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 Best Practices Guide – Provides best practice guidelines for multiple topics specific to the SF role. Also includes a Service Facilitator Checklist tool to keep SFs on track with expectations of the SF role.

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
- Collaboration in Teaming – Team Meeting Video
- WIWraparound.org – so many resources for wraparound and teaming
- 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

TOPICS we will cover today

- ❑ Rules/ Policies/ Statutes we have to follow in CCS –highlighting specific ones
- ❑ Intake process – briefly outline the process
- ❑ Recovery Teams – briefly highlight roles and expectations
- ❑ Service Facilitator's role – Best Practice
- ❑ MHP/ SAP role
- ❑ Comprehensive Assessment and Assessment Summary
- ❑ Recovery Plan
  - ➢ SMART Goals/ Action Steps
  - ➢ Service Authorizations
- ❑ Getting paid for your services / Progress Notes
- ❑ Resources/ Contact Info for QA team

QUALITY ASSURANCE

Ensuring we have high quality services

END GOAL: PARTICIPANT RECOVERY

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

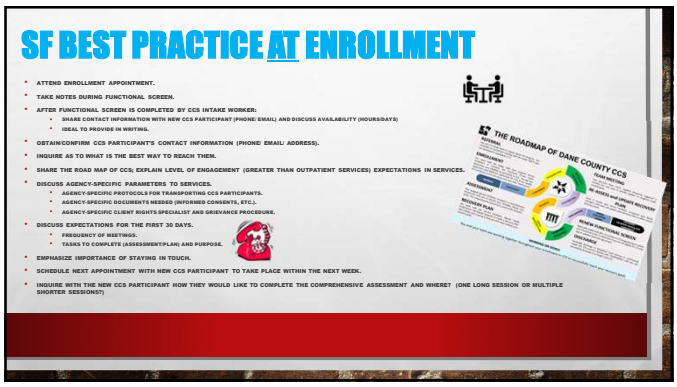
Forward Health CCS Online Handbook

DHS 36

DCDHS


analogy


HOW DO I GET SERVICES?
I WANT CCS!
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
IF YOU ARE THE SF ASSIGNED
MEET WITH INTAKE AND SERVICE FACILITATOR: SIGN APPLICATION AND ADMISSION AGREEMENT AND SHARE INFORMATION FOR FUNCTIONAL SCREEN
SF BEST PRACTICE before CCS Participant Enrollment
Review face sheet to understand CCS Participant's self-reported needs (keep in mind this could have changed since their referral phone call).
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.


SF BEST PRACTICE AT ENROLLMENT
ATTEND ENROLLMENT APPOINTMENT.
TAKE NOTES DURING FUNCTIONAL SCREEN.
AFTER FUNCTIONAL SCREEN IS COMPLETED BY CCS INTAKE WORKER:
SHARE CONTACT INFORMATION WITH NEW CCS PARTICIPANT (PHONE/ EMAIL) AND DISCUSS AVAILABILITY (HOURS/DAYS)
IDEAL TO PROVIDE IN WRITING.
OBTAIN/CONFIRM CCS PARTICIPANT'S CONTACT INFORMATION (PHONE/ EMAIL/ ADDRESS).
INQUIRE AS TO WHAT IS THE BEST WAY TO REACH THEM.
SHARE THE ROAD MAP OF CCS; EXPLAIN LEVEL OF ENGAGEMENT (GREATER THAN OUTPATIENT SERVICES) EXPECTATIONS IN SERVICES.
DISCUSS AGENCY-SPECIFIC PARAMETERS TO SERVICES.
AGENCY-SPECIFIC PROTOCOLS FOR TRANSPORTING CCS PARTICIPANTS.
AGENCY-SPECIFIC DOCUMENTS NEEDED (INFORMED CONSENTS, ETC.).
AGENCY-SPECIFIC CLIENT RIGHTS SPECIALIST AND GRIEVANCE PROCEDURE.
DISCUSS EXPECTATIONS FOR THE FIRST 30 DAYS.
FREQUENCY OF MEETINGS.
TASKS TO COMPLETE (ASSESSMENT/PLAN) AND PURPOSE.
EMPHASIZE IMPORTANCE OF STAYING IN TOUCH.
SCHEDULE NEXT APPOINTMENT WITH NEW CCS PARTICIPANT TO TAKE PLACE WITHIN THE NEXT WEEK.
INQUIRE WITH THE NEW CCS PARTICIPANT HOW THEY WOULD LIKE TO COMPLETE THE COMPREHENSIVE ASSESSMENT AND WHERE? (ONE LONG SESSION OR MULTIPLE SHORTER SESSIONS?)
THE ROADMAP OF DANE COUNTY CCS

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.

SF BEST PRACTICE first 30 days after Enrollment

Complete 30-day plan

- Authorize services for providers that are already established (ex. therapist/prescriber in CCS).

Build relationship with new CCS participant

- Present as warm, caring, outgoing and have good boundaries.
- Inquire about and assist with any immediate needs (food pantry, medications, etc.).
- Discuss consumer preferences.
- Educate participant about what CCS involves, level of participation expected, and supports that can be obtained.
- Schedule regular appointments. CCS Participant engagement levels are stronger when there is a consistent regularly scheduled (same day/ time each week/ month) meeting with the SF. (example: Every Tuesday at 10:00am)
- Advocate for the CCS participant.
- Discuss and understand barriers to participation the consumer may face.
  - Transportation challenges.
  - Participant's other time commitments/responsibilities.
  - Housing insecurity.
- Be resourceful. Go the extra mile. Fill in gaps.

Ensure that participant understands the services CCS can offer as well as service limitations

- Goal-based work.
- Services must be medically necessary (don't over-promise services).
- Transportation alone is not a CCS service.

Complete ROI's for natural supports and other providers

- Obtain any needed records (i.e. hospital discharge summary, neuropsych, IEP, etc.).

