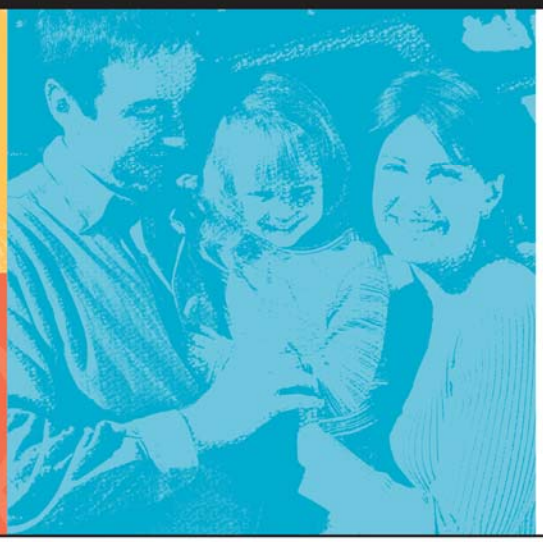
The Single Coordinated Technical Assistance Plan:

A Guide to Developing Your Community's Plan of Care



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INTRODUCTION

Systems of Care: At a Glance

The system of care (SOC) movement has been a powerful force in transforming our country's approach to mental health services for children, youth, and families. In a system of care world, prevention and intervention services are tailored to each family and deepen in effectiveness as family, community, and culture are valued and integrated as lifelong resources to the young person in need.

Home- and community based-services are created in partnership with the family. Evidence-based practice and practice-based evidence approaches work together to better support the needs of families. Local community members, community-based service providers, and others invested in building a healthy community work together to develop a theory of change—a way to identify what activities are needed to make meaningful and sustainable change to improve outcomes for children and families.

Creating a new system of care follows a path of transformation that requires energy, commitment, and the time to think through strategies to address challenging areas. For example, building a new, family-driven approach to services is uncharted territory for many. Many priorities must be juggled to make the approach work effectively, including:

- helping those in other child-serving systems understand the core values and principles of a system of care and assisting them as they alter their approach to community-based services;

- training and supporting staff on how to provide services within a system of care framework; and

- learning how to develop outcome evaluation and data systems that document service improvements and provide appropriate feedback processes for community members and decision-makers.

System of Care Technical Assistance

Developing a system of care is a difficult and complex process with strengths and challenges that often occur simultaneously at different levels, including the policy level, the local system design level, and the youth and family service delivery level. Technical assistance is available, however, through a national team of specialized providers (known as Technical Assistance Coordinators, or TACs) and research and training centers. This group of experts offers a wealth of resources on system of care implementation, cultural and linguistic competence, family-driven and youth-guided approaches, Tribal systems of care, social marketing, financing, outcome evaluation, continuous quality improvement, and research and training.

To facilitate this support, each funded community is assigned an TAC who serves as a broker and conduit for technical assistance resources. The technical assistance providers are organized to identify one centralized point person for each community. To date, each technical assistance provider offers support in their area of expertise to the communities and, in partnership with the community, develops a separate, individualized technical assistance plan. The purpose of this initiative is to ensure that each community develops a single coordinated technical assistance plan that will address all specialized technical assistance needs and support system transformation.

What is a Single Coordinated Technical Assistance Plan?

The Single Coordinated Technical Assistance Plan (SCTAP) process provides a framework to help identify technical assistance needs that a community may have in the 17 areas of system of care implementation, as outlined in the "Crosswalk to Implementing Your Cooperative Agreement."[1] Each system of care community identifies their priorities among the 17 areas. The SCTAP is a collaborative, cross-partner planning process and supports an ongoing, interactive relationship between the technical assistance partners and the local communities. The SCTAP is not intended to be burdensome to the local community; rather it is designed to integrate the various technical assistance plans together into one "plan of care" for the community. The SCTAP process provides a way to help communities develop a more thorough understanding of the range of resources available, while the technical assistance partners become more knowledgeable about the community's technical assistance needs.

The Role of the Council on Collaboration and Coordination

The Council on Collaboration and Coordination (CCC) is a national advisory group composed of representatives from the system of care communities, the Center for Mental Health Services (CMHS) Child, Adolescent and Family Branch, and the national system of care technical assistance partners. The CCC serves as the continuous quality improvement group for systems of care. The CCC Technical Assistance/Quality Improvement (TAQI) Work Group was tasked with the development of a protocol for a coordinated technical assistance plan to integrate national system of care technical assistance efforts.

