SF/MHP/SAP/SD TRAINING MATERIALS

DCDHS – Behavioral Health – CCS

Here are some helpful links and documents we will reference during today's training and will benefit you as you get started in your new role with Comprehensive Community Services (CCS)!

Rules/Policies/Principles for CCS

- ForwardHealth CCS Online Handbook
- DHS 36
- DHS 106
- SAMHSA
- Dane County CCS Policies
- DHS 101 – Definition of Medically Necessary
- Combatting Fraud, Waste, and Abuse
- Person Centered Planning
- Children's System of Care Foundations of WI Wraparound Video Series

The following documents and guides can be located on Dane County's website.

Service Facilitator Role

- Service Facilitator Boot Camp – Provides a timeline of all pieces that must be completed when a new client starts with CCS.
- Service Facilitator Checklist – Provides a detailed overview of SF expectations.

Document Templates & Helpful Hints

- Agency Fax Cover Sheet – Please use this if sending faxes to the CCS Inbox (ccs@danecounty.gov).
- Release of Information Word Version or PDF Version
- Physician Prescription for CCS – Clients are required to have a PhRx on file annually.
- Assessment Template – The comprehensive assessment is completed in the module, but this template offers some exploratory questions the SF can use to assess each domain.
- Comprehensive Guide – Assessments and Summaries – This provides an overview with examples on how to complete both the comprehensive assessment and summary.
- Columbia Suicide Severity Rating Scale
- Comprehensive Guide – Recovery Plans and RTM Rosters – This provides an overview with examples on how to complete the recovery plan and when a RTM roster is needed.
- Recovery Team Meeting Roster – This is a blank roster, but a client specific roster can be downloaded from the client chart in the module.
- Transfer Summary – This is completed if a client wishes to be transferred to a new SF Agency.
- Discharge Summary – This is completed when a client is being discharged from the CCS Program.

- Consumer Status Data Form – This document needs to be completed and sent to the CCS Inbox as a part of the discharge process.
- ROI Guide – This document provides an outline of all state statues outlining the requirements for informed consent and consent to release information. Additionally, this document outlines how to complete the Dane County CCS ROI.
- Irretrievable Documents Form – This document needs to be completed and sent to the CCS Inbox if client documents are considered irretrievable (please see further guidance on when documents can be considered irretrievable here, see page 4).

**Submitting Documents to CCS – This document provides guidance on how to get the above documents into the Dane County client file.

Progress Notes Tips

- Progress Note Guidance
    - Progress Note Checklist (p. 3)
    - Tips for Progress Notes (p. 4)
    - DAP Progress Note Scoring Sheet (p. 5)
- Capturing Multiple Contacts in the Same Day
- Unlock Notes, VOIDS and Addendums
- Why do Progress Notes get Denied?
- Billing Status of Progress Notes
- Sample DAP Notes for SF

Module Tips

- Nick's Module Assessment Training Video
- Workflow Tips for the Module

Other Resources

- Dane County CCS Provider Directory
- Wisconsin Department of Health Services CCS
- SMART Goals/Action Steps
- Collaborative Services Team Initiative – Team Meeting Vignettes
- UWGB Behavioral Health Training Partnership
- Wisconsin Public Psychiatry Network Teleconference
- United Way of Dane County

Dane County CCS Orientation

for
Service Facilitators
Mental health Professionals
Substance Abuse Professionals
Service Directors

HOSTED BY JESSICA GILBERT LPC
DANE COUNTY CCS SERVICE DIRECTOR

QUALITY ASSURANCE

Ensuring we have high quality services

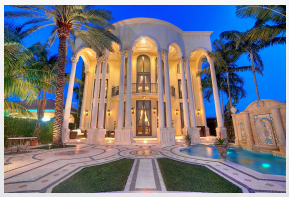
END GOAL: PARTICIPANT RECOVERY

While ensuring we follow Medicaid rules, Wisconsin DHS rules, and DCDHS policies

Forward Health CCS Online Handbook

DHS 36

DCDHS



analogy

I WANT A MANSION!

HOW CAN I GET ONE?

- 1ST STOP – CALL CCS INTAKE 608 242-6415
- REVIEW PROGRAM OPERATIONS AND REQUIREMENTS
  - MA / RX/ FUNCTIONAL SCREEN / ACTIVE PARTICIPATION/ CHOICE IN SERVICES
- SIGN DOCUMENTS (ROIS)
- PICK SERVICE FACILITATION AGENCY
- MEET WITH INTAKE AND SERVICE FACILITATOR: SIGN APPLICATION AND ADMISSION AGREEMENT AND SHARE INFORMATION FOR FUNCTIONAL SCREEN

LET'S WORK TOGETHER

★SF when you attend this meeting, know that this is not a meeting for you to facilitate. You are there to listen and gather info for the assessment. Prior to leaving the meeting, schedule your next meeting with the participant.

ROLES

CCS Enrolled Participant	Driver of treatment.
Intake Staff	Upon eligibility and assignment to SF – no longer involved until the annual renewal of the functional screen is due. Only other time involved is when transfer of SF agencies is requested.
Service Facilitator	ADVOCATE for Participant. Communication Hub. Service Coordinator
Mental Health Professional (MHP)	Clinical oversight and guidance of treatment.
Substance Abuse Professional (SAP)	Clinical oversight and guidance of AODA treatment.
Agency Service Director	Main support to SF for programmatic and clinical needs. Agency representative with DCDHS.
All other natural and paid supports	Added to team upon request from participant to fill a role and task on the team.

SERVICE FACILITATOR

MEET WITH PARTICIPANT ★

EXPLAIN YOUR ROLE

3. Service Facilitation (DHS 36.03, 36.10(2)(e)4, 36.17, Wis. Admin. Code)	Service facilitation includes activities that ensure the member receives: assessment services, service planning, service delivery, and supportive activities in an appropriate and timely manner. It also includes ensuring the service plan and service delivery for each member is coordinated, monitored, and designed to support the member in a manner that helps the member achieve the highest possible level of independent functioning. Service facilitation includes assisting the member in self-advocacy and helping the member obtain other necessary services such as medical, dental, legal, financial and housing services. Service facilitation for minors includes advocating, and assisting the minor's family in advocating, for the minor to obtain necessary services. When working with a minor, service facilitation that is designed to support the family must be directly related to the assessed needs of the minor. Service facilitation includes coordinating a member's crisis services, but not actually providing crisis services. Crisis services are provided by DHS 34, Wis. Admin. Code, certified programs. All services should be culturally, linguistically, and age (developmentally) appropriate.

SERVICE FACILITATOR

MEET WITH PARTICIPANT

BUILD RAPPORT AND INQUIRE WHO THEY WOULD LIKE TO BE A PART OF THE TEAM

REQUEST SIGNATURES ON ROIs

WHO CAN I COMMUNICATE WITH ABOUT AN ENROLLED CCS PARTICIPANT

Once an individual is enrolled in CCS, information can be shared between the Service Facilitator and other CCS Service Providers without a signed ROI as all are staff of the CCS Program and it is for the purposes of coordinating/providing treatment

- "Information about your care and progress may be shared between the members of your team and your service providers even though the team members and service providers may be from different agencies."
  –Admission Agreement

Please review our confidentiality policy with your supervisor

Needed for any non-CCS providers (including other Dane County programs)

Send copies of signed ROIs and any records obtained for CCS to ccs@danecounty.gov for participant central files

All treatment team requests for information should go to the Service Facilitator who will coordinate the sharing of pertinent information. (All non-treatment team requests for information go through DCDHS.)