Complete Comprehensive Assessment (+ Summary) in collaboration with CCS participant (do NOT rely only on information gathered from functional screen) see SF Best Practice and Comprehensive Assessment.

Complete first 6-month Recovery Plan see SF Best Practice and Recovery Plan.

Assess provider/agency fit during first 30 days. Although rare, if the agency fit is not ideal (due to cultural considerations for example) discuss with the participant next steps and whether transfer should be explored.

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

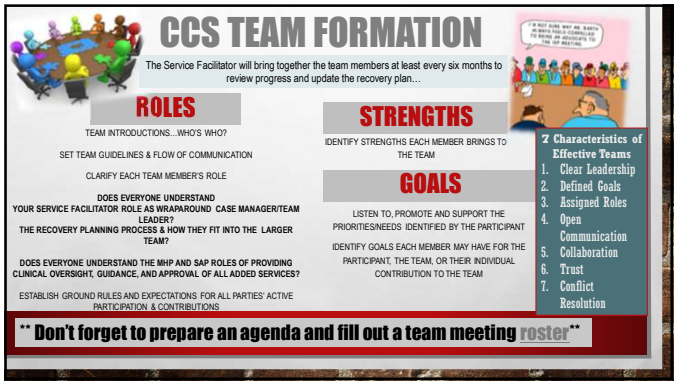
Once an individual is enrolled in CCS, information **can** be shared between the Service Facilitator and other CCS Service Providers without a signed ROI as all are staff of the CCS Program and it is for the purposes of coordinating/providing treatment

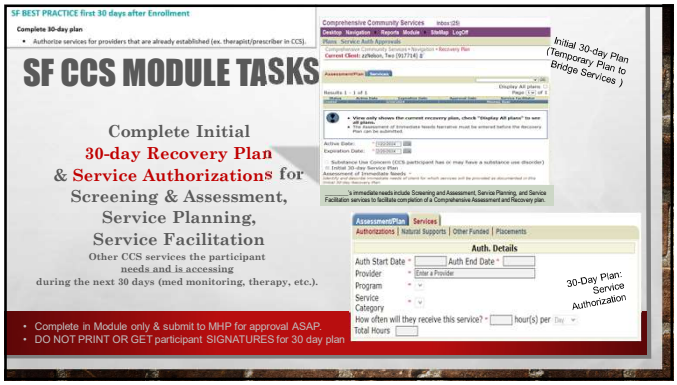
Please review our confidentiality policy with your supervisor

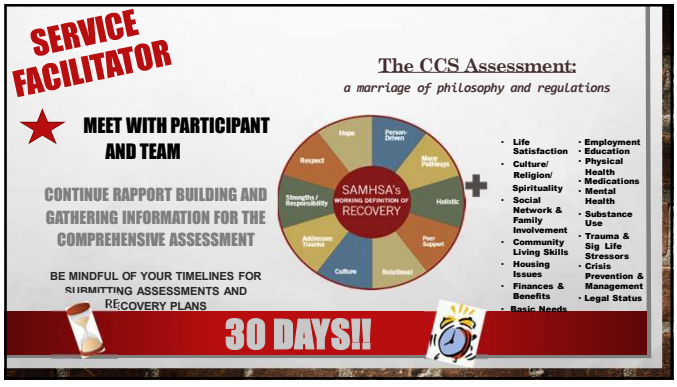
Needed for any non-CCS providers (including other Dane County programs)

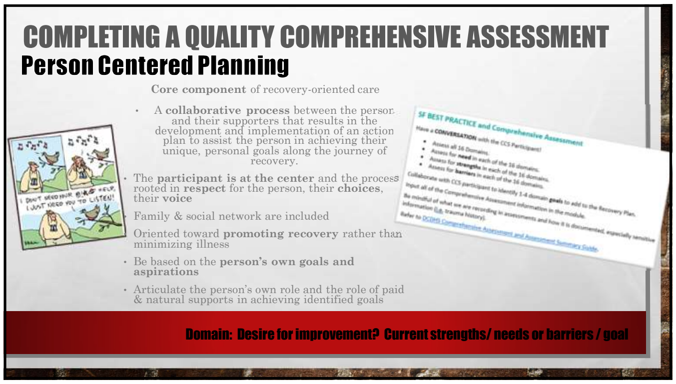
Send copies of signed ROIs and any records obtained for CCS to ccs@danecounty.gov for participant central files

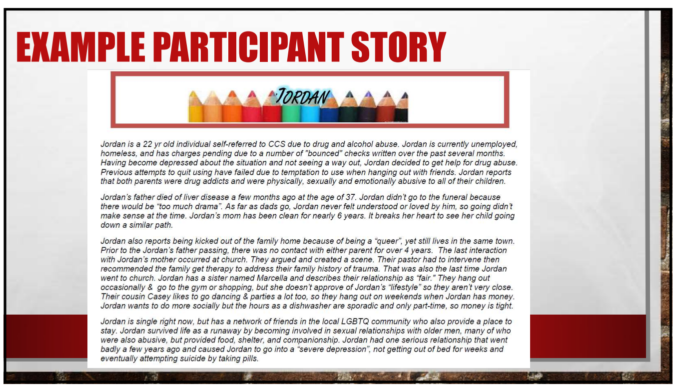
All treatment team requests for information should go to the Service Facilitator who will coordinate the sharing of pertinent information. (All non-treatment team requests for information go through DCDHS.)

