WESTERN REGION
Recovery and Wellness
CONSORTIUM

Comprehensive Community Services (CCS)
Program Procedures
Including CCS Plan

CCS Plan and Program Policies Approved: 9/24/19
Policy Approved: 10/15/18, 1/25/22
(Revision Dates)

Doing Business As:
The Recovery and Wellness Consortium (RWC)

Lead County Agency:
Chippewa County
Department of Human Services
711 N. Bridge Street
Chippewa Falls, WI 54729

Western Region Recovery & Wellness Consortium (WRRWC)
Doing Business as The Recovery & Wellness Consortium (RWC)
Comprehensive Community Services (CCS)
Program Procedures

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RWC and CCS Organizational Structure

Policy addresses: DHS 36.07

Comprehensive Community Services (CCS) Plan

Policy addresses: DHS 36.07 (1) & DHS 36.07 (1) (e)

Introductory Statement:

CCS uses a recovery model and is intended to provide a comprehensive continuum of care of mental health and substance abuse services for individuals and families not needing the intensity of a Community Support Program (CSP) approach to care management but needing more than outpatient services.

It is the goal of the RWC CCS program to further develop services to meet the recovery needs of consumers not adequately addressed under other areas of the system, enhance current services, or in some cases, avoid duplication of service delivery.

Consumer choice, in collaboration with an assessment process, shall direct service provision. CCS is a needs-based service with the service plan being individualized and person/family-centered.

Governance:

The Western Region Recovery and Wellness Consortium (WRRWC) has a governance under the authority granted by Wis. Stat. § 66.0301, *et seq.*, to develop a multi-county services model between counties. The governance outlines the role and responsibilities of the lead county agency.

The bylaws outline the processes under which the WRRWC shall be operated and managed.

Each county shall enter into an addendum that outlines the applicability of the governance to the specific services and responsibilities of each member county.

The details regarding consumer engagement within the consortium and the process are outlined within the governance documents.

The WRRWC is a consortium of counties working together to improve mental health and substance abuse delivery systems for public sector recipients. The WRRWC is engaged in multiple projects with varying county participants.

The CCS participating counties include: Buffalo, Burnett, Chippewa, Dunn, Pepin, Pierce, Polk, Rusk, and Washburn.

The Core Services counties include: Buffalo, Chippewa, and Pepin.

The consortium uses a “hub and spokes” model and Wis. Stat. § 66.0301 to guide its governance.

Chippewa County Department of Human Services is the "Lead County Agency." The lead county agency shall hold the certification and complete fiscal processes associated with the CCS Program and Core Services, as outlined by the governance.

The role and responsibilities of the Lead County Agency include:

- Hub and spokes model with the potential for change over time.
- Centralized fiscal management structure (e.g. billing of third party payers, contracts for services).
- Each county maintains an employee base. Human Resources shall not be combined.
- Staff answers to the consortium programmatically and to their county of hire administratively.
- Provider contracts shall be developed and maintained by the lead county agency, with approval of the Leadership Committee.
- Certifications for programming shall be held by the lead county agency.
- The lead county agency shall hold contract with the State of WI, Department of Health Services.
- The lead county agency shall subcontract with the participating counties.

Counties, other than Chippewa, shall function as branch offices of the lead county agency's primary office in Chippewa Falls, WI. Although Chippewa County holds the certification, each county has agreed that they shall comply with applicable administrative code.

The Mental Health and Substance Abuse Operations Administrator, employed by Chippewa County as the Lead County Agency, shall provide oversight to the regional CCS program and serve as the leader of the management team associated with CCS.

The Main and Branch offices shall each have personnel assigned to required roles.

- A person with their Master's degree and licensure, Clinical Coordinator, shall complete the following responsibilities: review of assessment, completion of Mental Status Exam and Determination of Need, leadership of recovery planning and team process, oversight of discharge planning, supervision of Service Facilitators and day-to-day consultation with CCS staff.
- The Clinical Coordinator shall complete weekly supervision. Supervision may be performed in a group or individual setting, in-person or via video conferencing.
- The Clinical Coordinator shall be available for consultation during work hours.
- The county-based On-Site Administrator will provide administrative oversight to the county-based staff.
- Service Facilitators shall be located within each of the branch locations.