CCS TEAM FORMATION

The Service Facilitator will bring together the team members at least every six months to review progress and update the recovery plan…

ROLES

TEAM INTRODUCTIONS…WHO'S WHO?

SET TEAM GUIDELINES & FLOW OF COMMUNICATION

CLARIFY EACH TEAM MEMBER'S ROLE

DOES EVERYONE UNDERSTAND
YOUR SERVICE FACILITATOR ROLE AS WRAPAROUND CASE MANAGER/TEAM LEADER?
THE RECOVERY PLANNING PROCESS & HOW THEY FIT INTO THE LARGER TEAM?

DOES EVERYONE UNDERSTAND THE MHP AND SAP ROLES OF PROVIDING CLINICAL OVERSIGHT, GUIDANCE, AND APPROVAL OF ALL ADDED SERVICES?

ESTABLISH GROUND RULES AND EXPECTATIONS FOR ALL PARTIES' ACTIVE PARTICIPATION & CONTRIBUTIONS

STRENGTHS

IDENTIFY STRENGTHS EACH MEMBER BRINGS TO THE TEAM

GOALS

LISTEN TO, PROMOTE AND SUPPORT THE PRIORITIES/NEEDS IDENTIFIED BY THE PARTICIPANT

IDENTIFY GOALS EACH MEMBER MAY HAVE FOR THE PARTICIPANT, THE TEAM, OR THEIR INDIVIDUAL CONTRIBUTION TO THE TEAM

**** Don't forget to fill out a team meeting roster****

7 Characteristics of Effective Teams

1. Clear Leadership
2. Defined Goals
3. Assigned Roles
4. Open Communication
5. Collaboration
6. Trust
7. Conflict Resolution

SF CCS MODULE TASKS

Complete Initial
30-day Recovery Plan
& **Service Authorizations** for
Screening & Assessment,
Service Planning,
Service Facilitation
Other CCS services the participant needs and is accessing during the next 30 days (med monitoring, therapy, etc.).

Initial 30-day Plan (Temporary Plan to Bridge Services)

30-Day Plan: Service Authorization

- Complete in Module only & submit to MHP for approval ASAP.
- DO NOT PRINT OR GET participant SIGNATURES for 30 day plan

SERVICE FACILITATOR

★ **MEET WITH PARTICIPANT AND TEAM**

CONTINUE RAPPORT BUILDING AND GATHERING INFORMATION FOR THE COMPREHENSIVE ASSESSMENT

BE MINDFUL OF YOUR TIMELINES FOR SUBMITTING ASSESSMENTS AND RECOVERY PLANS

The CCS Assessment:

a marriage of philosophy and regulations

- Life Satisfaction
- Culture/ Religion/ Spirituality
- Social Network & Family Involvement
- Community Living Skills
- Housing Issues
- Finances & Benefits
- Basic Needs
- Employment
- Education
- Physical Health
- Medications
- Mental Health
- Substance Use
- Trauma & Sig Life Stressors
- Crisis Prevention & Management
- Legal Status

30 DAYS!!

COMPLETING A QUALITY COMPREHENSIVE ASSESSMENT

Person Centered Planning

Core component of recovery-oriented care

A **collaborative process** between the person and their supporters that results in the development and implementation of an action plan to assist the person in achieving their unique, personal goals along the journey of recovery.

- The **participant is at the center** and the process rooted in **respect** for the person, their **choices**, their **voice**
- Family & social network are included
- Oriented toward **promoting recovery** rather than minimizing illness
- Be based on the **person's own goals and aspirations**
- Articulate the person's own role and the role of paid & natural supports in achieving identified goals
- **Focus on capacities, strengths, and interests** (current and emerging)
- Emphasize natural community settings
- Allow for uncertainty, setbacks, and disagreements

Domain: Desire for improvement? Current strengths/ needs or barriers / goal

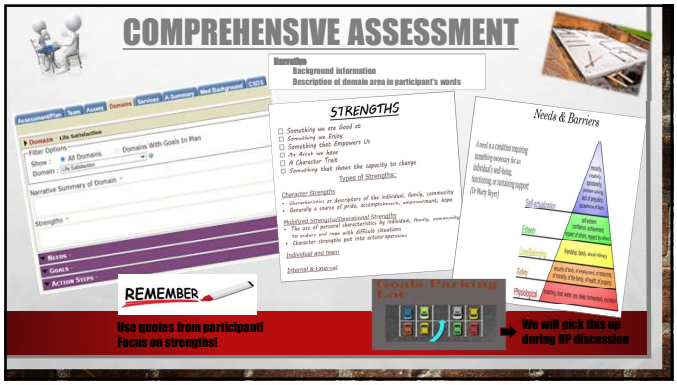
EXAMPLE PARTICIPANT STORY

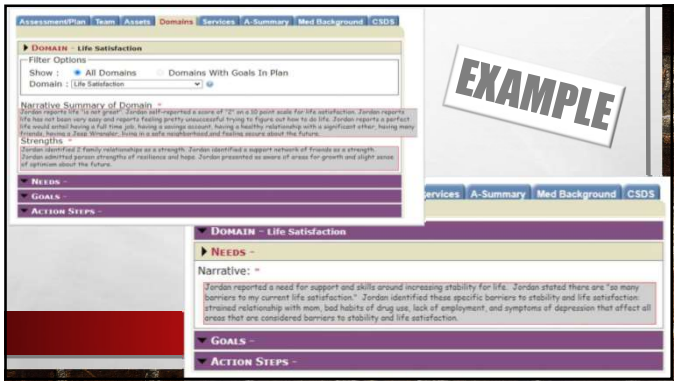
Jordan is a 22 yr old individual self-referred to CCS due to drug and alcohol abuse. Jordan is currently unemployed, homeless, and has charges pending due to a number of "bounced" checks written over the past several months. Having become depressed about the situation and not seeing a way out, Jordan decided to get help for drug abuse. Previous attempts to quit using have failed due to temptation to use when hanging out with friends. Jordan reports that both parents were drug addicts and were physically, sexually and emotionally abusive to all of their children.

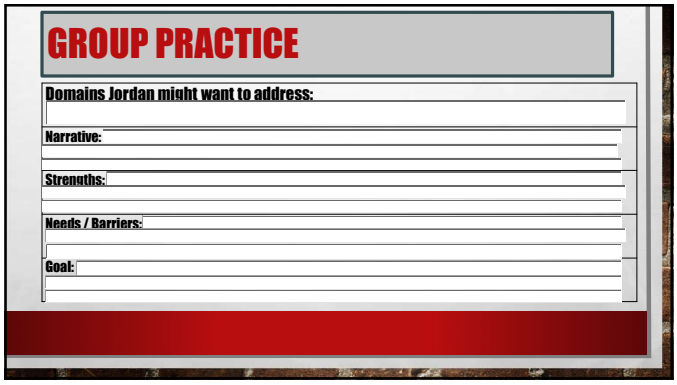
Jordan's father died of liver disease a few months ago at the age of 37. Jordan didn't go to the funeral because there would be "too much drama". As far as dads go, Jordan never felt understood or loved by him, so going didn't make sense at the time. Jordan's mom has been clean for nearly 6 years. It breaks her heart to see her child going down a similar path.

