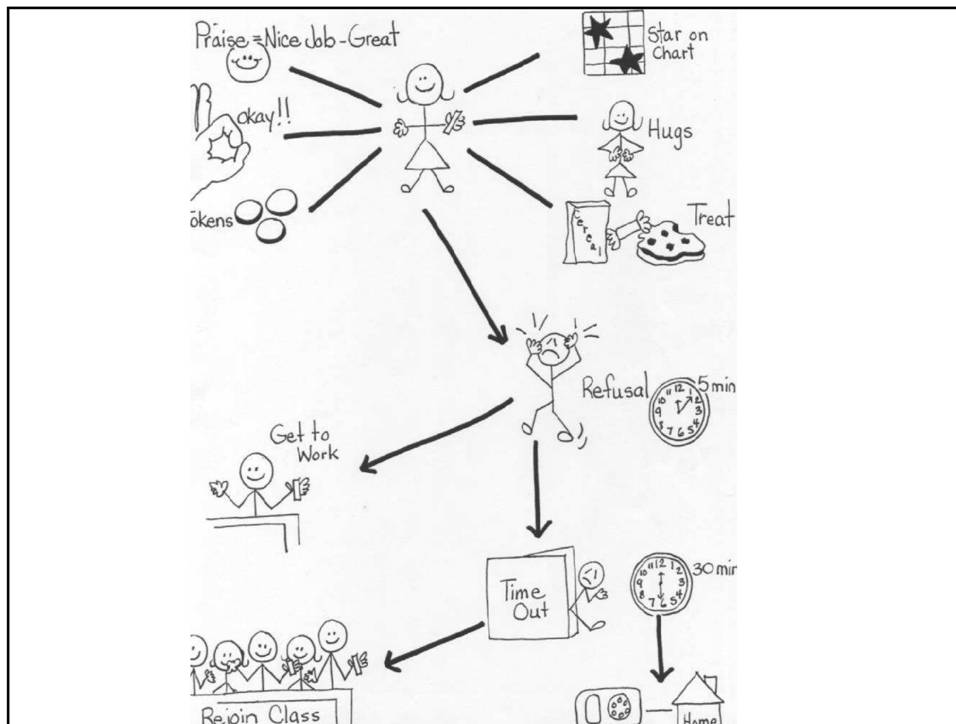
1. If Billy refuses to comply with a request or routine, he usually physically distances himself from others (e.g. pushing his chair away from the table, crossing his arms and putting his head down). Allow Billy a *5-minute refusal*. Billy knows that he has this five minutes to regroup and come back to join the class.
2. If Billy's behavior escalates to the point of swearing or physical aggressiveness, the teacher's aide, Miss Jane, will ask Billy to take a walk with her.

3. If Billy is not able to re-join the class after 30 minutes, he will be ***removed from school***.
   a. The following individuals can be contacted in this situation:
      - Jo & Susan Smith (parents) 555-2503
      - Don Jones (family advocate) 555-5120
      - Marsha Miller (mentor) 555-5026

   b. If the above individuals are not available, and Billy has not committed a crime (e.g. property destruction, harming someone) he will receive 1:1 supervision by school staff (if possible) until someone can be reached to come get Billy. If 1:1 supervision is not possible, move on to step 5…
4. Contact law enforcement (555-3321) to transport Billy to the Work Release Center.
   a. Once there, the officer should contact DHS intake (555-3303). A social worker or on-call staff will come over as soon as possible. *Note to responding officer:* ***Billy has a cognitive disability – it is important to be firm with him, but to also use very simplistic language; don't try and reason with him***

   b. Social worker/on-call staff: If Billy is o.k. to go home, try and contact one of the individuals listed under 3A to come and get Billy. If no one can be reached by 3:30 OR if it is determined that Billy should not go home, the following options should be considered:
      - "Village of Learning" daycare center (to be used only for a few hours and if Billy is not a danger to self or others)
      - County receiving home (see Child & Family Unit supervisor - Beth)
      - Hospitalization at St. Elizabeth's (if hospitalization is needed)

   This Safety Plan has been distributed to: DHS: Crisis On-Call Unit and Child & Family Unit, Sheriff's Department, Police Department, Riverview School, Jo & Susan Smith, & Integrated Services team members



When are We Done?

- Outcome indicators demonstrate that goals are being met or in the process of being met
- Informal/natural supports are involved in ongoing support to the consumer
- Consumer has access, voice and ownership

Transition

- The intent of the team is *not to solve every problem* that the participant or the providers have, rather to *develop skills, gain knowledge and identify and access resources necessary to* ***meet the needs***.
- Once this process is working and doesn't necessitate team support, the formal team process should end.
- This doesn't mean that services aren't necessary or that supports aren't needed. It simply means the participant has *voice, access and ownership*.