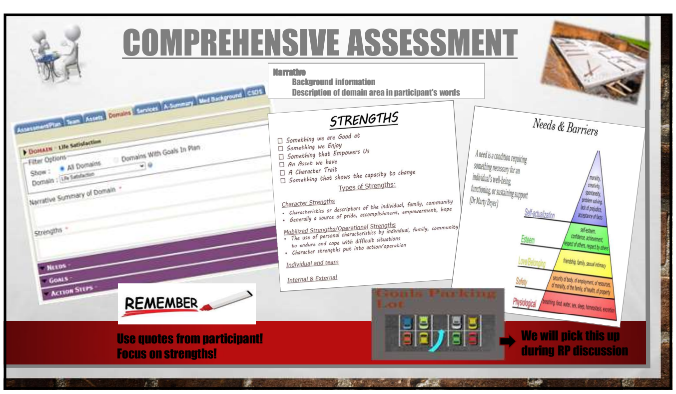

CCS TEAM FORMATION
The Service Facilitator will bring together the team members at least every six months to review progress and update the recovery plan…
ROLES
TEAM INTRODUCTIONS…WHO'S WHO?
SET TEAM GUIDELINES & FLOW OF COMMUNICATION
CLARIFY EACH TEAM MEMBER'S ROLE
DOES EVERYONE UNDERSTAND YOUR SERVICE 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
7 Characteristics of Effective Teams
1. Clear Leadership
2. Defined Goals
3. Assigned Roles
4. Open Communication
5. Collaboration
6. Trust
7. Conflict Resolution
** Don't forget to prepare an agenda and fill out a team meeting roster**

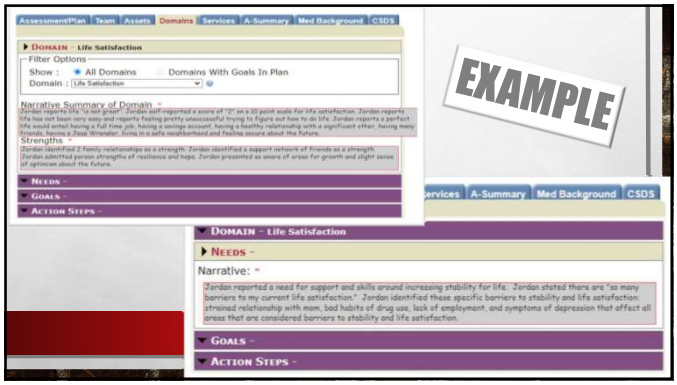

SF BEST PRACTICE first 30 days after Enrollment
Complete 30-day plan
Authorize services for providers that are already established (ex. therapist/prescriber in CCS).
SF CCS MODULE TASKS
Complete Initial
30-day Recovery Plan
& Service Authorizations for
Screening & Assessment,
Service Planning,
Service 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
Auth. Details
Complete in Module only & submit to MHP for approval ASAP.
DO NOT PRINT OR GET participant SIGNATURES for 30 day plan

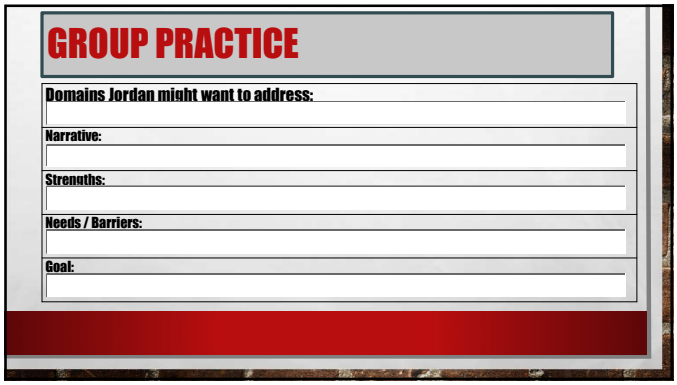

SERVICE FACILITATOR
MEET WITH PARTICIPANT AND TEAM
CONTINUE RAPPORT BUILDING AND GATHERING INFORMATION FOR THE COMPREHENSIVE ASSESSMENT
BE MINDFUL OF YOUR TIMELINES FOR SUBMITTING ASSESSMENTS AND RECOVERY PLANS
30 DAYS!!
The CCS Assessment:
a marriage of philosophy and regulations
SAMHSA's WORKING DEFINITION OF RECOVERY
Hope
Person-Driven
Many Pathways
Holistic
Peer Support
Relational
Culture
Addresses Trauma
Strengths / Responsibility
Respect
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

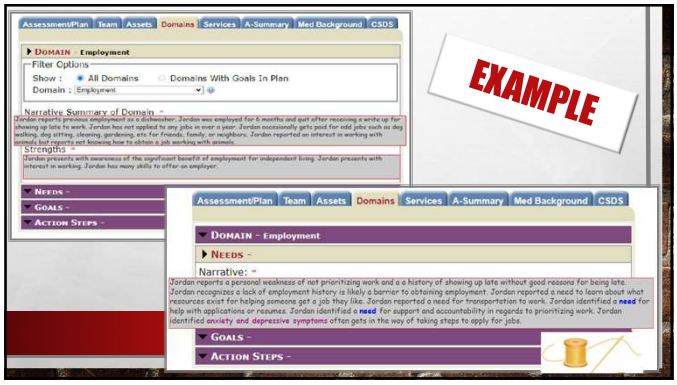

COMPLETING A QUALITY COMPREHENSIVE ASSESSMENT
Person Centered Planning
Core component of recovery-oriented care
• A collaborative process between the person and their supporters that results in the development and implementation of an action plan to assist the person in achieving their unique, personal 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
I DON'T NEED YOUR HELP, I JUST NEED YOU TO LISTEN!
SF BEST PRACTICE and Comprehensive Assessment
Have a CONVERSATION with the CCS Participant!
• Assess all 16 Domains.
• Assess for need in each of the 16 domains.
• Assess for strengths in each of the 16 domains.
• Assess for barriers in each of the 16 domains.
Collaborate with CCS participant to identify 1-4 domain goals to add to the Recovery Plan.
Input all of the Comprehensive Assessment information in the module.
Be mindful of what we are recording in assessments and how it is documented, especially sensitive information (i.e. trauma history).
Refer to DCDHS Comprehensive Assessment and Assessment Summary Guide.
Domain: Desire for improvement? Current strengths/ needs or barriers / goal