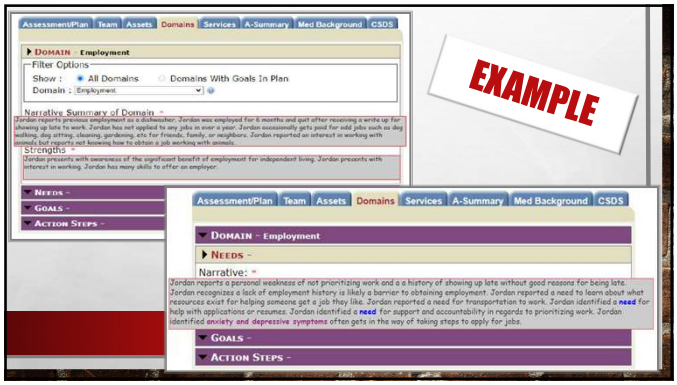
Jordan also reports being kicked out of the family home because of being a "queer", yet still lives in the same town. Prior to the Jordan's father passing, there was no contact with either parent for over 4 years. The last interaction with Jordan's mother occurred at church. They argued and created a scene. Their pastor had to intervene then recommended the family get therapy to address their family history of trauma. That was also the last time Jordan went to church. Jordan has a sister named Marcella and describes their relationship as "fair." They hang out occasionally & go to the gym or shopping, but she doesn't approve of Jordan's "lifestyle" so they aren't very close. Their cousin Casey likes to go dancing & parties a lot too, so they hang out on weekends when Jordan has money. Jordan wants to do more socially but the hours as a dishwasher are sporadic and only part-time, so money is tight.

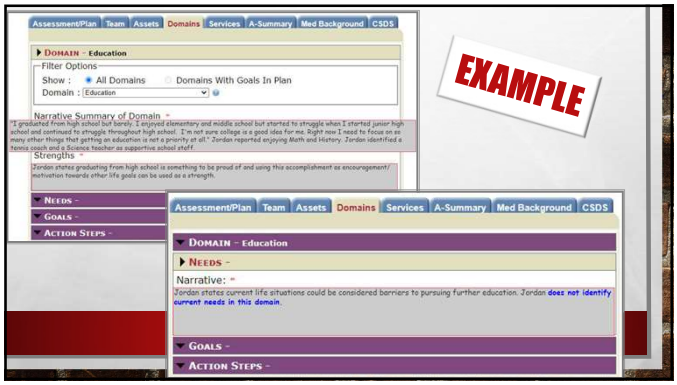
Jordan is single right now, but has a network of friends in the local LGBTQ community who also provide a place to stay. Jordan survived life as a runaway by becoming involved in sexual relationships with older men, many of who were also abusive, but provided food, shelter, and companionship. Jordan had one serious relationship that went badly a few years ago and caused Jordan to go into a "severe depression", not getting out of bed for weeks and eventually attempting suicide by taking pills.

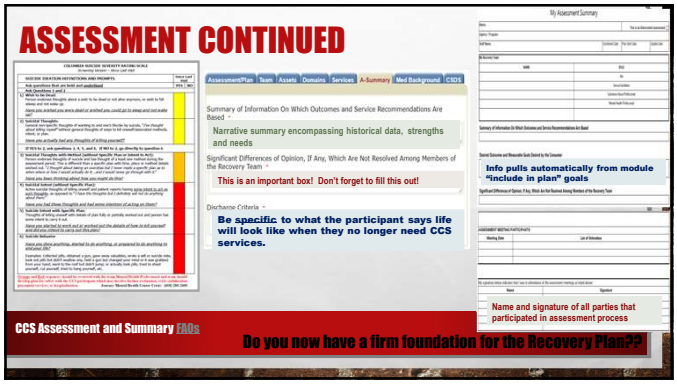

COMPREHENSIVE ASSESSMENT
Narrative
Background information
Description of domain area in participant's words
STRENGTHS
Something we are Good at
Something we Enjoy
Something that Empowers Us
An Asset we have
A Character Trait
Something that shows the capacity to change
Types of Strengths:
Character Strengths
Mobilized Strengths/Operational Strengths
Individual and Family
Internal & External
Needs & Barriers
Goals Parking Lot
REMEMBER
Use quotes from participant!
Focus on strengths!
We will pick this up during RP discussion


Assessment/Plan
Team
Assets
Domains
Services
A-Summary
Med Background
CSDS
DOMAIN - Life Satisfaction
Filter Options
Show : All Domains
Domains With Goals In Plan
Domain : Life Satisfaction
Narrative Summary of Domain
Strengths
NEEDS -
GOALS -
ACTION STEPS -
EXAMPLE
Narrative:
Jordan reported a need for support and skills around increasing stability for life. Jordan stated there are "so many barriers to my current life satisfaction." Jordan identified these specific barriers to stability and life satisfaction: strained relationship with mom, bad habits of drug use, lack of employment, and symptoms of depression that affect all areas that are considered barriers to stability and life satisfaction.


GROUP PRACTICE
Domains Jordan might want to address:
Narrative:
Strengths:
Needs / Barriers:
Goal:


Assessment/Plan Team Assets Domains Services A-Summary Med Background CSDS
DOMAIN - Employment
Filter Options
Show : All Domains Domains With Goals In Plan
Domain : Employment
Narrative Summary of Domain
Jordan reports previous employment as a dishwasher. Jordan was employed for 6 months and quit after receiving a write up for showing up late to work. Jordan has not applied to any jobs in over a year. Jordan occasionally gets paid for odd jobs such as dog walking, dog sitting, cleaning, gardening, etc. for friends, family, or neighbors. Jordan reported an interest in working with animals but reports not knowing how to obtain a job working with animals.
Strengths
Jordan presents with awareness of the significant benefit of employment for independent living. Jordan presents with interest in working. Jordan has many skills to offer an employer.
NEEDS -
GOALS -
ACTION STEPS -
EXAMPLE
Assessment/Plan Team Assets Domains Services A-Summary Med Background CSDS
DOMAIN - Employment
NEEDS -
Narrative:
Jordan reports a personal weakness of not prioritizing work and a a history of showing up late without good reasons for being late. Jordan recognizes a lack of employment history is likely a barrier to obtaining employment. Jordan reported a need to learn about what resources exist for helping someone get a job they like. Jordan reported a need for transportation to work. Jordan identified a need for help with applications or resumes. Jordan identified a need for support and accountability in regards to prioritizing work. Jordan identified anxiety and depressive symptoms often gets in the way of taking steps to apply for jobs.
GOALS -
ACTION STEPS -