Things to Talk about in the Final Team Meetings

- Consumer
  - Thorough evaluation of consumer's perceptions regarding their ownership of the plan and process
  - Review of how and in what form they would like the team process to be continued
  - Review of plan: how will needs continue to be met? How will necessary services be continued?
  - Plan a celebration/transition event or time
- Team
  - Review of team process continuation: roles, time frames, form of team, communication
  - Review of plan, especially continuation of necessary team members and services
  - Final evaluation of progress and process

Tools to Use

- Consumer Closure Survey
- Team Member Closure Survey
- Plan of Care
- Crisis Response Plan

Alumni Involvement

- Informal Resource
- Advocacy
- Support Groups
- Coordinating Committee Membership
- Screening Committee Membership

Barriers to the Collaborative Team Process

- I don't have signed releases to share or obtain information
- There's no money available to pay for services for needs identified in the Plan
- If I make an exception for one participant, it wouldn't be fair for the others
- My workload is too large – I don't have time!
- My boss is pressuring me to stay in the office & increase "face-to-face" time
- I've never been involved in Wraparound and don't know anything about it
- I've been involved before – it wasn't beneficial
- I must maintain professional boundaries with clients
- I can't stand working with that person/agency!

Common Responses to Conflict

- Avoiding the conflict
- Smoothing over the conflict
- Forcing the conflict
- Compromising
- Problem-solving through conflict management

Approaches to Managing Conflict

Flight

- Denial
- Avoidance

Fight

- Tempers cloud rational responses
- Focus is on the person rather than the problem
- Little is accomplished
- Results in hurt feelings, or worse

Approaches to Managing Conflict *Continued*

Confronting Conflict

- Stimulates the search for new information
- Provides a forum for people to share their perspectives and hear others' perspectives
- Understand that conflicts are not intrinsically good or bad
- View conflict as an opportunity

Conflict Management Tips

Go to the balcony
- Know our hot buttons
- Talk to a mentor

Step to their side
- Listen
- Clarify position

Reframe
- Why?
- Why not?
- What if?

Adopted from William Ury

Conflict Management Tips - Continued

- Talk to a mentor for guidance, suggestions, options
  - Home Improvement – Tim and Wilson
  - Colleague
  - Supervisor
  - Professor
  - Pastor
  - Friend

Conflict Management Tips – Continued

Talk to a mentor for guidance, suggestions, options utilizing the following process:

- Describe the situation
- Express your perspective/feelings
- Specify what you would like to see or how you want to feel
- Explore the consequences of the options and decision

Sharon Anthony Bower, Asserting Yourself

Listening Skills

- To be heard and truly understood by another person is a gratifying experience and a rare privilege
- Try to react to ideas, not the person
- Most of us are taught to read, write and speak; few of us are taught to listen

“In America, what’s the opposite of speaking –

waiting to speak.”

- Aaron Wolfe

Factors that Facilitate Conflict Management

- Common objectives and goals
- Faith in one’s own conflict resolution ability
- A belief in the validity of the other’s position
- The motivation and commitment to work together
- Existence of trust
- Clear and accurate communication

Adapted from Negotiation, Lewicki, 1994

Principles for Conflict Management

- Encourage equal participation: we are in this together
- Actively listen: you are important and valued
- Separate fact from opinion: challenge categorical statements
- Separate people from the problem: use the board
- Focus on the big picture: reaffirm goals, principles, values
- Build consensus

Adapted from Conflict Management, Hendricks, 1989

"Speak when you are angry and you will make the best speech you will ever regret."

\- Ambrose Bierce

Bias Self-Checklist

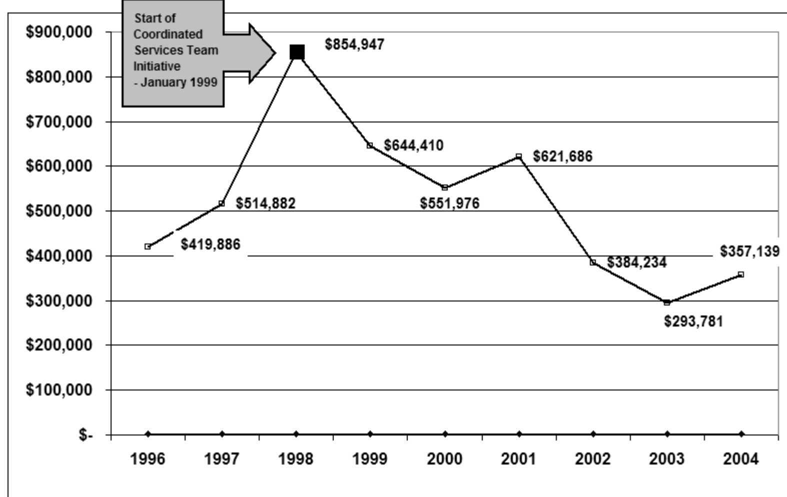
Key Stages in Collaborative Conflict Management