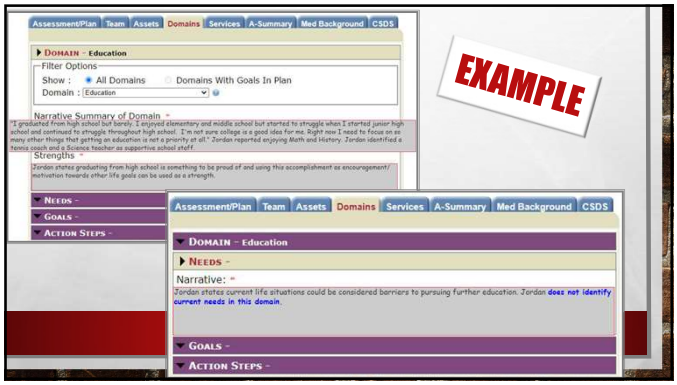

EXAMPLE PARTICIPANT STORY
JORDAN
Jordan is a 22 yr old individual self-referred to CCS due to drug and alcohol abuse. Jordan is currently unemployed, homeless, and has charges pending due to a number of "bounced" checks written over the past several months. Having become depressed about the situation 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.

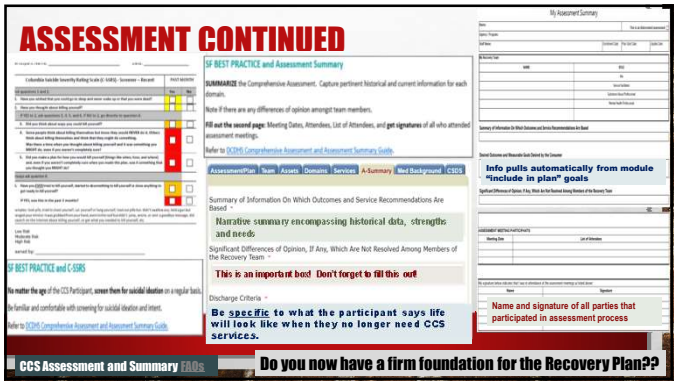

COMPREHENSIVE ASSESSMENT
Narrative
Background information
Description of domain area in participant's words
Assessment/Plan Team Assets Domains Services A-Summary Med Background CSDS
Domain - Life Satisfaction
Filter Options
Show: All Domains Domains With Goals In Plan
Domain: Life Satisfaction
Narrative Summary of Domain
Strengths
Needs
Goals
Action Steps
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
• Characteristics or descriptors of the individual, family, community
• Generally a source of pride, accomplishment, empowerment, hope
Mobilized Strengths/Operational Strengths
• The use of personal characteristics by individual, family, community to endure and cope with difficult situations
• Character strengths put into action/operation
Individual and team
Internal & External
Needs & Barriers
A need is a condition requiring something necessary for an individual's well-being, functioning, or sustaining support (Dr Marty Beyer)
Self-actualization
morality, creativity, spontaneity, problem solving, lack of prejudice, acceptance of facts
Esteem
self-esteem, confidence, achievement, respect of others, respect by others
Love/Belonging
friendship, family, sexual intimacy
Safety
security of body, of employment, of resources, of morality, of the family, of health, of property
Physiological
breathing, food, water, sex, sleep, homeostasis, excretion
REMEMBER
Use quotes from participant!
Focus on strengths!
Goals Parking Lot
We will pick this up during RP discussion

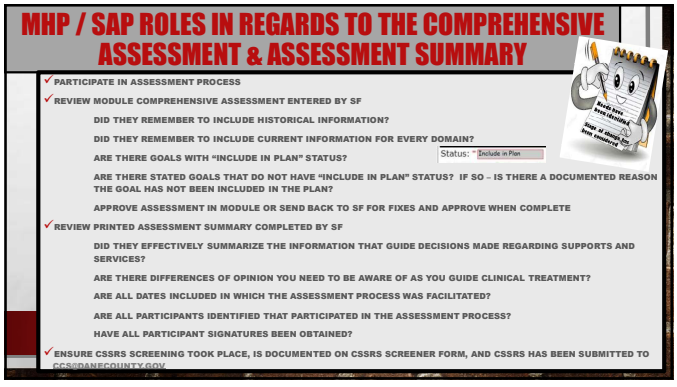

EXAMPLE
Assessment/Plan
Team
Assets
Domains
Services
A-Summary
Med Background
CSDS
DOMAIN - Life Satisfaction
Filter Options
Show : All Domains Domains With Goals In Plan
Domain : Life Satisfaction
Narrative Summary of Domain *
Strengths *
NEEDS -
GOALS -
ACTION STEPS -
DOMAIN - Life Satisfaction
NEEDS -
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.
GOALS -
ACTION STEPS -


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


EXAMPLE
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 *
Strengths *
NEEDS -
GOALS -
ACTION STEPS -
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 *
Strengths *
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
SF BEST PRACTICE and Assessment Summary
SUMMARIZE the Comprehensive Assessment. Capture pertinent historical and current information for each domain.
Note if there are any differences of opinion amongst team members.
Fill out the second page: Meeting Dates, Attendees, List of Attendees, and get signatures of all who attended assessment meetings.
Refer to DCSMS Comprehensive Assessment and Assessment Summary Guide.
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.
SF BEST PRACTICE and C-SSRS
No matter the age of the CCS Participant, screen them for suicidal ideation on a regular basis.
Be familiar and comfortable with screening for suicidal ideation and intent.
Refer to DCSMS Comprehensive Assessment and Assessment Summary Guide.
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?
DID THEY REMEMBER TO INCLUDE CURRENT INFORMATION FOR EVERY DOMAIN?
ARE THERE GOALS WITH "INCLUDE IN PLAN" STATUS?
Status: * Include in Plan
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.*
- ✓ *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.*
- ✓ *GOALS identified in assessment have been transferred to current recovery plan. "Include in Plan" Status*
- ✓ *Assessment Summary effectively summarizes all information from assessment, the DATE correlates with the assessment, meeting dates correlate with claims for screening and assessment, signatures have been obtained from all team members who participated in the assessment process.*
- ✓ Updating Assessments: ensure you reassess participants in every domain every 6 months and add the updates

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!!