About This Guide

This resource guide was produced by the Council on Collaboration and Coordination Technical Assistance/Quality Improvement Work Group. Special thanks to Holly Echo-Hawk, Jody Levison-Johnson, Ivonn Ellis-Wiggan, Keith Pirtle, and Regenia Hicks for their contributions to its development.

[1] The crosswalk can be accessed at *www.tapartnership.org*.

THE SINGLE COORDINATED TECHNICAL ASSISTANCE PLAN APPROACH

The Single Coordinated Technical Assistance Plan (SCTAP) process is the community-level equivalent to the child and family team or wraparound process that is used at the practice level. The SCTAP serves as the communities' "plan of care" identifying needs, strengths, strategies, and ensuring accountability of all team members whether at the community or national level. All participants in the SCTAP process can find their equivalent role in a child's family team. The goals, principles, and philosophies are the same. Both processes are strength-based and start where the community (family) wants to start. So relax and have fun. You know wraparound, so you know how to do this.

System of care development is a process and can feel like a complex and sometimes monumental task. During the six-year journey you will learn lessons and receive information and technical assistance. The SCTAP is a mechanism to keep this information organized, integrated, and on track. It is intended to support the community and all of the program partners in identifying and meeting community needs in order to promote effectiveness and sustainability.

Partners, Roles, and Expectations for the SCTAP

As in a wraparound process, the family—or in this case, the local funded community—should take ownership and co-lead the SCTAP process. Each community, like each family, is different and therefore each community needs to decide who will serve as their SCTAP community lead. The community lead may be the Project Director, the Principal Investigator, the lead Family Contact, or TA Coordinator. No matter who is chosen by the community to serve as the community lead for these purposes, everyone plays a critical role and all are responsible for the overall success of the project. For the purposes of this document we will refer to the person selected at the community level to lead the SCTAP process as the Community Lead (CL).

The Role of the Community Lead

Though key local staff will work as a team, the CL will be primarily responsible for moving the process forward. Throughout the process the CL should make sure the community's voice is being heard, and that all technical assistance and other efforts and information are integrated into the SCTAP. The CL should develop relationships with the Technical Assistance Coordinator (TAC) or Community Development Specialist (CDS) for Tribal communities and other Federal partners involved in the overall system of care (SOC) effort. They should make sure that the TA calls focus on the highest priorities for their project and that the community members and staff involved in the process are aware of their role and the associated expectations.

The Role of the TAC/CDS

The TAC/CDS is the equivalent of the Care Coordinator or wraparound facilitator in a wraparound process. Like a Care Coordinator, they are not expected to establish or push a specific agenda, but rather facilitate the agenda of the community team—whatever that agenda is and wherever in the process that community is.

The TAC/CDS should:

- take the lead in organizing the SCTAP preparation calls;
- organize and prepare for the SCTAP quarterly calls;
- ensure that those participating in the calls are aware of the calls and their roles;
- make sure minutes are taken and distributed;
- support the community in ensuring that the SCTAP is updated;
- ensure that assignments are made and addressed in a timely manner;
- support the CL in establishing and knowing his/her role and what they are doing;
- reach out to content experts as needed; and
- generally make sure the process runs as smoothly as possible.

The CL and TAC/CDS should work in close partnership. Just like a Care Coordinator, over time the role of the TAC/CDS will be emphasized less as the community comes into their own. However, the TAC/CDS is responsible for ensuring the community's needs are being met and the process is being followed.

The Role of Partners

The role of Federal partners, such as the National Evaluation Program, which is responsible for National Evaluation, as well as the Caring for Every Child's Mental Health Campaign, which is responsible for Social Marketing, is similar to the role played by the various child- serving agencies on the child and family team. If the community wants to review or discuss social marketing/communication issues, for example, then the appropriate campaign representative should be an active participant in the calls and other related activities addressing this subject. If a specific task or goal becomes part of the SCTAP, then that representative needs to take responsibility for following through with their agreed-upon tasks.

Action steps and commitments made by program partners will be documented in the SCTAP and serve as the foundation for accountability.