1. **Identify and define the problem**
   - Mutually acceptable to everyone
   - Clear and simple
   - Stated as a goal
   - Separate from the search for solutions
   - Separate the people from the problem
2. **Generate alternative solutions**
   - Push creativity
   - Prioritize
3. **Evaluate and select the alternative**
   - Agree to criteria in advance
   - Evaluate on basis of quality and acceptability
   - Find a “bridging” solution
   - Identify “Plan B”

Activity:
Generate a Plan to
Respond to the Situation

Outcomes

- Reduction in the need for long-term placements in residential care centers and hospitals.
- Counties see an overall positive system impact, especially in terms of people working together better.
- Some counties report saving significant money.
- Family/consumer satisfaction is very high.
- Wraparound in the system has achieved a life of it’s own.


CALUMET COUNTY
Child Alternative Care Costs
1996 - 2004
Start of Coordinated Services Team Initiative - January 1999
$900,000
$800,000
$700,000
$600,000
$500,000
$400,000
$300,000
$200,000
$100,000
$-
$419,886
$514,882
$854,947
$644,410
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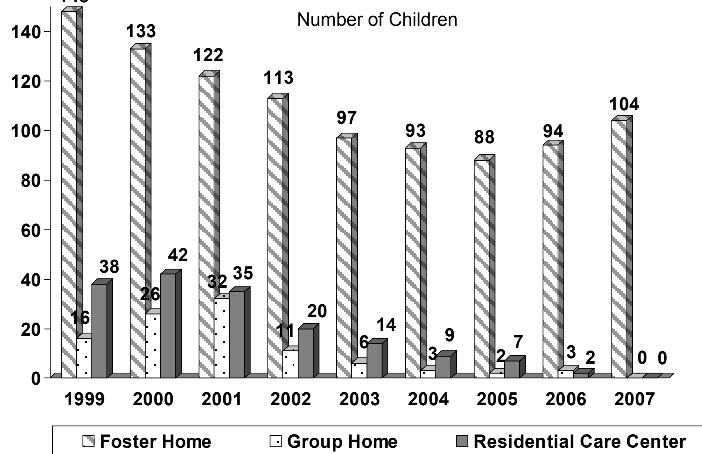
MANITOWOC COUNTY
1999-2007
YOUTH PLACED IN FOSTER HOMES,
GROUP HOMES AND RESIDENTIAL CARE CENTERS
Number of Children
148 16 38
133 26 42
122 32 35
113 11 20
97 6 14
93 3 9
88 2 7
94 3 2
104 0 0
1999
2000
2001
2002
2003
2004
2005
2006
2007
Foster Home
Group Home
Residential Care Center

Coordinating Committee Membership

- Human Services representing AODA, mental health, developmental disabilities, family support, child welfare, and juvenile justice systems
- Consumers/individuals representing the target population (min 25% of membership)
- Representation from:
  - Education – School Districts, CESA, School Board, Head Start
  - Health Department
  - Domestic Violence Program
  - Law Enforcement
  - Probation & Parole
  - Vocational/Technical School
  - Tribal Community
  - Clergy
  - County Board
  - UW Extension
  - Private Business
  - Additional Community Groups as desired

The Coordinating Committee Suggested Responsibilities

- Prepare Interagency Agreement; update as needed – at least annually
- Develop plan for sustainability, starting year 1
- Assess how the program relates to other service coordination programs, taking steps to avoid duplication of services
- Identify and respond to gaps in services
- Be involved in the review (screening) of referrals
- Establish operational policies & procedures; ensure they are monitored and adhered to
- Ensure quality, including consumer & agency satisfaction
- Plan for sustainability of the system change – beginning year 1
- Ensure any realized savings from substitute care budgets are reinvested in the community-based CST process
- Establish target group to be served
- Be a liaison to the agency/group you represent on the committee
- Attend and participate in Committee meetings and activities

Key Elements in an Interagency Agreement

- State mission & principles
- Define the persons to be supported (target group)
- Define partner roles & responsibilities
  - At the family team level
  - Of individuals on the Coordinating Committee
  - Agency role & responsibilities (e.g. referral, funding, system change)
- Define the process for accessing & delivering services
- Define the process for paying for services
- Define the conflict management process
- Define evaluation processes

www.wicollaborative.org

Wisconsin's Collaborative Systems of Care (WCSOC) Resource Website

Home | Core Values | Resources | Contacts | Parents | Partners

Coordinated Services Team Initiative (CST)

Integrated Services Projects (ISP)

Women's AODA

Welcome

This website is meant to serve as a resource...

Materials from Recent Trainings

Wisconsin's Collaborative Systems of Care

Trainings and Events

WCSOC Handbooks

Success Stories