- 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

SF BEST PRACTICE and Recovery Plan

Recovery Plan **goals need to be based on needs** identified in the Comprehensive Assessment.

Discharge Criteria = CCS Participant specific statement as to what they believe life will look like when they will no longer need the level of support offered by CCS.

Assist CCS participant with identifying priorities; where do they want to start?

Keep number of goals on Recovery Plan reasonable—1-4 maximum is ideal.

Goals should be stated in CCS participant's own words.

Action steps = specific directions to team members who are given a task to help the CCS participant reach their goal. Define what we are going to pay them to do.

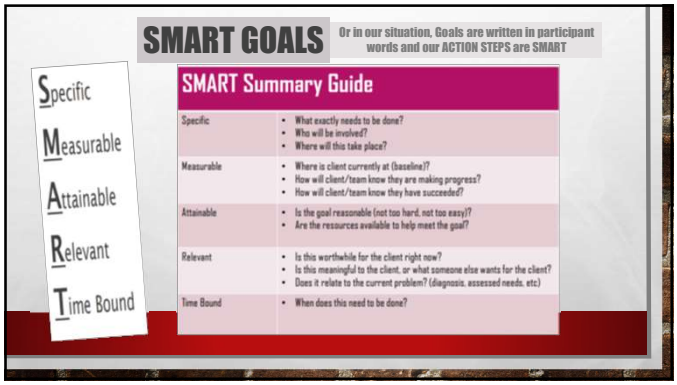
How Progress is Measured – needs information pertaining to baseline, measuring tool used, and timeline for completion.

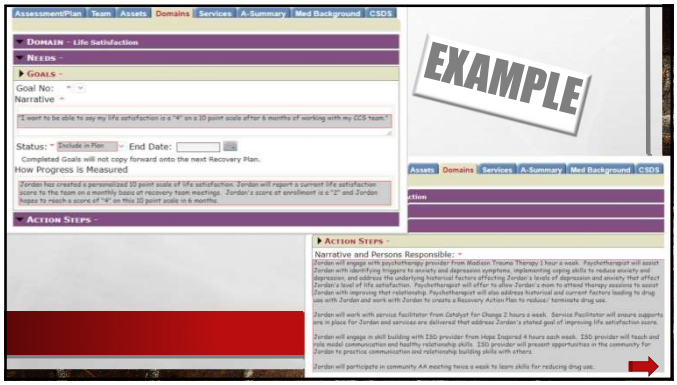
Services- Be realistic about adding services, what can CCS Participants successfully complete/attend? Remember services need to be medically necessary to be added to the recovery plan.

Service Authorizations – Service Array + Agency + Goal provider is addressing needs to match the correlating Action Step. Ensure authorization is approved prior to services starting.

Refer to DCDHS Recovery Plan and Recovery Meeting Roster Guide.

S M A R T G O A L S


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?


EXAMPLE
Assessment/Plan
Team
Assets
Domains
Services
A-Summary
Med Background
CSDS
Domain - Life Satisfaction
Needs -
Goals -
Goal No:
Narrative
Status:
End Date:
Completed Goals will not copy forward onto the next Recovery Plan.
How Progress is Measured
Action Steps -
Narrative and Persons Responsible:

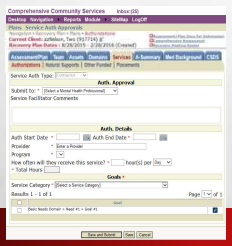

SERVICE AUTHORIZATIONS MUST have a correlating ACTION STEP under each identified goal that agency has been assigned to work on with the client.
My Recovery Plan
How Progress is measured
Identify baseline, timeline, and measuring tool used.
Example: Client will apply to 2 jobs each week. Client will secure a job within the time frame of this recovery plan (06/24/20XX)
SERVICE AUTHORIZATION
Adding a provider to the team through the Services tab in the module. Identify service array from the list of approved Forward Health service arrays, identify the provider agency, frequency of service, and goal that provider is working on
Progress Notes
Providers need to write notes that speak to the progress being made towards recovery goals.
Life Area/ Domain Goal
Quotes from clients about what they want different in that life domain
Example: Life Area/ Domain: Employment
Goal: "I want to have a full time job and successfully keep the job for a year or more"
ACTION STEPS
Clear directions to the provider on what the team is asking them to do in regards to assisting the participant in reaching recovery
ACTION STEPS
Identify Service Array, Agency, + Task
Example: Client will work with ERST provider from Agency X to apply to 2 jobs each week until a job is obtained.
Reminder: If SF is authorized to address every goal, you need an action step for SF under each goal.
Progress Updates
Need to speak directly to "How progress is measured" section

GROUP PRACTICE

- **GOAL** Quotes
- **HOW PROGRESS WILL BE MEASURED**
- **ACTION STEPS** SMART
- **GOAL** Quotes
- **HOW PROGRESS WILL BE MEASURED**
- **ACTION STEPS** SMART

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

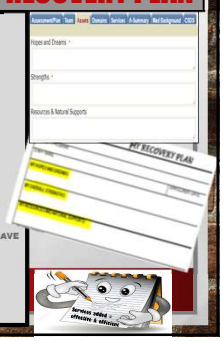
ENSURE YOUR PARTICIPANT IS SATISFIED WITH SERVICES AND PROGRESS IS TAKING PLACE

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?



DON'T FORGET TO SEND IT ALL IN!!!