Program partners play different roles within each community. It is vital to balance the need for including a cross section of partners to provide a holistic approach while also ensuring that technical assistance providers are using their hours wisely in this time of budget limitations. Program partners can be asked to participate in the SCTAP calls so that they can develop a more thorough understanding of the community. The SCTAP calls can also serve to cement relationships between the community and their team members, which is a critical component of effective technical assistance. For this reason, it is suggested that Social Marketing Liaisons, National Evaluation Liaisons, and appropriate TA Partnership Resource Specialists participate on all SCTAP calls.

As the SCTAP will serve as the overarching planning mechanism, it is recommended that these calls occur every three months. Other calls on specific subject matter will continue to occur with Federal and local partners between SCTAP calls. It is vital, however, that the needs and challenges addressed are incorporated into the overall SCTAP through documentation in the action steps section.

It is the responsibility of all parties involved to make sure that any and all technical assistance and standard reports become a part of the overall SCTAP process and resulting plan. This is essential as all TA provided or reports written or received must be incorporated into the overall SCTAP in order to ensure the integration and coordination of TA being delivered to communities and facilitate a "data-driven" approach to technical assistance delivery. For more information about "data-driven" technical assistance, please review the CQI Progress Report Protocol.

The Role of the Government Project Officer

The Government Project Officer (GPO) is responsible for monitoring each grantee's progress in the implementation of program requirements and providing direct assistance regarding adherence to program goals and effectiveness of service delivery. GPOs must review and approve each stage of program implementation, including budget revisions, as well as the use of technical assistance resources.

With respect to the SCTAP process, the GPO is responsible for:

- identifying priority areas to focus on during the SCTAP calls;
- participating in the initial SCTAP conference call;
- sharing decision-making responsibility with the community for development and implementation of the strategic plan and other program requirements;
- coordination with the TAC to ensure that the site receives the technical assistance they have requested;
- conducting the second and fourth year Federal site visits and ensuring that the site receives the technical assistance identified through the Recommendations and Action Steps sections of the Federal site visit report;
- facilitating coordination of technical assistance and linkages with the other system of care grantees and other Substance Abuse and Mental Health Services Administration (SAMHSA) programs;
- reviewing continuation applications and other progress reports to ensure that the site is using all available resources, including start-up team reports, Federal site visit reports, and CQI reports to develop the SCTAP, and implementing the plan with the assistance providers.

SCTAP Phases and Steps

The SCTAP is intended to provide a structure and framework to identify technical assistance needs and delineate strategies to meet these needs in a format that is helpful to both newly funded and more experienced sites. The process outlined below is a suggested method for developing a community's SCTAP that effectively integrates information from the myriad sources that connect to each community's system of care.

Ideally, the SCTAP process is initiated with communities at the start of their funding. However, for those sites that have been funded for one year or longer, opportunities do exist to initiate the process. Specifically, a community can use the Federal Site Visit report, the System of Care Assessment visit report, or the CQI progress reports as tools to identify needs and prompt the planning process.

Communities that are unfamiliar with these reports can find out more by contacting their GPO or TAC/CDS.

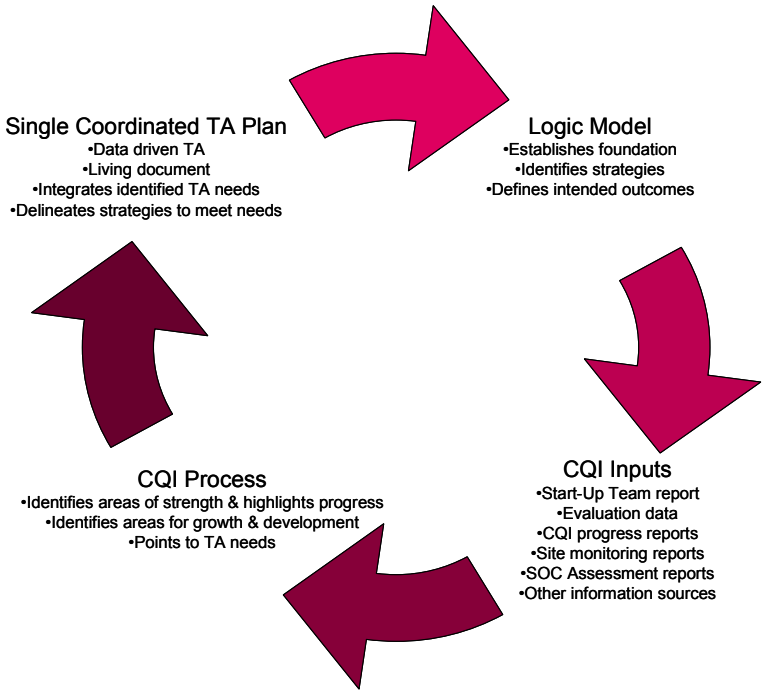
The Logic Model, the Strategic Plan, and the SCTAP

