Dane County CCS Best Practices for Service Facilitation

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Service Facilitation Defined by ForwardHealth

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 with JMHC; Dane County's emergency services provider.

All services should be culturally, linguistically, and age (developmentally) appropriate.

Service Planning Defined by ForwardHealth

Service planning includes the development of a written plan of the psychosocial rehabilitation services that will be provided or arranged for the member. All services must be authorized by a mental health professional and a substance abuse professional if substance abuse services will be provided. This can be a single professional for whom mental health and substance abuse services are in scope. The service plan is based on the assessed needs of the member. It must include measurable goals and the type and frequency of data that will be used to measure progress toward the desired outcomes. It must be completed within 30 days of the member's application for CCS services. The completed service plan must be signed by the member, a mental health or substance abuse professional, and the service facilitator.

The service plan must be reviewed and updated based on the needs of the member or at least every six months. The review must include an assessment of the progress toward goals and member satisfaction with the services. The service plan review must be facilitated by the service facilitator in collaboration with the member and the recovery team.

Screening and Assessment Defined by ForwardHealth

Screening and assessment services include: completion of initial and annual functional screens and completion of the initial comprehensive assessment and ongoing assessments as needed. The assessment must cover all the domains, including substance use, which may include using the Uniform Placement Criteria or the American Society of Addiction Medicine Criteria. The assessment must address the strengths, needs, recovery goals, priorities, preferences, values, and lifestyle of the member and identify how to evaluate progress toward the member's desired outcomes.

Assessments for minors must address the minor's and family's strengths, needs, recovery and/or resilience goals, priorities, preferences, values, and lifestyle of the member including an assessment of the relationships between the minor and his or her family. Assessments for minors should be age (developmentally) appropriate.

SF BEST PRACTICE and Training

DCDHS CCS Orientation – Best practice is to take the module training and SF/MHP/SAP/SD training at least twice.

Training | Dane County Human Services Provider Resources

Ensure you take all 3 core Dane County CCS Orientation Trainings within your first 3 months of employment.

Consider retaking the Module Training and the SF/MHP/SAP/SD Training 6 months after you have been providing SF services.

You are welcome to take Dane County CCS Orientation Trainings as many times as you want/need.

Person Centered Planning – Best practice is to take **Person Centered Planning Training** within your first 3 months of SF services and retake it every couple of years to refresh your memory on implementation of Person Centered Planning concepts.

WRAPAROUND – Best practice is to watch the 6 part video series on WI DHS website (**Children's System of Care: Foundations of Wisconsin Wraparound Video Series | Wisconsin Department of Health Services**) and review the National Wraparound Initiative website (**National Wraparound Initiative (NWI)**) within your first 3 months of SF services. Best practice is to participate in more intensive WRAPAROUND trainings facilitated by White Pines Consulting (**https://wiwraparound.org/)** within your first year of providing SF services.

Progress Notes – Best Practice is to frequently review **CCS - FAQ - Progress Notes | Dane County Human Services Provider Resources**, regularly monitor the quality of your progress notes using the provided checklists in Dane County CCS Progress Note guide, and participate in a training specific to progress notes for psychosocial rehabilitative services within the first year of your employment in CCS. One example of training on progress notes that exists: **Documentation with a jury in mind**

What are we paying you for?

What intervention did you offer?

What was the purpose of your services?

What progress has been made toward goals?

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).

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?)

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.

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.

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.

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 DCDHS Comprehensive Assessment and Assessment Summary Guide.

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.

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 DCDHS Comprehensive Assessment and Assessment Summary Guide.

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 CCS 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.

SF BEST PRACTICE and Policies you need to know

Know all of our CCS policies and review them frequently!

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.

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 were ineffective.

- 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.

SF BEST PRACTICE and collaborating with Dane County Care Center (DCCC)