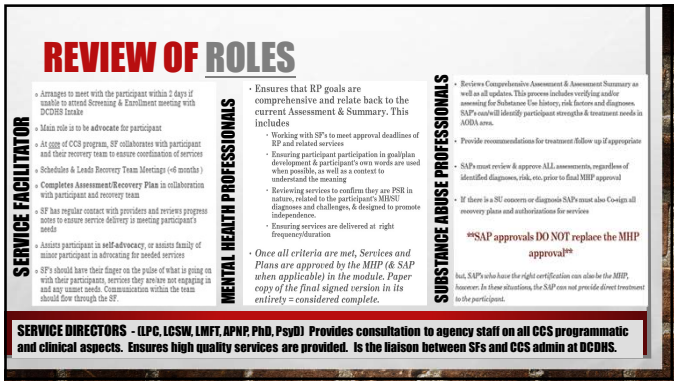
- ROIs
- Any records you obtained to complete the Comprehensive Assessment
- Assessment Summary
- CSSRS
- Recovery Plan
- Team Meeting Roster

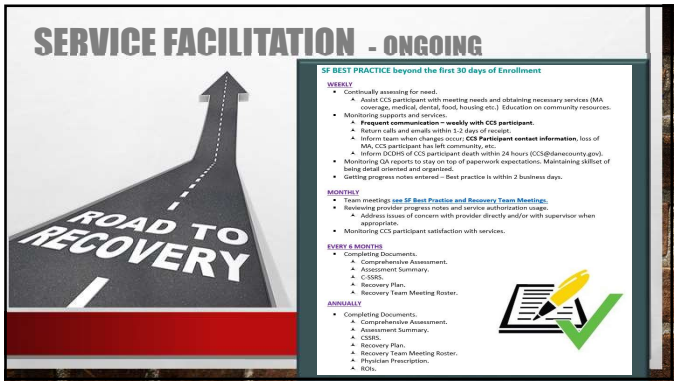
Helpful Hints

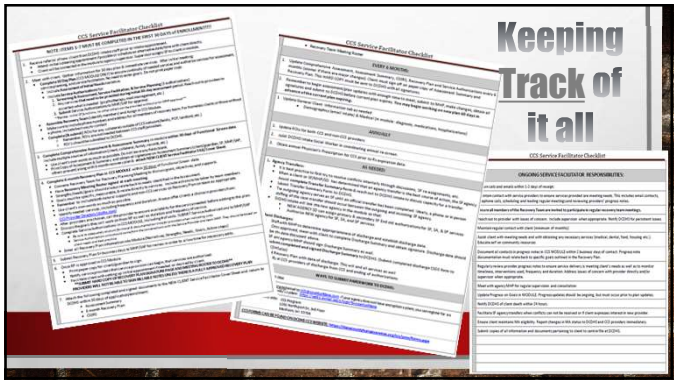
Fax: 608 283-2994
Email: CCS@danecounty.gov

REVIEW OF WORKFLOW FOR FIRST 30 DAYS

- MEET NEW CCS PARTICIPANT AT ENROLLMENT MEETING
- COMPLETE INITIAL 30 DAY RECOVERY PLAN AND SERVICE AUTHS FOR SCREENING & ASSESSMENT, SERVICE PLANNING, AND SERVICE FACILITATION
- ESTABLISH RECOVERY TEAM & SCHEDULE TEAM MEETING WITHIN FIRST FEW DAYS/ WEEKS
- COMPLETE ASSESSMENT & ASSESSMENT SUMMARY
- COMPLETE RECOVERY PLAN
- DOCUMENT IN PROGRESS NOTES THROUGHOUT THIS PROCESS
- SUBMIT DOCUMENTS TO DCDHS


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. SAPs can/will identify participant strengths & treatment needs in AODA area.
Provide recommendations for treatment follow up if appropriate
SAPs must review & approve ALL assessments, regardless of identified diagnoses, risk, etc. prior to final MHP approval
If there is a SU concern or diagnosis SAPs must also Co-sign all recovery plans and authorizations for services
SAP approvals DO NOT replace the MHP approval!
but, SAPs 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
SF BEST PRACTICE beyond the first 30 days of Enrollment
WEEKLY
Continually assessing for need.
Assist CCS participant with meeting needs and obtaining necessary services (MA coverage, medical, dental, food, housing etc.) Education on community resources.
Monitoring supports and services.
Frequent communication – weekly with CCS participant.
Return calls and emails within 1-2 days of receipt.
Inform team when changes occur; CCS Participant contact information, loss of MA, CCS participant has left community, etc.
Inform DCDHS of CCS participant death within 24 hours (CCS@danecounty.gov).
Monitoring QA reports to stay on top of paperwork expectations. Maintaining skillset of being detail oriented and organized.
Getting progress notes entered – Best practice is within 2 business days.
MONTHLY
Team meetings see SF Best Practice and Recovery Team Meetings.
Reviewing provider progress notes and service authorization usage.
Address issues of concern with provider directly and/or with supervisor when appropriate.
Monitoring CCS participant satisfaction with services.
EVERY 6 MONTHS
Completing documents.
Comprehensive Assessment.
Assessment Summary.
C-SSRS.
Recovery Plan.
Recovery Team Meeting Roster.
ANNUALLY
Completing Documents.
Comprehensive Assessment.
Assessment Summary.
CSSRS.
Recovery Plan.
Recovery Team Meeting Roster.
Physician Prescription.
ROIs.


Keeping Track of it all
CCS Service Facilitator Checklist
CCS Service Facilitator Checklist

SF BEST PRACTICE AND RECOVERY TEAM MEETINGS

As you are creating the team with the CCS participant, ensure you get ROIs completed for any non-CCS provider team members. Express expectations with each team member about attending and participating in team meetings.

Schedule team meetings 1-2 months in advance.

Invite EVERYONE on the team to the team meetings! Natural Supports + Paid Supports.

Assign a team member to support CCS participant's presence and participation if needed.

Prepare an agenda.

Review/ confirm contact information for team members.

Review progress towards goals.

Assess if the plan is working.

Adjust the plan if necessary.

Assign new tasks if necessary.

Fill out a Recovery Team Meeting **Roster.**

Schedule future team meetings while everyone is present at current team meeting.