It is important to note the relationship between a community's Logic Model, overall Strategic Plan, and the SCTAP. The Logic Model and the Strategic Plan serves as the community's articulated theory of change. As such, it should clearly define the community's vision for their system of care, the specific outcomes the community hopes to achieve throughout the funding cycle, the strengths and resources available within the community, and the community's self-identified strategies for achieving outcomes. All of these components play a central role in the community's SCTAP and have been integrated into the SCTAP template.

In a sense, the Logic Model serves as the community's roadmap for system of care development while the Strategic Plan provides strategies and tactics. The SCTAP complements this map by offering additional detail on the possible routes and roads that will successfully complete the journey.

As with any journey, one can anticipate curves and detours; the SCTAP allows the community to explore these as opportunities, thus setting the stage for the community's continuous quality improvement efforts. Figure 1 on the following page illustrates one community's view on how these items are integrated in their Continuous Quality Improvement approach.

Figure 1: Continuous Quality Improvement Cycle



Source: Sheehan, A.K. Theories of change from a continuous quality improvement (CQI) perspective: Logic modeling, measuring performance and benchmarking. March 2007.

GETTING YOUR SCTAP OFF THE GROUND

The process defined below is driven by the practices currently in place for newly funded sites. More experienced sites can begin the process at step one by substituting the "Community TA visit" with any activity or information source that prompts the process (i.e., the reports noted above or any other catalyst that drives the need to begin the process).

The single coordinated TA planning process includes three general phases:

1. Orientation to the SCTAP process
2. Planning for the SCTAP process
3. SCTAP development

Orientation to the SCTAP Process

The first step in the orientation process is the community's decision to participate in the SCTAP process and, soon thereafter, the identification of an SCTAP Community Lead. As explained earlier, the SCTAP is not intended to be a burdensome task, but rather a means to connect all of the various technical assistance activities together within an integrated "plan of care."

This decision to participate can be indicated in several ways, including a discussion between the community and their TAC/ CDS (for Tribal sites), connecting a potentially interested community with a community who has experienced the process, or connecting potentially interested community members with members of the CCC TAQI Work Group who have spearheaded these efforts.

SCTAP Orientation Process

Step 1: Decide to participate in the SCTAP process

Step 2: Identify an SCTAP Community Lead

Step 3: Participate in SCTAP orientation webinar

Step 4: Connect with experienced site for mentoring and support

Once a community has decided to participate, a more formal orientation session should be held via webinar or conference call. This session should include representatives from the community (at a minimum, the SCTAP Community Lead is required), TACs/CDSs from participating communities, representatives from the program partners, and community site representatives who have conducted the SCTAP process. The session should include the SCTAP process, an overview of this guide, and review the SCTAP template (see **Appendix A**).

The SCTAP Template

The SCTAP Template is divided into 17 areas of focus that are consistent with the "Crosswalk to Implementing Your Cooperative Agreement" document, which is available on the TA Partnership Web site *(www.tapartnership.org)* to support a community's system of care implementation efforts.

The areas of focus include:

1. Family-Driven

Family voice must drive every aspect of your system of care—planning, implementation, governance, and evaluation. Becoming family-driven refers to actively engaging and partnering with family members at all levels—the practice level, the organizational/agency level, and the system level. The system of care must seek to incorporate the family perspective from a diverse group of family members who are representative of the population of focus, as well as those from the broader community and who have experience with the child-serving systems. Family-driven also includes collaborative efforts to build and sustain a viable family organization that serves as a lead in system of care efforts. Community stakeholders often have individual pictures of what a family-driven system of care looks like; bringing together all stakeholders to develop a single, clear picture of a family-driven system of care will ensure that all are working with the same outcome in mind.