Overarching Philosophy and Culture:

Developing and implementing the recovery culture shall be an integrated and ongoing process for the program. Training of core concepts shall be the first step in the process with ongoing direction from the CCS Coordinating Committee, supervision and clinical guidance being the ongoing tools for implementation. The five core trainings include: Recovery Concepts, Trauma Awareness, Person-Centered Planning, Integrated Mental

Health and Substance Abuse Services, and Motivational Interviewing. The Mental Health and Substance Abuse Operations Administrator shall work with the On-site Administrators and Clinical Coordinators to develop systems that support the philosophy and culture.

The CCS program shall be guided by the CCS Coordinating Committee. The CCS Coordinating Committee is comprised of 1/3 consumers, 1/3 providers/advocates, and 1/3 county personnel. The Coordinating Committee role and responsibilities shall be outlined in policy.

Staffing Structure & Supervision:

Qualifications, Roles and Responsibilities:

Mental Health and Substance Abuse Operations Administrator

- Qualifications: Master's level
- Responsibilities: serve as the Program Administrator for CCS, which includes: overall responsibility of CCS, including compliance with administrative code DHS 36 and other applicable state and federal regulations and developing and implementing policies and procedures.
- Reports to: Lead County Agency Director under advisement of the Leadership Committee

On-Site Administrator

- Qualifications: Main or Branch County Employed Supervisor
- Responsibilities: Program Administrator On-Site Designee, Direct Administrative Supervision of CCS Clinical Coordinator, CCS Substance Abuse Professionals, and CCS Service Facilitators
- Reports to: Respective County Director and CCS Mental Health and Substance Abuse Operations Administrator in regards to CCS program functions only

CCS Clinical Coordinator shall function as the CCS Mental Health Professional and CCS Service Director

- Qualifications: Master's level and Licensure
- Responsibilities: Assessment, Recovery Planning, Clinical Supervision, Day-to-Day Consultation and Guidance, Lead the Recovery Process, Discharge, Oversee Quality of Services to Consumer.
- Reports to: On-site Administrator

CCS Substance Abuse Professional (assigned when substance use issues are identified)

- Qualifications: Certified by the State of Wisconsin- Department of Safety and Professional Services
- Responsibilities: Assessment, Recovery Planning, and leading the recovery team process, Discharge
- Reports to: On-site Administrator

CCS Service Facilitator

- Qualifications: Any person meeting the qualifications and credentials under DHS 36.10(1) through (22).

- Responsibilities: Ensures the service plan and service delivery to consumer is integrated, coordinated and monitored, and is designed to support the consumer in a manner that helps the consumer to achieve the highest possible level of independent functioning.
- Reports to: On-site Administrator

Oversight:

- The CCS Mental Health and Substance Abuse Operations Administrator is responsible for the overall program.
- The CCS Mental Health and Substance Abuse Operations Administrator shall work as a team with On-site Administrator.
- The County-based On-Site Administrator is the CCS Program Administrator's on-site Designee.
- Clinical Coordinators shall provide clinical supervision and day-to-day consultation to Service Facilitators.
- When a branch location does not have the volume of consumer load to support an on-site Clinical Coordinator, then supervision and consultation shall be arranged.
- The CCS Mental Health and Substance Abuse Operations Administrator is responsible for the overall subcontracted provider services. Service Facilitators shall work with the providers whenever possible and notify the Mental Health and Substance Abuse Operations Administrator of concerns with service provision.

The CCS On-Site Administrator is assigned by each respective county. They supervise the assigned county staff. It is expected that the Mental Health and Substance Abuse Operations Administrator and On-Site Administrator shall be a team in the program management process. The On-Site Administrator role is important as the assigned On-Site Administrator has the authority over both the Clinical Coordinator and the Service Facilitator roles. Within this model, the lead county agency, or its employee, does not have the authority to hire, fire, or discipline staff of other counties. However, through the governance, counties have agreed to uphold the expectations of the applicable administrative code.