1. Communication expectations
   a. Establishing contact
      i. DCCC staff will reach out to the individual's CCS service facilitator within 24 hours of the CCS participant's admission (not including holidays).
      ii. The SF will get back to DCCC staff as soon as possible, and no later than 24 hours after DCCC made contact (not including holidays or weekends).
      iii. Initial contact (preferably a live, synchronous conversation via phone, zoom, or in person) will address:
         - The CCS participant's presenting concerns and goals
         - The anticipated length of stay and discharge plan/destination
         - A plan for the division of case management tasks during the stay
         - A plan for subsequent contacts between the SF, DCCC staff, and the CCS participant (how and when)
      iv. Note: if an individual's SF makes the referral to DCCC, they may be asked at the time of referral to share their availability to meet (in person or virtually) within the first 24 hours of the CCS Participant's stay (not including holidays or weekends).
   b. Communication throughout stay
      i. SFs should expect to touch base with the DCCC staff each day during the CCS participant's admission (not including holidays or weekends) to discuss progress, status of referrals, and discharge planning.
   c. Communication regarding discharge
      i. DCCC staff and SFs will discuss the discharge plan (date, time, discharge location, aftercare plan) beginning at the initial contact and throughout the stay. The CCS participant should be included in these discussions.
      ii. DCCC staff will alert the SF if there are changes to the working discharge plan or if the CCS participant discharges earlier than anticipated, including if there are any safety concerns associated with the individual's discharge.
      iii. A follow up appointment with the SF should be scheduled prior to discharge from DCCC.

2. Referral responsibilities
   a. Group home referrals should generally be prepared and submitted by SFs. DCCC staff can support this process as needed. Making a group home referral while an individual is at DCCC does not necessarily mean that the person will be able to stay at DCCC until the outcome of the referral is known, or, if accepted, until they can move in.
   b. SFs must be the ones to make referrals to other CCS providers such as to a therapist, psychiatrist, ERI, etc.
   c. SFs must be the ones to make referrals to CSP/TCM as they have to explain why the individual needs more than a CCS level of care.
   d. DCCC staff can assist with AODA tx referrals (ASAMs), housing referrals, primary care physicians, etc.

3. Appointments/transportation
    a. For appointments set up by DCCC staff and falling during a CCS Participant's DCCC stay, DCCC staff will set up a ride/transport.
    b. For appointments during the DCCC stay that were scheduled prior to arrival, the SF will transport or set up a ride.

DEFINITIONS of Key Terms

Comprehensive Community Services: (WI DHS)
Comprehensive Community Services (CCS) is a program that helps people of all ages live their best lives. It focuses on unique needs that relate to mental health and substance use.

> **Who is eligible?** CCS is for people who have needs that, if ignored, could lead to being hospitalized in times of crisis. The CCS screening process confirms who is eligible for the program. A tribal nation or county CCS provider completes the screening process.

WHAT IS WRAPAROUND? (NATIONAL WRAPAROUND INITIATIVE)
Wraparound differs from many service delivery strategies, in that it provides a comprehensive, holistic, youth and family-driven way of responding when children or youth experience serious mental health or behavioral challenges. Wraparound puts the child or youth and family at the center. With support from a team of professionals and natural supports, the family's ideas and perspectives about what they need and what will be helpful drive all of the work in Wraparound.

The young person and their family members work with a Wraparound facilitator to build their Wraparound team, which can include the family's friends and people from the wider community, as well as providers of services and supports.

With the help of the team, the family and young person take the lead in deciding team vision and goals, and in developing creative and individualized services and supports that will help them achieve the goals and vision. Team members work together to put the plan into action, monitor how well it's working, and change it as needed.

Person-Centered Planning
Planning is something that all people do. People set goals. People dream of things they want in order to live their best life. Over time, with individual effort and outside supports, goals can be achieved.

> **Promoting choice and autonomy**
> In human service work, best practice is to use Person-Centered Planning methods. Person-Centered Planning, also known as PCP, has a constructive focus verses a focus on problems, tending to symptoms, and treating a diagnosis. Services exist to benefit the people served (and not vice versa). Person-Centered Planning is done with the people served, for the people served. When practitioners and recovery-oriented systems embrace Person-Centered Planning, they see each person as an essential partner in making decisions about services.
>
> Person-Centered Planning involves ongoing conversations about action, as well as the creation of a written document about action. Planning is not something done once and then finished. Written plans change and evolve as the person does. No two plans are identical. Natural supports and the strengths and resources they offer are encouraged and engaged. Services and action steps are collaboratively identified, and balance what is important to the person and what is important for the person.

CCS Service Facilitator Checklist

NOTE: ITEMS 1-7 MUST BE COMPLETED IN THE FIRST 30 DAYS (calendar days) of ENROLLMENT!!!!

1. Receive referral of new CCS Participant from DCDHS Intake staff prior to Intake appointment.
   - **Attend initial screening appointment** if possible or schedule an alternative date/time with CCS Participant directly.
   - CCS Participant will be connected in the module to agency supervisor. Supervisor assigns SF to CCS Participant in module.