2. Youth-Guided

Youth voice also must be infused into every aspect of your system of care. Becoming youth-guided refers to actively engaging youth in all levels—practice, organizational/agency, and system. The system of care must seek to incorporate the youth perspective from a diverse group of youth who are representative of the population of focus, as well as the broader community. Youth-guided also includes collaborative efforts to build and sustain a viable youth organization to serve in an advisory capacity in the system of care efforts.

3. Culturally and Linguistically Competent

Cultural and linguistic competence includes having a defined set of values and principles, and demonstrating behaviors, attitudes, policies, and structures that allow your system of care to work effectively cross-culturally. It also includes having the capacity to: 1) value diversity, 2) conduct self-assessment, 3) manage the dynamics of difference, 4) acquire and institutionalize cultural knowledge, and 5) adapt to diversity and the cultural contexts of the communities you serve. Systems of care must incorporate the above in all aspects of policy making, administration, practice, and service delivery, and involve systematically youth, family members, key stakeholders, and community members. Cultural and linguistic competence is a developmental process that evolves over an extended period (adapted from Cross et al., 1989).

4. New Community Relationship-Building, and Introduction to Systems of Care

Upon funding notification, communities are thrust into a flurry of year-one activities. This focus area includes establishing relationships with your GPO, TAC, and other national TA Providers and Program Partners. Other critical components include a review of the cooperative agreement with all key stakeholders and partners identified in your application, and conceptualizing how to present your system of care and associated change processes.

5. Staff Structure and Retention

Hiring staff is a critical task of the cooperative agreement. This process requires key members of the hiring team (which should include system partners, families, and youth) to understand

the true intent of the system of care, which is to support the transformation process within your community to develop a new service or program. Creating a clear organizational chart that accurately depicts the system of care staff and delineates reporting structure is also critical to your success. Each position should have a defined job description that identifies the roles and responsibilities for the position.

In addition to your administrative team, constructing similar structures for contracted staff and/or service delivery staff that will be funded through the cooperative agreement may be needed. There should be a concerted effort to recruit individuals who reflect the diversity of the population to be served.

6. Logic Model/Strategic Plan

The Logic Model articulates the community's theory of change. By effectively defining the population of focus, goals, strategies, and outcomes, all involved will have a clear sense of the vision and mission for the system of care. Using an inclusive process to create this shared vision and common set of goals with system partners, families, and youth establishes the foundation for the system of care and facilitates the formal commitment necessary by all to truly achieve the vision. The Logic Model will allow you to develop a more specific strategic plan that details action steps to take to achieve intended outcomes. It serves as a road map for implementation, supports a data-driven approach to the identification of technical assistance needs, and allows for the development of continuous quality improvement processes later on.

7. Governance

A critical focus area during system of care planning and development is establishing the governance structure. "The governing body is a group of individuals with the authority to make policy decisions for the system of care….This body develops and upholds formal agreements and memoranda of understanding between the collaborating child-serving agencies, including those from all relevant political subdivisions. It also holds the system of care accountable for meeting high standards of care, including standards for cultural competence and family involvement, as well as standards of practice that have been shown to be effective through research and evaluation studies." (Technical Assistance Resource Guide for the Comprehensive Community Mental Health for Children and Their Families Program). The structure should include family and youth in decision-making capacities and be broad and inclusive to ensure many opportunities for partners to participate in the decision-making process.

8. Effective Collaboration

This focus area includes identifying and developing partnerships with other systems, families, youth, and stakeholders, ensuring that all partners in the system of care agree on the values and direction for the effort. Developing true collaboration is an activity that requires patience, tenacity, and persistence. Effective collaboration should not be mistaken as agreement on all things; in fact, through disagreement, dialog, and discussion, a new collective understanding is often born that will support real transformation efforts.

9. Internal Communication

Establishing processes and protocols that clearly define communication channels and expectations (e.g., how information is shared amongst grant staff, across governance and committees/workgroups, and others) is critical. Communication in systems of care is not linear; it is a complex process of ensuring access to necessary information, transparency, adaptation of previously held beliefs and styles, and a willingness to do things differently. It also necessitates the ability to tolerate conflict and distress that often results from an attempt to move away from business as usual and achieve true transformation.

10. Social Marketing

Social marketing plays a critical role in achieving the goals of your system of care. True transformation will require broad-based education and marketing to stimulate the interest and commitment from your system partners and the broader community. Social marketing may also play a key role in reaching your population of focus. For systems of care to be sustainable, you will need to provide compelling messaging to various audiences to clearly articulate what is "in it for them." A critical component of social marketing includes effective use of data to convey messages and provide compelling stories. During initial system of care development, national data sources can be used to support partner engagement efforts.