Assessment/Plan Team Assets Domains Services A-Summary Med Background CSDS
DOMAIN - Education
Filter Options
Show : All Domains Domains With Goals In Plan
Domain : Education
Narrative Summary of Domain
"I graduated from high school but barely. I enjoyed elementary and middle school but started to struggle when I started junior high school and continued to struggle throughout high school. I'm not sure college is a good idea for me. Right now I need to focus on so many other things that getting an education is not a priority at all." Jordan reported enjoying Math and History. Jordan identified a tennis coach and a Science teacher as supportive school staff.
Strengths
Jordan states graduating from high school is something to be proud of and using this accomplishment as encouragement/ motivation towards other life goals can be used as a strength.
NEEDS -
GOALS -
ACTION STEPS -
EXAMPLE
Assessment/Plan Team Assets Domains Services A-Summary Med Background CSDS
DOMAIN - Education
NEEDS -
Narrative:
Jordan states current life situations could be considered barriers to pursuing further education. Jordan does not identify current needs in this domain.
GOALS -
ACTION STEPS -


ASSESSMENT CONTINUED
Assessment/Plan Team Assets Domains Services A-Summary Med Background CSDS
Summary of Information On Which Outcomes and Service Recommendations Are Based
Narrative summary encompassing historical data, strengths and needs
Significant Differences of Opinion, If Any, Which Are Not Resolved Among Members of the Recovery Team
This is an important box! Don't forget to fill this out!
Discharge Criteria
Be specific to what the participant says life will look like when they no longer need CCS services.
My Assessment Summary
Info pulls automatically from module "include in plan" goals
Name and signature of all parties that participated in assessment process
CCS Assessment and Summary FAQs
Do you now have a firm foundation for the Recovery Plan??

MHP / SAP ROLES IN REGARDS TO THE COMPREHENSIVE ASSESSMENT & ASSESSMENT SUMMARY

- ✓ PARTICIPATE IN ASSESSMENT PROCESS
- ✓ REVIEW MODULE COMPREHENSIVE ASSESSMENT ENTERED BY SF
  - DID THEY REMEMBER TO INCLUDE HISTORICAL INFORMATION FOR ESTABLISHED CCS PARTICIPANT?
  - DID THEY REMEMBER TO INCLUDE CURRENT INFORMATION FOR EVERY DOMAIN?
  - ARE THERE GOALS WITH "INCLUDE IN PLAN" STATUS?
  - ARE THERE STATED GOALS THAT DO NOT HAVE "INCLUDE IN PLAN" STATUS? IF SO – IS THERE A DOCUMENTED REASON THE GOAL HAS NOT BEEN INCLUDED IN THE PLAN?
  - APPROVE ASSESSMENT IN MODULE OR SEND BACK TO SF FOR FIXES AND APPROVE WHEN COMPLETE
- ✓ REVIEW PRINTED ASSESSMENT SUMMARY COMPLETED BY SF
  - DID THEY EFFECTIVELY SUMMARIZE THE INFORMATION THAT GUIDE DECISIONS MADE REGARDING SUPPORTS AND SERVICES?
  - ARE THERE DIFFERENCES OF OPINION YOU NEED TO BE AWARE OF AS YOU GUIDE CLINICAL TREATMENT?
  - ARE ALL DATES INCLUDED IN WHICH THE ASSESSMENT PROCESS WAS FACILITATED?
  - ARE ALL PARTICIPANTS IDENTIFIED THAT PARTICIPATED IN THE ASSESSMENT PROCESS?
  - HAVE ALL PARTICIPANT SIGNATURES BEEN OBTAINED?
- ✓ ENSURE CSSRS SCREENING TOOK PLACE, IS DOCUMENTED ON CSSRS SCREENER FORM, AND CSSRS HAS BEEN SUBMITTED TO CCS@DANECOUNTY.GOV

Comprehensive Assessments

Quality Assessment Rubric

- ✓ *Progress notes verify a conversation occurred with CCS participant to assess for need.*
- ✓ *DATE of assessment correlates with claims submitted for Screening and Assessment services.*
- ✓ *Date of assessment falls within required timelines. (30 days from application date for initial assessment. Within 6 months from last assessment for updated assessment)*
- ✓ *ALL fields have information. Historical and current if participant is established client. (N/A is not accepted as a response in any field)*
- ✓ *Medication section contains current, complete, and accurate information.*
- ✓ *Diagnosis section includes most recent diagnosis and prescribing physician from CCS physician prescription. (module automatically transfers this info to your assessment)*
- ✓ *Signatures of agreement with assessment include: SF, MHP, SAP. (Module applies these signatures to document)*
- ✓ *GOALS identified in assessment have been transferred to current recovery plan. "Include in Plan" Status*
- ✓ *Assessment Summary effectively summarizes all information from assessment, meeting dates correlate with claims for screening and assessment, signatures have been obtained from all team members who participated in the assessment process.*

RECOVERY PLAN – CREATING AN EFFECTIVE PERSON CENTERED PLAN

- DO YOU HAVE A CLEAR PICTURE OF THE "END GAME"/ DISCHARGE CRITERIA?
- DID YOUR PARTICIPANT AND THEIR TEAM IDENTIFY GOALS FOR RECOVERY?
- HAVE YOU ENGAGED IN CONSULTATION WITH MHP OR SD?
- AS YOU DRAFT THE PLAN, REMEMBER TO UTILIZE NATURAL SUPPORTS OFTEN AND REMEMBER MEDICAL NECESSITY CONCEPTS FOR SERVICES YOU HOPE TO ADD.

Complete within first 30 days!!

S M A R T G O A L S

- ACTION STEPS ARE CLEAR DIRECTIONS TO ALL TEAM PARTICIPANTS REGARDING WHAT THEY ARE BEING ASKED TO DO IN REGARDS TO ASSISTING THE PARTICIPANT REACH THIS GOAL.
- HOW PROGRESS WILL BE MEASURED NEEDS INFORMATION PERTAINING TO BASELINE, MEASURING TOOL BEING USED, AND MEASURABLE PROGRESS HOPED FOR.

Golden Thread of Medicaid funded services = Presenting symptoms ➡ Diagnosis ➡ Assessed Need ➡ Created Goal

SMART GOALS

Or in our situation, Goals are written in participant words and our ACTION STEPS are SMART

Specific
Measurable
Attainable
Relevant
Time Bound

SMART Summary Guide

Specific	• What exactly needs to be done? • Who will be involved? • Where will this take place?
Measurable	• Where is client currently at (baseline)? • How will client/team know they are making progress? • How will client/team know they have succeeded?
Attainable	• Is the goal reasonable (not too hard, not too easy)? • Are the resources available to help meet the goal?
Relevant	• Is this worthwhile for the client right now? • Is this meaningful to the client, or what someone else wants for the client? • Does it relate to the current problem? (diagnosis, assessed needs, etc)
Time Bound	• When does this need to be done?

What Does It Mean to be Specific?