2. **Meet with CCS Participant**. Gather information for 30 day plan & immediate services. After initial meeting:
   - **Complete 30 Day Plan** (CCS MODULE ONLY) No need to enter goals. Do not print paper copy.
     - Include **Assessment of Initial Needs** narrative.
     - Include **Service Authorizations** for:
       1. **Screening** & **Assessment, Service Facilitation,** & **Service Planning** (3 authorizations)
       2. Any services **that need to be provided during initial 30-day assessment** period. Reach out to providers to ascertain what is needed (psychotherapy, med management, etc.)
       3. **Submit** Service Authorizations to MHP/SAP for approval.
   - **Assemble Recovery Team**
   - Make sure to include phone numbers and address for all members of recovery team in Teams Tab. For homeless CCS Participants or those without a phone, include best way to contact
   - **Complete** (& **submit)** ROIs for any collaterals outside of CCS network (family, PCP, landlord, etc.)
     - Remember, ROIs are not needed between CCS staff/providers.
     - ROIs should be submitted to DCDHS.

3. **Complete Comprehensive Assessment** & **Assessment Summary** in module **within 30 calendar days of Functional Screen date.**
   Include multiple sources of information (CCS Participant, collateral, family, records, etc.)
   - Use CCS Participant's own words as much as possible. Do not leave any fields blank.
   - Print Copy of Assessment & Summary and obtain all signatures on Assessment Summary (CCS Participant/guardian, SF, MHP/SAP, others present)

4. **Complete 6-month Recovery Plan in CCS MODULE** within 30 calendar days of *Functional Screen* date.
   - Convene Recovery Team for Recovery Planning Meeting to discuss goals, objectives, and supports.
   - Have **Recovery Meeting Roster signed at each meeting.**
   - Strengths/needs/goals should always relate back to needs identified in the Assessment.
   - Goals should be quotes from CCS Participant.
   - ACTION STEPS must be specific and measurable instructions to each team member on what the team is asking them to do to assist CCS Participant in achieving goal for each identified domain.
   - Remember to include both natural supports and non-CCS services on Recovery Plan on team as appropriate.
   - Use CCS Participant's own words as much as possible.
   - Identify needed services, including frequency and duration. Always offer CCS Participants a choice in providers from: CCS Provider Directory (dcdhs.com)
   - After providers are chosen, call the provider to ensure availability for the service needed before adding to the plan.
   - Discuss the goals they will work on from RP as well as duration and frequency of service.
   - Complete Service Authorizations in CCS MODULE, including # of units. SUBMIT Service Authorizations to MHP/SAP
     - *Be sure to adequately account for travel & documentation time for providers when indicating units.*
     - *Service Authorization units should come from the conversations with the Service Provider and team MHP. They should be based on CCS Participant needs and best practice.*
   - Enter all Recovery Plan information into Module (Narratives, Strengths, Needs, Goals, Action steps)

5. Submit Recovery Plan 5+ business days early to MHP/SAP for review in order to allow time for necessary edits.

6. Once RP is approved in CCS Module:
   - Print paper copy for CCS Participant/guardian to sign.
   - Notify service providers that service provision can begin, that services are authorized.
   - Facilitate CCS Participant with setting up initial appointment if needed or desired by CCS Participant.

   ****SUBMIT HARD COPY OF RECOVERY PLAN SIGNATURE PAGE AND MEETING ROSTER TO DCDHS****
   PROVIDERS WILL NOT BE ABLE TO SIGN BILLABLE NOTES UNLESS THERE IS A FULLY APPROVED RECOVERY PLAN

7. Submit all documents to CCS@danecounty.gov
   - Assessment Summary
   - Recovery Plan
   - CSSRS
   - Recovery Team Meeting Roster
   - ROIs

CCS Service Facilitator Checklist

EVERY 6 MONTHS:

1. Update Comprehensive Assessment, Assessment Summary, CSSRS, Recovery Plan and Service Authorizations every 6 months (sooner if there are major changes). CCS Participant must sign off on paper copy of Assessment Summary and Recovery Plan. This HARD COPY must be sent to DCDHS with all signatures.
2. Remember to begin assessment/plan updates with enough time to meet, submit to MHP, make changes, obtain all signatures and submit to DCDHS before current plan expires. **You may begin working on new plan 60 calendar days in advance of the current plan expiring.**
3. Update General CCS Participant Information tab as needed
    - Demographics & Medical (in module: diagnosis, medications, hospitalizations)

ANNUALLY

1. Update ROIs for both CCS and non-CCS providers
2. Assist DCDHS Intake Social Worker in coordinating annual re-screen.
3. Obtain annual Physician's Prescription form prior to Rx expiration date.