11. Clinical Services and Supports

This focus area includes the development of the array of required services as defined within the cooperative agreement. Additional areas for consideration are identification of evidence-based practices and practice-based evidence, including natural, informal, and non-traditional services that emphasize cultural and linguistic competence. Consideration should be given to the critical importance of developing partnerships with other child-serving systems.

12. Technical Assistance (TA) and Training

Myriad opportunities for TA and training are available for funded system of care communities, both through national partners and through your own local efforts. The purpose of the SCTAP framework and template is to support your efforts to identify and coordinate the technical assistance and training for your community, reduce redundancy, and prioritize those areas of greatest need. A helpful way to do this is to refer to your community's Logic Model once developed to ensure that the TA and training offered is in line with your priority outcomes.

13. Management Information Systems (MIS)

A well-planned and designed information system is a critical infrastructure component for developing systems of care. It enables information-sharing, promotes collaboration, supports continuous quality improvement (CQI) and evaluation efforts, and facilitates coordinated care for children and families. A well-planned and integrated management information system can provide useful information to support decision-making at the clinical, program, and system levels.

14. National Evaluation
The National Evaluation is a cooperative agreement requirement. This focus area refers to:

- developing a thorough understanding of national evaluation requirements;
- understanding the staffing requirements as well as the roles and responsibilities of the local evaluation team;
- creating a workgroup or committee that includes family and youth to plan for the implementation of the National Evaluation, including Institutional Review Board submission and approval; and
- supporting the development of the system of care Logic Model.

15. Local Evaluation
To complement National Evaluation activities, communities are encouraged to engage in local evaluation efforts to assess progress toward identified outcomes not readily answered by the national evaluation. Local evaluation efforts can include both quantitative and qualitative efforts to understand how your community is doing in particular areas of importance. The evaluation workgroup and other stakeholders should play a key role in establishing these priorities and selecting methods to measure them. The design of the local evaluation offers an opportunity to measure outcomes that are important to key stakeholders, which will facilitate their engagement and buy-in and lead ultimately to sustainability.

16. Continuous Quality Improvement (CQI)
In system of care initiatives, the need for data review and quality improvement processes is critical to determining adherence to the values-based model. System of care communities must be sure to review information that is available and determine if defined strategies are resulting in intended outcomes. If so, these strategies should be promulgated. If not, revisiting options to create new mechanisms to achieve outcomes is critical. Through the national evaluation and any local evaluation activities, there is an extensive amount of information available to facilitate engagement and buy-in for quality improvement and sustainability. In addition to these sources, each community has access to, but is not limited to, the Federal Site Monitoring visit report, the System of Care Assessment report, and the CQI Progress Reports. Establishing a CQI process early on will set the foundation to ensure the system of care is dynamic and adaptable and moving in the direction the community intends.

17. Sustainability
Sustainability is more than just creating or maintaining strategic financing partnerships, it is creating, developing, and maintaining strategic relationships that will support the transformation in attitudes, beliefs, and behaviors within a community. Planning for sustainability must begin early on to ensure that creative mechanisms are identified that will allow the system of care to thrive beyond Federal funding. Data available nationally and from your system of care evaluation efforts are essential elements of sustainability planning in that it provides the proof that investing in the system of care long-term is worth it for all of those involved.

SCTAP Planning

Following the orientation phase, the next step in preparing for the SCTAP is identifying the inputs or foundation data sources for your planning efforts. For newly or recently funded sites, the SCTAP process begins with the New Team Community TA visit. Throughout this visit, the TAC/CDS and participating team members will work with the community to identify community strengths and needs. This may result in preliminary or initial suggested strategies or may be followed up on during regularly scheduled community calls. This information and the resulting start-up team visit report serve as the basis for the initial SCTAP.

For those communities who did not have a New Community TA visit or who are further into the cooperative agreement cycle, the reports generated from the Federal site visit, the year two or four system of care assessment visit, or the community's CQI progress report can serve as the foundation for the SCTAP. Included within all of these reports are community strengths and areas identified for growth and development. These areas can serve as the basis for the community's SCTAP.

It should also be noted that communities, either themselves or in collaboration with their program partners, may identify other information sources that can be used to begin the SCTAP planning process.