Ensure the next 1-2 Recovery Team Meeting dates are already scheduled.

If CCS providers are not attending team meetings as invited, first work to resolve the concern and if needed, consider replacing their services with a provider who operates within strong WRAPAROUND principles.

Refer to DCDHS Recovery Plan and Recovery Meeting Roster Guide.

SF BEST PRACTICE AND COLLABORATING WITH OTHER PROVIDERS

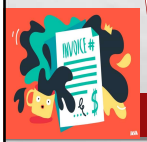
THAT HAVE DIFFERING PHILOSOPHIES, STANDARDS, AND AGENCY EXPECTATIONS

Consult with the MHP on the team when concerns arise. Allow MHP to take a lead role in resolving concerns.

- ❑ Work to resolve the concerns.
- ❑ Understand DCDHS defers to the MHP on the team to guide clinical treatment.
- ❑ Report as necessary any ethical, licensing, HIPAA, or Medicaid fraud violations to Dane County and the appropriate entities.
- ❑ Understand that natural consequences of reduction of referrals is likely if there are CCS provider agencies that cannot effectively collaborate to resolve concerns.

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 participants 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 are described in action steps in the recovery plan!

(See DAP & Tips for Progress Note Review Handouts)

D = DATA

- **Who**…Who did provider work with? Use 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? When is next session scheduled?
- What is the writer doing next? Is follow up with others on team necessary?

REVIEW Progress Notes Guidance

MHP/SAP *Billable Services*

Screening and Assessment Service Array tasks performed

- Facilitating any part of Comprehensive Assessment (time spent in communication with CCS participant for the purposes of completing the Comprehensive Assessment)
- Reviewing Comprehensive Assessment and Assessment Summary

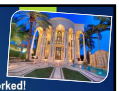
Service Planning Service Array tasks performed

- Attending team meetings
- Reviewing and approving service authorizations and Recovery Plans

Array services *other than Psychotherapy, Diagnostic Evaluations, and Peer Support*

- On an ad-hoc basis, as needed, in times of staff shortage, absence, illness, etc. to ensure continuity of services for the CCS participant if your progress note indicates these reasons for your services.

Discharge from CCS

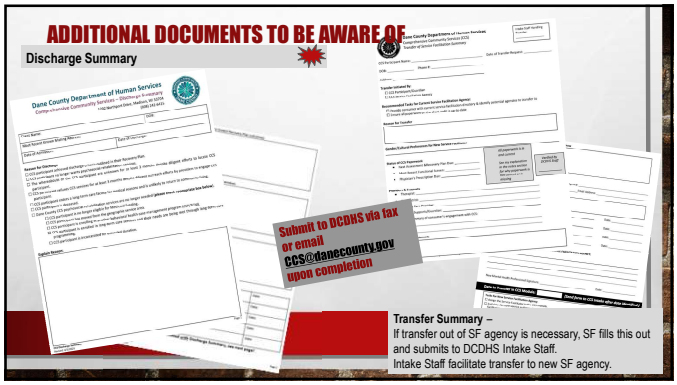


1. Participant has reached recovery goals.
2. The participant no longer wants psychosocial rehabilitation services.
3. The whereabouts of the participant are unknown for at least 3 months despite diligent efforts to locate the participant.
4. The participant refuses services from the CCS for at least 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!!

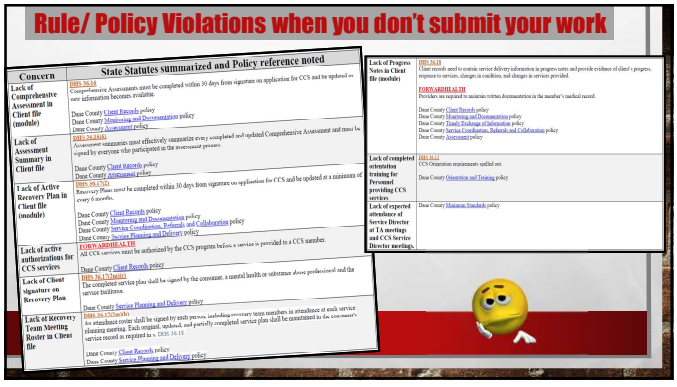
ADDITIONAL DOCUMENTS TO BE AWARE OF

Discharge Summary

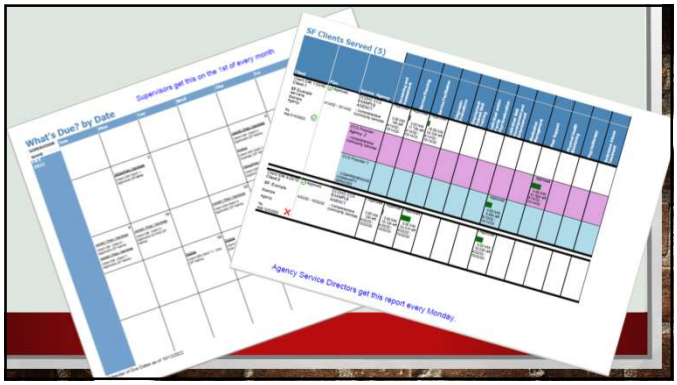


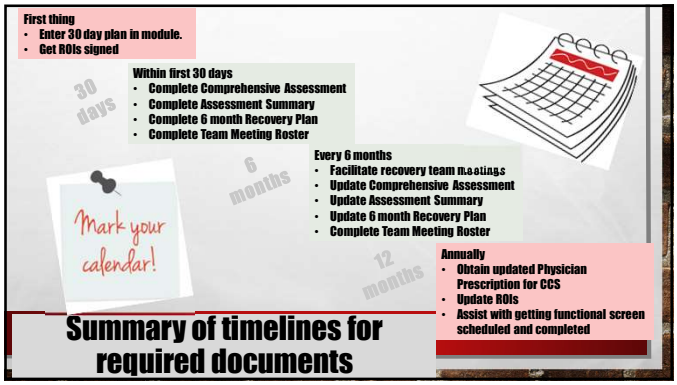
Transfer Summary –
If transfer out of SF agency is necessary, SF fills this out and submits to DCDHS Intake Staff.
Intake Staff facilitate transfer to new SF agency.