Instead of…	Use…
Decrease out of control behaviors	Decrease yelling and throwing objects across the room
Increase use of coping skills	Increase use of identified coping skills (deep breathing, counting, listening to music)
Find a job	Apply to 3 jobs each week
Express emotion	Identify 2 different feelings each day

How Can it Be Measurable?

- Counting
  - Find the baseline and develop a target
    - Example: John has applied for 0 jobs this week (baseline). John will try to submit 2 applications next week
    - Example: Sally spits at her parents 27x each day (baseline). Parents would like to be spit on 10x each day
  - What can you count?
    - Frequency – how often — Ex – *Reduce angry outbursts to 2x/week*
    - Duration – how long — Ex – *Calm self from anger after 10 minutes*
    - Intensity – how extreme — Ex – *Rip paper instead of breaking furniture*

Other Ways to Measure

- Scaling
  - Consumer rates themselves on a scale (0-10).
  - Consumer identifies what each number equates to.
    - Example: Eric feels his depression is at a 2 today because he didn't get out of the house.
    - When asked Eric feels a 3 = getting out of the house, 4 = out of the house to go to a public place (store, library), 5 = saying hello to someone, etc
    - Eric is feeling a 2 today, wants to feel at a 4 next week
  - Use an Existing Scale
    - Feelings Thermometer (TF-CBT intervention)

What is Attainable?

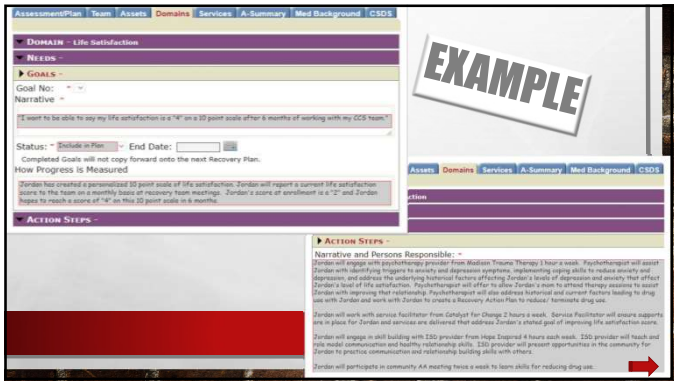
- Can the objective realistically be accomplished by the consumer?
- Are there resources available to support the objective?
- Example: Fred has been drinking 8-12 alcoholic drinks each day for 15 years.
  - Goal: Fred would like to be sober.
  - Objective: "Fred will have 0 drinks/week for 6 months"
    - Probably not attainable for Fred
    - It may be more attainable for Fred to attend 4 AA meetings each week
- Example: Wilma is failing all classes because she is truant 4 days each week
  - Objective: "Wilma will go to school 5 days/week" or "Wilma will earn all A's by next report card"
    - = not realistic
  - Start smaller - "Wilma will attend art class each day", "Wilma will attend school 2 days/week"

How do I know if it is Relevant?

- Does the objective relate back to the mental health diagnosis?
- Does the objective relate back to needs identified in the assessment?
- Is it important to the client at this time?
- Is this something the client wants? Or is it what someone else wants?
- Is objective relevant to multiple supports and providers

When will it be completed? Time Bound

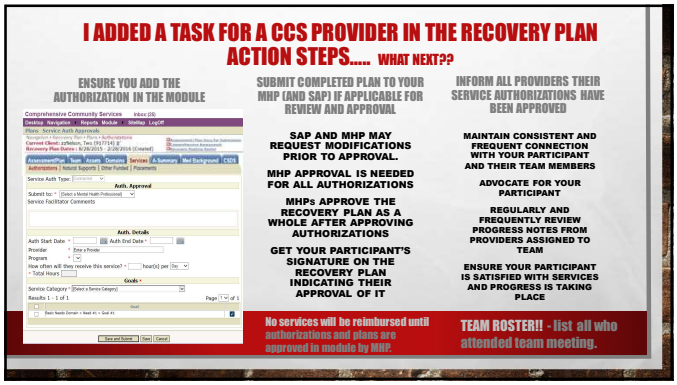
- All service plans are defaulted to a 6-month time frame.
- Objectives can be time bound further.
  - Ex - Consumer will attend one community event each month

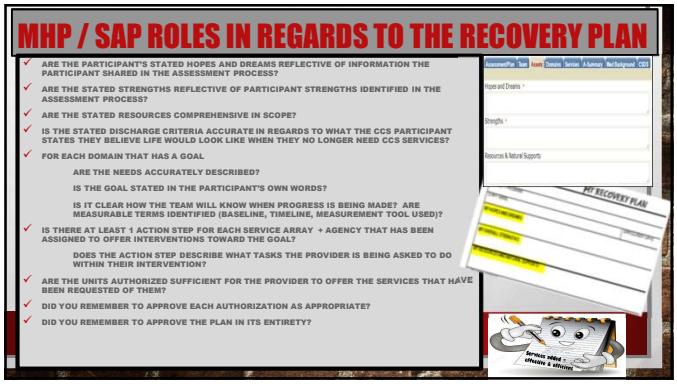


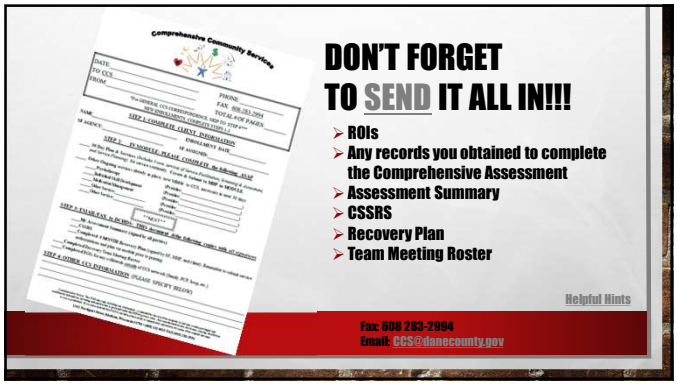
GROUP PRACTICE

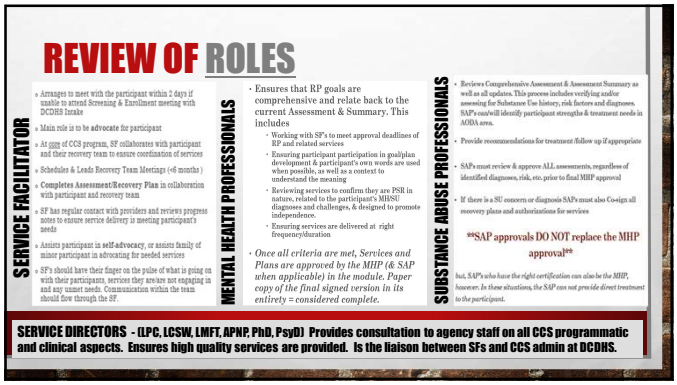
- **GOAL** Quotes
- **ACTION STEPS** SMART
- **GOAL** Quotes
- **ACTION STEPS** SMART

EXAMPLES
Needs and goals do not equal services! Always pay attention to medical necessity! DHS 101
If you were by chance to add 2 agencies / providers to provide the same service array, be VERY specific about how their action steps differ. AVOID DUPLICATION OF Services.