AS NEEDED:

1. **Agency Transfers:**
    - Consult with MHP to determine appropriateness of transfer to new SF.
    - It is best practice to first try to resolve conflicts internally through discussions, SF re-assignments, etc.
    - When a CCS Participant or SF/MHP/SD has determined that an agency transfer is the best course of action, the SF agency should work with CCS Participant to identify desired SFA, confirm new SFA has availability to accept transfer, complete Transfer Summary Form and obtain all signatures.
    - Submit Transfer Summary Form to DCDHS.
    - The outgoing agency serves as SF until an official transfer has been completed. Ideally, a phone or in person staffing of the case transfer should occur between the outgoing and incoming SF agency.
    - DCDHS Intake will link the new agency in the module so that:
        - NEW AGENCY SD can assign primary & secondary SF End old authorizations for SF, SA, & SP services
        - Authorize NEW agency for SF, SA, and SP services.

2. **CCS Participant Discharges:**
    - Consult with MHP to determine appropriateness of discharge and establish discharge date.
    - Once approved, meet with CCS Participant to complete Discharge Summary and obtain signature. Discharge date should be the date discussed above.
    - SF and agency MHP should sign Discharge Summary as well.
    - **Submit completed and signed Discharge Summary** to DCDHS. (Submit completed discharge CSDS form to DCDHS also)
    - End Recovery Plan with date of discharge. This will end all services as well
    - Notify all CCS providers of discharge from CCS and ending of authorizations.

WAYS TO SUBMIT PAPERWORK TO DCDHS:

1. FAX: (608) 283-2994

2. EMAIL: Send encrypted email to CCS@danecounty.gov If your agency does not have encryption system, you can register for an account on Dane County's system: https:LLwebl.zixmail.netlsLlogin?b=countyofdane

3. MAIL: DCDHS Attn: CCS Program
1202 NorthportDr,3rd Floor
Madison, WI 53704

CCS Service Facilitator Checklist

	CCS FORMS CAN BE FOUND ON DCDHS CCS WEBSITE: CCS Forms | Dane County Human Services Provider Resources

	ONGOING SERVICE FACILITATOR RESPONSIBILITIES:
	Maintain regular contact with CCS Participant (minimum of monthly)
	Return calls and emails within 1-2 business days of receipt.
	Assist CCS Participant with meeting needs and with obtaining any necessary services (medical, dental, food, housing etc.). Educate self on community resources
	Ensure CCS Participants have choice in supports/ services. Contact providers with referrals. Ensure Recovery Plan has the essentials to allow for provider to bill for services: Goal + ACTION STEP + Authorization.
	Maintain contact with service providers to ensure services provided are meeting needs. This includes notifying providers when CCS Participant is in a crisis situation, notifying providers of status changes (out of state, hospitalized, incarcerated, transferring SF, discharging, etc.), scheduling, leading and following up with regular meetings and reviewing providers' progress notes. Document communication with providers in progress notes.
	Document all contacts in progress notes in CCS MODULE within 2 business days of contact. Progress note documentation must relate back to specific goals outlined in the Recovery Plan.
	Regularly review provider progress notes to ensure service delivery is meeting CCS Participant's needs as well as to monitor quality, timeliness, interventions used, frequency and duration. Address issues of concern with provider directly and/or supervisor when appropriate.
	Ensure **all members of the Recovery Team are invited to participate in regular recovery team meetings.**
	Ensure CCS Participant maintains MA eligibility. Report changes in MA status to DCDHS and CCS providers immediately. Authorized REP Form: F-10126B, APPOINT, CHANGE, OR REMOVE AN AUTHORIZED REPRESENTATIVE: ORGANIZATION If CCS Participant loses MA, assist them with reinstating coverage if appropriate.
	Ensure CCS Participant always has current Physician Prescription (expires after 365 calendar days from date of provider signature)
	Facilitate SF agency transfers when conflicts cannot be resolved or if CCS Participant expresses interest in new provider.
	Meet with agency MHP for regular supervision and consultation.
	Notify DCDHS of CCS Participant death within 24 hours.
	Submit copies of all information and documents pertaining to CCS Participant to central file CCS@danecounty.gov
	CHECK OUT and REFER to DCDHS FAQ WEBPAGE frequently for questions related to CCS