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 36.18 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 36.18(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(6) 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 Person 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(6)(d)1 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(6)(b)3 An attendance roster shall be signed by each person, including necessary 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 36.15.
	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


What's Due? by Date
Supervisors get this on the 1st of every month
SF Clients Served (S)
Agency Service Directors get this report every Monday.


First thing
Enter 30 day plan in module.
Get ROIs signed
30 days
Within first 30 days
Complete Comprehensive Assessment
Complete Assessment Summary
Complete 6 month Recovery Plan
Complete Team Meeting Roster
6 months
Every 6 months
Facilitate recovery team meetings
Update Comprehensive Assessment
Update Assessment Summary
Update 6 month Recovery Plan
Complete Team Meeting Roster
Mark your calendar!
12 months
Annually
Obtain updated Physician Prescription for CCS
Update ROIs
Assist with getting functional screen scheduled and completed
Summary of timelines for required documents


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
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

SF BEST PRACTICE AND SUPERVISION

Receive weekly supervision

Serving CCS participants with **high intensity or acute needs** (We defer to the MHP's clinical guidance for the team but here are some general suggestions).

If CCS Participant has **acute suicidal ideation or intent**:

- receive daily supervision/consult with the MHP.
- collaborate closely with JMHC Emergency Services Unit.
- have a current crisis plan readily available for all team members to reference.
- INVOLVE natural supports in the recovery planning and process.
- ensure a member of the CCS team is regularly/consistently checking in with the CCS Participant and documenting risk in progress notes.

If CCS Participant is **high intensity due to traits of Borderline Personality Disorder:**

- keep the CCS team small in number.
- have the CCS team meet frequently (monthly) to avoid triangulation trends.
- set clear boundaries for your availability to respond to their expressed needs.
- receive frequent (weekly) supervision.

If CCS Participant is **high intensity due to active psychosis**:

- ensure safety by collaborating with JMHC Emergency Services Unit.
- have a current crisis plan readily available for all team members to reference.
- incorporate medication monitoring/adherence services.
- receive frequent (daily) supervision.

If CCS Participant is **high intensity due to marked reactivity in mood or behavior:**

- receive frequent (daily) supervision.
- INVOLVE natural supports in the recovery planning and process.
- offer intensive (daily) psychosocial rehabilitative supports/services from CCS team members.

SF BEST PRACTICE AND SUPERVISION (CONTINUED)

Serving CCS Participants who are **minimally engaged**: (We defer to the MHP's clinical guidance but here are some general suggestions)

- assess for CCS participant's current stage of change.
- assess for readiness to transfer to outpatient level services.
- INVOLVE natural supports in the recovery planning and process.
- Use Motivational Interviewing techniques to increase CCS participant's awareness of their own personal strengths, abilities, resources, and goals.
- express clear expectations of participation; verbally and in writing.
- have frequent (monthly) team meetings.
- collaboratively set small, measurable, incremental goals for increasing engagement
- collaborate with MHP regularly (monthly).

Considering Discharge from CCS: (we defer to the MHP's clinical guidance but here are some general suggestions

- assess for discharge criteria from day 1 of working with CCS participant.
- ensure CCS participant has individualized criteria for what their life will look like when they no longer need intensive psychosocial rehabilitative services.
- review/update discharge criteria at bare minimum every 6 months.
- consider if the CCS participant is currently receiving higher intensity services or is in an ineligible setting that currently meet their needs (Example: If CCS Participant is placed in an RCC, Skilled Nursing Facility, Jail, etc., and the duration of the situation is unknown, discharge may be most appropriate.) They can always reapply to CCS at the time CCS levels of service are most appropriate.
- Consider if the CCS Participant is currently receiving lower intensity services that currently meet their needs (Example: If CCS Participant is only receiving outpatient level psychotherapy, outpatient level psychiatry services, not expressing needs for more intensive services, and can independently seek supports/ resources/ services for meeting basic needs, discharge to outpatient level services may be most appropriate.)
- receive frequent (weekly) supervision.

Considering a transfer of a CCS participant to a different Service Facilitator: (We defer to the MHP's clinical guidance but here are some general suggestions)

- receive frequent (weekly) supervision.
- consider what needs are not being met with current SF.
- consider additional training/supervision to increase capability of current SF working with CCS participant.
- consider MHP participating in active role in assessment/planning process to assess why current SF may not be effective fit for CCS participant.

- If considering transferring to another Service Facilitation Agency, understand lack of engagement in and of itself is not a good reason to transfer the CCS Participant to a new agency. Consider if discharge is more appropriate if documented SF outreach strategies
- If considering transferring CCS Participant to another Service Facilitation Agency, follow the Transfer Process as outlined on DCDHS CCS FAQ web page. Remember to use strength-based language on the TOSF form.

NEXT STEPS

RECEIVE ONGOING TRAINING FROM YOUR AGENCY SUPERVISOR ☺

ATTEND PERSON CENTERED PLANNING TRAINING:

- PCP: WISCONSIN'S MODEL | WISCONSIN DEPARTMENT OF HEALTH SERVICES

ATTEND WRAPAROUND TRAINING

- CHILDREN'S SYSTEM OF CARE: FOUNDATIONS OF WISCONSIN WRAPAROUND VIDEO SERIES | WISCONSIN DEPARTMENT OF HEALTH SERVICES
- HOME - WISCONSIN WRAPAROUND TRAINING SYSTEM

REVIEW DANE COUNTY HUMAN SERVICES WEBSITE REGULARLY

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  HTTPS://DANECOUNTYHUMANSERVICES.ORG/CCS/CLNT/DEFAULT.ASPX


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
Sadogierkski.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