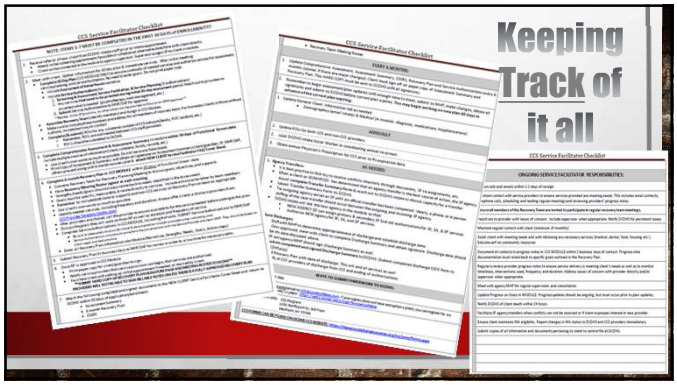

I ADDED A TASK FOR A CCS PROVIDER IN THE RECOVERY PLAN ACTION STEPS..... WHAT NEXT??
ENSURE YOU ADD THE AUTHORIZATION IN THE MODULE
SUBMIT COMPLETED PLAN TO YOUR MHP (AND SAP) IF APPLICABLE FOR REVIEW AND APPROVAL
SAP AND MHP MAY REQUEST MODIFICATIONS PRIOR TO APPROVAL.
MHP APPROVAL IS NEEDED FOR ALL AUTHORIZATIONS
MHPs APPROVE THE RECOVERY PLAN AS A WHOLE AFTER APPROVING AUTHORIZATIONS
GET YOUR PARTICIPANT'S SIGNATURE ON THE RECOVERY PLAN INDICATING THEIR APPROVAL OF IT
INFORM ALL PROVIDERS THEIR SERVICE AUTHORIZATIONS HAVE BEEN APPROVED
MAINTAIN CONSISTENT AND FREQUENT CONNECTION WITH YOUR PARTICIPANT AND THEIR TEAM MEMBERS
ADVOCATE FOR YOUR PARTICIPANT
REGULARLY AND FREQUENTLY REVIEW PROGRESS NOTES FROM PROVIDERS ASSIGNED TO TEAM
ENSURE YOUR PARTICIPANT IS SATISFIED WITH SERVICES AND PROGRESS IS TAKING PLACE
No services will be reimbursed until authorizations and plans are approved in module by MHP.
TEAM ROSTER!! - list all who attended team meeting.

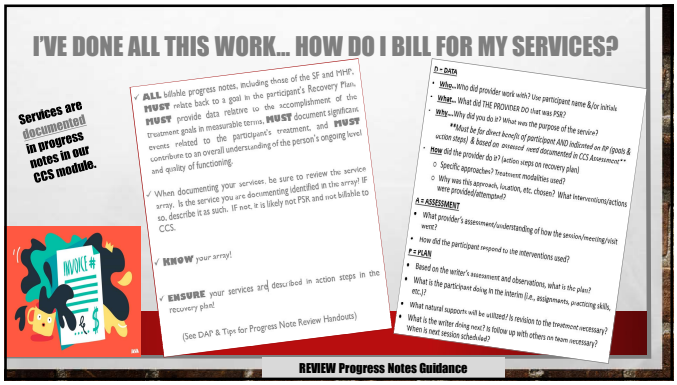

MHP / SAP ROLES IN REGARDS TO THE RECOVERY PLAN
ARE THE PARTICIPANT'S STATED HOPES AND DREAMS REFLECTIVE OF INFORMATION THE PARTICIPANT SHARED IN THE ASSESSMENT PROCESS?
ARE THE STATED STRENGTHS REFLECTIVE OF PARTICIPANT STRENGTHS IDENTIFIED IN THE ASSESSMENT PROCESS?
ARE THE STATED RESOURCES COMPREHENSIVE IN SCOPE?
IS THE STATED DISCHARGE CRITERIA ACCURATE IN REGARDS TO WHAT THE CCS PARTICIPANT STATES THEY BELIEVE LIFE WOULD LOOK LIKE WHEN THEY NO LONGER NEED CCS SERVICES?
FOR EACH DOMAIN THAT HAS A GOAL
ARE THE NEEDS ACCURATELY DESCRIBED?
IS THE GOAL STATED IN THE PARTICIPANT'S OWN WORDS?
IS IT CLEAR HOW THE TEAM WILL KNOW WHEN PROGRESS IS BEING MADE? ARE MEASURABLE TERMS IDENTIFIED (BASELINE, TIMELINE, MEASUREMENT TOOL USED)?
IS THERE AT LEAST 1 ACTION STEP FOR EACH SERVICE ARRAY + AGENCY THAT HAS BEEN ASSIGNED TO OFFER INTERVENTIONS TOWARD THE GOAL?
DOES THE ACTION STEP DESCRIBE WHAT TASKS THE PROVIDER IS BEING ASKED TO DO WITHIN THEIR INTERVENTION?
ARE THE UNITS AUTHORIZED SUFFICIENT FOR THE PROVIDER TO OFFER THE SERVICES THAT HAVE BEEN REQUESTED OF THEM?
DID YOU REMEMBER TO APPROVE EACH AUTHORIZATION AS APPROPRIATE?
DID YOU REMEMBER TO APPROVE THE PLAN IN ITS ENTIRETY?


Comprehensive Community Services
DON'T FORGET
TO SEND IT ALL IN!!!
ROIs
Any records you obtained to complete the Comprehensive Assessment
Assessment Summary
CSSRS
Recovery Plan
Team Meeting Roster
Helpful Hints
Fax: 608 283-2994
Email: CCS@danecounty.gov


REVIEW OF ROLES
SERVICE FACILITATOR
Arranges to meet with the participant within 2 days if unable to attend Screening & Enrollment meeting with DCDHS Intake
Main role is to be advocate for participant
At core of CCS program, SF collaborates with participant and their recovery team to ensure coordination of services
Schedules & Leads Recovery Team Meetings (<6 months)
Completes Assessment/Recovery Plan in collaboration with participant and recovery team
SF has regular contact with providers and reviews progress notes to ensure service delivery is meeting participant's needs
Assists participant in self-advocacy, or assists family of minor participant in advocating for needed services
SF's should have their finger on the pulse of what is going on with their participants, services they are/are not engaging in and any unmet needs. Communication within the team should flow through the SF.
MENTAL HEALTH PROFESSIONALS
Ensures that RP goals are comprehensive and relate back to the current Assessment & Summary. This includes
Working with SF's to meet approval deadlines of RP and related services
Ensuring participant participation in goal/plan development & participant's own words are used when possible, as well as a context to understand the meaning
Reviewing services to confirm they are PSR in nature, related to the participant's MH/SU diagnoses and challenges, & designed to promote independence.
Ensuring services are delivered at right frequency/duration
Once all criteria are met, Services and Plans are approved by the MHP (& SAP when applicable) in the module. Paper copy of the final signed version in its entirety = considered complete.
SUBSTANCE ABUSE PROFESSIONALS
Reviews Comprehensive Assessment & Assessment Summary as well as all updates. This process includes verifying and/or assessing for Substance Use history, risk factors and diagnoses. SAP's can/will identify participant strengths & treatment needs in AODA area.
Provide recommendations for treatment /follow up if appropriate
SAP's must review & approve ALL assessments, regardless of identified diagnoses, risk, etc. prior to final MHP approval
If there is a SU concern or diagnosis SAP's must also Co-sign all recovery plans and authorizations for services
SAP approvals DO NOT replace the MHP approval
but, SAP's who have the right certification can also be the MHP, however. In these situations, the SAP can not provide direct treatment to the participant.
SERVICE DIRECTORS - (LPC, LCSW, LMFT, APNP, PhD, PsyD) Provides consultation to agency staff on all CCS programmatic and clinical aspects. Ensures high quality services are provided. Is the liaison between SFs and CCS admin at DCDHS.