SCTAP Planning Process

Step 1: Identify inputs or foundation data resources

Step 2: Select priority areas for SCTAP calls

Step 3: Conduct planning call between SCTAP Community Lead and TAC/CDS to set agenda and strategize

Step 4: Notify GPO and program partners of SCTAP call dates, agenda and prioritized focus areas

Once the inputs/foundation data sources have been identified, the community, with input from their TAC/CDS and GPO, selects the priority areas for their SCTAP calls. For communities conducting this process as part of their Start-Up Team visit, priority areas of focus should be selected during visit planning calls. It should be noted that while all 17 domains can be covered through the SCTAP process, communities must prioritize their needs and narrow their efforts.

After these priority areas have been identified, a minimum of one planning call between the SCTAP Community Lead and the TAC/CDS should be scheduled. The purpose of this call is to:

- select possible SCTAP call dates;
- identify SCTAP team members;
- set the SCTAP call agenda, including identifying who is responsible for what portions of the agenda;
- review roles and responsibilities of the GPO, TAC/CDS, and the Community Lead;

- identify any potential challenges to the SCTAP planning process; and
- brainstorm possible solutions to these challenges.

It is strongly recommended that SCTAP calls be scheduled during regularly scheduled community calls so as not to add additional burden; however, extending these calls to 90 minutes is suggested.

After the planning call has been completed, the TAC/CDS will notify the GPO and all program partners of SCTAP call dates, the agenda, and priority areas for each call. This communication should be made at least three weeks prior to the initial call to ensure program partner and GPO availability and allow time for each partner to complete any preparation necessary for the call. For communities who are conducting their SCTAP planning during the New Community visit, the decision to involve others in a conference call during specific components of the visit can be determined while planning with the TAC/CDS.

SCTAP Development

Prior to the initial SCTAP call, the community should begin to complete the SCTAP template. Each priority area requires that a point person be identified from both the community and the technical assistance team. This component is intended to reflect the shared accountability between the community and the program partners to identify and meet technical assistance needs. The next steps are outlined below.

Completing the SCTAP Template

- The community should begin to develop the **description of the area of focus**—a brief summary that explains why this issue was selected. This information is often found in the community's cooperative agreement submission, Logic Model or Strategic Plan. It is often helpful to complete this section of the plan and distribute it prior to the visit or initial meeting.
- The community should articulate the **desired outcomes** they are seeking for this particular area of focus, in measurable terms. The ability to identify intended outcomes is critical to the community's CQI process. A clearly defined outcome will allow the SCTAP team to determine if an identified need has been met.
- The **Strengths and TA Needs** section can often be compiled before the New Community Team visit by using other foundation data sources or a simple brainstorming activity. Often sites can use their knowledge and the information found in their identified foundation data sources to populate this section. These components can be added at any time.
- The remainder of the SCTAP, which includes the **Action Steps section**, is generally developed through the New Community Team visit or a series of conference calls (generally one to two over the course of two months), which include representatives from all program partners. (See **Appendix B** for agenda templates for SCTAP calls.) Both of these activities will focus on clear identification and prioritization of needs and specific strategies and action steps. This information should also be recorded in minutes and incorporated into the community's SCTAP by the Community Lead or point person. It is important that the community owns the plan, taking responsibility for its development. It will be necessary to have someone record the actions and TA resources that are suggested by the participants to be incorporated into the SCTAP. A draft of the SCTAP will be developed for review and comments before being finalized.

FOLLOWING UP

Each community can determine the most appropriate person is to follow-up on a particular area. This may be the TAC/CDS, the Community Lead, the focus area point person or others. As needs are addressed and action steps/strategies implemented, the SCTAP is updated to reflect progress. This information is captured within the *Status section* of the plan. In addition, new needs and resources/strategies can be incorporated as they are identified. It is important to note that the SCTAP calls are not intended to replace the calls that occur between specific system of care team members and program partners. The SCTAP is intended to be the planning process whereas focused technical assistance should be ongoing, delivered through regularly scheduled calls.

As the first SCTAP is finalized and work begins to meet the community's initial technical assistance needs, follow-up calls are scheduled to occur on a quarterly basis (or at a frequency determined by the community and program partners). This allows the community to avail itself of the collective expertise and synergy that results when all program partners are together on a call.