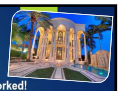
SERVICE FACILITATION - ONGOING
ROAD TO RECOVERY
Keeping an active Rx for CCS
Assisting with coordinating and participating in annual re-screens for CCS
Coordinating and monitoring service provision
Reviewing team member progress notes
Bringing together the recovery team at a minimum every 6 months to review progress and update the recovery plan
Keeping CCS documentation and other records up to date
Help participants monitor and maintain MA eligibility and/ or other benefits
Notify providers when participants leave the community
Plan and Coordinate SF agency transfers and discharges. Notify all providers of these changes.
Keep communication open with all team members


Keeping Track of it all
CCS Service Facilitator Checklist
ONGOING SERVICE FACILITATOR RESPONSIBILITIES:


I'VE DONE ALL THIS WORK... HOW DO I BILL FOR MY SERVICES?
Services are documented in progress notes in our CCS module.
✓ ALL billable progress notes, including those of the SF and MHP, MUST relate back to a goal in the participant's Recovery Plan. MUST provide data relative to the accomplishment of the treatment goals in measurable terms. MUST document significant events related to the participant's treatment, and MUST contribute to an overall understanding of the person's ongoing level and quality of functioning.
✓ When documenting your services, be sure to review the service array. Is the service you are documenting identified in the array? IF so, describe it as such. IF not, it is likely not PSR and not billable to CCS.
✓ KNOW your array!
✓ ENSURE your services and described in action steps in the recovery plan!
(See DAP & Tips for Progress Note Review Handouts)
D = DATA
Who...Who did provider work with? (the participant name &/or initials
What... What did THE PROVIDER DO that was PSR?
Why...Why did you do it? What was the purpose of the service?
Must be for direct benefit of participant AND indicated on RP (goals & action steps) & based on assessed need documented in CCS Assessment
How did the provider do it? (action steps on recovery plan)
Specific approaches? Treatment modalities used?
Why was this approach, location, etc. chosen? What interventions/actions were provided/attempted?
A = ASSESSMENT
What provider's assessment/understanding of how the session/meeting/visit went?
How did the participant respond to the interventions used?
P = PLAN
Based on the writer's assessment and observations, what is the plan?
What is the participant doing in the interim (i.e., assignments, practicing skills, etc.)?
What natural supports will be utilized? Is revision to the treatment necessary?
What is the writer doing next? Is follow up with others on team necessary? When is next session scheduled?
REVIEW Progress Notes Guidance

QUALITY SERVICE FACILITATION SERVICES
✓ COMMUNICATION - FREQUENCY / RAPPORT / ADVOCACY / KEEPING EVERYONE INFORMED / KNOWING OUR HIPAA LAWS / INFORMING PARTICIPANTS OF THEIR RIGHTS AND HOW TO FILE A GRIEVANCE
✓ PAPERWORK - KNOWING TIMELINES/ PLANNING AHEAD / UTILIZING QA REPORTS / UNDERSTANDING PURPOSE OF REQUIRED DOCUMENTS / UNDERSTANDING MEDICAL NECESSITY
✓ AVOIDING BURNOUT - RECEIVING ONGOING AND FREQUENT CLINICAL SUPERVISION / EMPOWER PARTICIPANT / ESTABLISHING HEALTHY BOUNDARIES WITH TEAMS – EVERYONE HAS A ROLE TO PLAY
Best CCS Practices
Communications with participants
✓ Provide information about who participant should contact if feeling unsafe or in crisis (911)
✓ Provide information on how to reach program staff, SF, members of team
✓ Provide information on how to file grievance
✓ Return all phone calls or other contacts within 2 working days max
✓ Make every effort to share information with participants
✓ Always offer participant copy of all paperwork completed
✓ Viewing of clinical record within one working day
✓ Copy of entire clinical record within 5 working days
YOU ROCK

Discharge from CCS

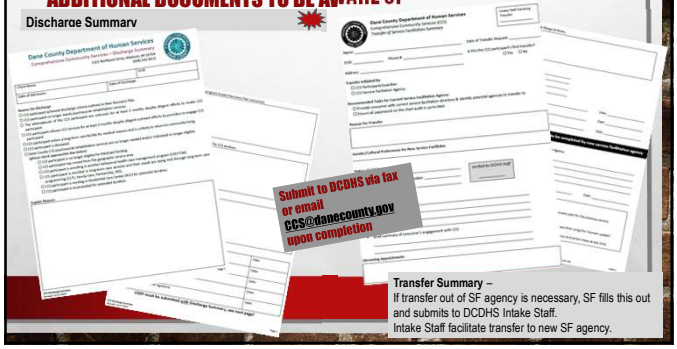


1. Participant has reached recovery goals.
2. The participant no longer wants psychosocial rehabilitation services.
3. The whereabouts of the participant are unknown for at least 3 months despite diligent efforts to locate the participant.
4. The participant refuses services from the CCS for at least 3 months despite diligent efforts to engage the participant.
5. The participant enters a long-term care facility for medical reasons and is unlikely to return to community living.
6. The participant is deceased.
7. Psychosocial rehabilitation services are no longer needed.

- **YAY!! CCS Services worked!**
- Ensure your progress note documents the conversation you were involved in where it was stated the participant no longer wants CCS services.
- Document your diligent efforts (phone call, text, email, letter, in person attempts, checking CCAP and Dane County Jail list). Document your attempts for a minimum of 3 months immediately prior to the discharge date.
- Document your diligent attempts (phone call, text, email, letter, in person attempts). Document your attempts for a minimum of 3 months immediately prior to the discharge date. "Contact" from participant does not equal "engagement". Engagement entails participation in a CCS service.
- Document your knowledge of where participant was admitted to and why it is unlikely they will return to community living.
- Document your awareness of participant's death and ensure you have notified Jessica and Julie about the participant's death.
- i.e. participant has reached their recovery goals –YAY!!

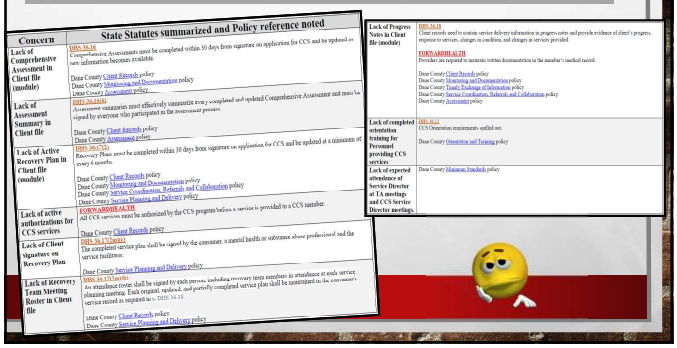
ADDITIONAL DOCUMENTS TO BE AWARE OF

Discharge Summary

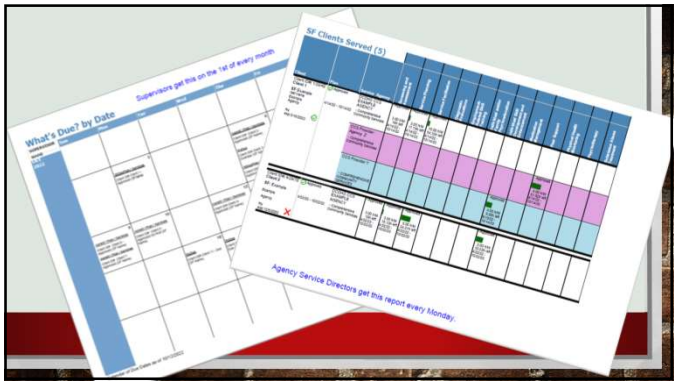


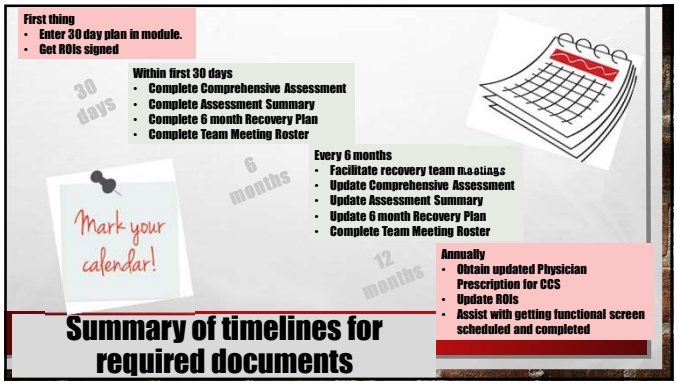
Transfer Summary –
If transfer out of SF agency is necessary, SF fills this out and submits to DCDHS Intake Staff.
Intake Staff facilitate transfer to new SF agency.

Rule/ Policy Violations when you don't submit your work



Concern	State Statutes summarized and Policy reference noted
Lack of Comprehensive Assessment in Client file (module)	DHS 36.16 Comprehensive Assessments must be completed within 30 days from signature on application for CCS and be updated as new information becomes available. Dane County Client Records policy Dane County Monitoring and Documentation policy Dane County Assessment policy
Lack of Assessment Summary in Client file	DHS 36.16(6) Assessment summaries must effectively summarize every completed and updated Comprehensive Assessment and must be signed by everyone who participated in the assessment process. Dane County Client Records policy Dane County Assessment policy
Lack of Active Recovery Plan in Client file (module)	DHS 36.17(5) Recovery Plans must be completed within 30 days from signature on application for CCS and be updated at a minimum of every 6 months. Dane County Client Records policy Dane County Monitoring and Documentation policy Dane County Service Coordination, Referrals and Collaboration policy Dane County Service Planning and Delivery policy
Lack of active authorizations for CCS services	FORWARDHEALTH All CCS services must be authorized by the CCS programs before a service is provided to a CCS member.
Lack of Client signature on Recovery Plan	Dane County Client Records policy DHS 36.17(b)(4) The completed service plan shall be signed by the consumer, a mental health or substance abuse professional and the service facilitator. Dane County Service Planning and Delivery policy
Lack of Recovery Team Meeting Roster in Client file	DHS 36.17(b)(b) An attendance roster shall be signed by each person, including recovery team members in attendance at each service planning meeting. Each original, updated, and partially completed service plan shall be maintained in the consumer's service record as required in s. DHS 34.18. Dane County Client Records policy Dane County Service Planning and Delivery policy
Lack of Progress Notes in Client file (module)	DHS 36.18 Client records need to contain service delivery information in progress notes and provide evidence of client's progress, response to services, changes in condition, and changes in services provided. FORWARDHEALTH Providers are required to maintain written documentation in the member's medical record. Dane County Client Records policy Dane County Monitoring and Documentation policy Dane County Timely Exchange of Information policy Dane County Service Coordination, Referrals and Collaboration policy Dane County Assessment policy
Lack of completed orientation training for Personnel providing CCS services	DHS 36.11 CCS Orientation requirements spelled out. Dane County Orientation and Training policy
Lack of expected attendance of Service Director at TA meetings and CCS Service Director meetings.	Dane County Minimum Standards policy





RESOURCES

YOUR AGENCY SUPERVISOR ☺

DHS WEBSITES:

- HTTPS://WWW.DHS.WISCONSIN.GOV/CCS/EXPANSION/INDEX.HTM
- HTTP://WWW.WICOLLABORATIVE.ORG/FAMILY-TEAM-MEETING-VIGNETTES.HTML

DANE COUNTY HUMAN SERVICES WEBSITE

- FORMS, RESOURCES, POLICIES AND PROCEDURES, DIRECTORY
  HTTPS://DANECOUNTYHUMANSERVICES.ORG/CCS/CLNT/DEFAULT.ASPX

UWGB – 16 HR CCS ONLINE TRAINING

- HTTPS://WWW.UWGB.EDU/BEHAVIORAL-HEALTH-TRAINING-PARTNERSHIP/TRAINING/

UNITED WAY 211

- HTTPS://WWW.UNITEDWAYDANECOUNTY.ORG/2-1-1/
  PHONE / IN PERSON / ONLINE DATABASE OF RESOURCES
  CAN ASSIST WITH RESOURCES IN MULTIPLE LANGUAGES

Tools

- CCS FAQ webpage
- Training handout with all the links
- Monthly SF/ QA office hours
- SF checklist
- Weekly chart audit
- Module reports

DEPARTMENT OF HUMAN SERVICES
EMPOWERED PEOPLE THRIVING IN SAFE, JUST, AND CARING COMMUNITIES
DANE COUNTY
Julie Meister
CCS Administrator
608 242-6413
meister.Julie@danecounty.gov
Jessica Gilbert
CCS Service Director
608 334-8030
Gilbert.Jessica@danecounty.gov
DCDHS QA TEAM
Erin Rodell
QA Specialist
608 334-1674
Rodell.Erin@danecounty.gov
Rachel Sadogierski
QA Specialist
608 334-7640
Sadogierski.Rachel@danecounty.gov
Sydney Kamp
QA Specialist
608 334-4024
Kamp.Sydney@danecounty.gov
Holly Rasmussen
QA Admin Assistant
608 334-9168
Rasmussen.Holly@danecounty.gov
Niki Sustr
CCS Clerk
CCS@danecounty.gov
Nick Nelson
CCS IT Specialist
Nelson.Nick@danecounty.gov
DEPARTMENT OF HUMAN SERVICES