The SCTAP is considered to be a living document and should be modified and revised as progress is made and as new foundation data sources are made available. For example, for newly funded communities, the reports from the Federal site visit or system of care assessment and the CQI progress reports should result in review of and revision to the SCTAP, therefore establishing a pattern of data driven technical assistance for each community. Communities should feel empowered to reconvene their SCTAP team at any time throughout their funding cycle to support the identification of technical assistance needs and brainstorming about potential action steps and strategies.

The template in **Appendix A** provides the suggested framework for compiling the SCTAP. It is intended that each community would copy the "Area of Focus" section and table for each focus area addressed.

CONCLUSION

The TAQI Work Group of the CCC hopes that this guide is a useful tool in planning for your community's SCTAP. We also hope that the SCTAP is a valuable process to support your community's system of care development and results in a data-informed approach to identify, organize, and support your technical assistance needs.

Appendix A: Single Coordinated Technical Assistance Plan Template

SINGLE COORDINATED TECHNICAL ASSISTANCE PLAN
[ENTER COMMUNITY NAME]
[ENTER DATE]

GENERAL INFORMATION

Community Name:	
Location:	
Year Funded:	
Government Project Officer:	
Technical Assistance Coordinator or Community Development Specialist:	
Technical Assistance Team Members (indicate all community participants and program partners):	
Prepared by:	

AREA OF FOCUS:
COMMUNITY LEAD:
PROGRAM PARTNER POINT PERSON:

Description of Areas of Focus	Desired Outcomes	Strengths	Needs	Action Steps	Status	Benchmarks/Due Dates

Appendix B: Agenda Templates for SCTAP Calls

[ENTER COMMUNITY NAME]
SINGLE COORDINATED TECHNICAL ASSISTANCE PLAN
Initial Meeting/Conference Call
Agenda

[ENTER DATE]

I. Welcome and Introductions (TAC and SCTAP Community Lead) 5 minutes
- a. CMHS Participants: Name and role
- b. Community participants: Name and role
- c. Program Partner participants: Name and role
- d. Recorder

II. History and Purpose of the SCTAP Process (CCC Representative) 5 minutes
- a. Role of the CCC
- b. TA Work Group
- c. Evolution of the SCTAP

III. Local Purpose for SCTAP (SCTAP Community Lead) 5 minutes
- a. Brief review on inputs/foundation data sources
- b. Brief review of any documentation developed to date

IV. Development of the SCTAP (All) 60 minutes
- a. Priority Area #1
  - i. Needs
  - ii. Strategies/Resources
  - iii. Timeline
  - iv. Responsible Parties
- b. Priority Area #2
  - i. Needs
  - ii. Strategies/Resources
  - iii. Timeline
  - iv. Responsible Parties
- c. Priority Area #3
  - i. Needs
  - ii. Strategies/Resources
  - iii. Timeline
  - iv. Responsible Parties

V. Debrief (TAC and SCTAP Community Lead) 15 minutes
- a. Strengths and challenges – communication process for accolades and/or grievances
- b. Review of action steps – process to ensure community needs are met
- c. Next call

[ENTER COMMUNITY NAME]
SINGLE COORDINATED TECHNICAL ASSISTANCE PLAN
Follow-up Meeting/Conference Call
Agenda

[ENTER DATE]

I. Welcome and Introductions (TAC and SCTAP Community Lead) 5 minutes

a. CMHS Participants: Name and role
b. Community participants: Name and role
c. Program Partner participants: Name and role
d. Recorder

II. Community Updates and FYI's (Community) 5 minutes

III. Follow-up on Action Items from Initial Call (Community/Program Partner Point People) 10 minutes

a. Priority Area #1
b. Priority Area #2
c. Priority Area #3

IV. Development of the SCTAP (All) 60 minutes

a. Priority Area #4
   i. Needs
   ii. Strategies/Resources
   iii. Timeline
   iv. Responsible Parties

b. Priority Area #5
   i. Needs
   ii. Strategies/Resources
   iii. Timeline
   iv. Responsible Parties

c. Priority Area #6
   i. Needs
   ii. Strategies/Resources
   iii. Timeline
   iv. Responsible Parties

V. Debrief (TAC and SCTAP Community Lead) 10 minutes

a. Strengths and challenges — communication process for accolades and/or grievances
b. Review of action steps — process to ensure community needs are met
c. Next call