The Clinical Coordinator shall work collaboratively with the On-Site Administrator and Mental Health and Substance Abuse Operations Administrator. The clinical focus and content of the program is led by the Clinical Coordinator. This position provides targeted clinical supervision and daily guidance to the direct service staff in order to foster high quality services and the culture of recovery.

The Service Facilitator provides facilitation and direct services as outlined within the consumer's individualized service plan. It has been decided, county-by-county, how the workload would be distributed at the site.

In general, RWC counties are in agreement with the following ratios. Service Facilitation Ratio = 1 staff for 20 adult consumers and 1 staff for 15 youth consumers and their families.

The table below outlines how the roles would be filled for the CCS program.

County:	Clinical Coordinator and Substance Abuse Professional:	On-site Administrator:
Buffalo	Kayla Buck (MH and SA)	Carri Renchin
Burnett	Kayla Rinkel (MH and SA)	Byron Hopke
Chippewa	Michelle Phelps (MH & SA)	Kyra Secraw – Youth Tom Diel - Adults
Dunn	Jocelyn Lingel-Kufner (MH & SA) Jeff Imler (MH)	Sara Olinger Kasey Pogorelski
Pepin	Kayla Buck (MH and SA)	Carol Pulkrabeck
Pierce	Kelly Kivel (MH) Kayla Buck (SA)	Elizabeth Anez
Polk	Maddie Kortes (MH & SA)	Lisa Lavasseur
Rusk	Andy Wolf- Aurora (MH) Steven Schreiber (SA)	Chris Soltis
Washburn	Kayla Rinkel (MH and SA)	Kim Campion

When a Clinical Coordinator is able to be co-located with the Service Facilitators, such a model shall be the first choice.

Communication Plan:

Communication is a critical component to the success of a program. The communication shall be more structured. However, creating increased structure in our communication processes does not mean "less" or "completely formalized" communication. It means that we need to all be sharing a consistent vision, mission, philosophy, and message. Sharing a common big picture shall allow us to continue to honor the unique needs of our consumers and communities within each of our branch offices.

The goal is to have interactive and engaging meetings that result in solutions to our natural challenges.

- Ongoing e-mail communication – Weekly updates with necessary information from across the system. This communication may be used to clarify and/or define processes that need to occur within the program. Reminders and/or guidance on detail issues may be processed with this method of communication.
- Monthly In-Person administrative meetings including both remote access and in-person discussions as appropriate. If needed, we will meet more frequently. This is an opportunity to problem solve regarding management issues, subcontracted provider issues, program issues, explore better ways to provide service, and review our progress toward our outcomes.
- Weekly clinical supervision meetings at the main and branch offices. This is the time to share in discussion on consumer and program issues. We maintain a strength-based, recovery approach while problem solving ways to better engage and assist consumers. These meetings consistently carry the recovery philosophy and challenge us to hold to our common philosophy through our service.

- Provider meetings shall be held quarterly or more frequently in the program development stage. This shall ensure that subcontracted providers are working in collaboration with the county-based providers. Additionally, monthly provider trainings and check in opportunities are held to network and provide opportunities to connect with the Lead County as needed.

Subcontracted Service Provision:

Our goal is to provide services, as defined by the service array, throughout the region and according to the expectations of the RWC, CCS administrative code, and third party payers.

At this time, foster care and treatment foster care services will not be provided within the CCS program.

In order to achieve this goal, our providers may be contracted through the following processes:

- Option 1: Existing Provider agrees to outcomes, expectations and rates. Complete contracting (includes rate setting process and contracting) and credentialing process.

- Option 2: Consumer requests a provider that is not currently contracted. Provider agrees to outcomes, expectations, and rates. Complete contracting (includes rate setting process and contracting) and credentialing process.

- Option 3: In situations where the RWC does not have a service, the service area is not completely covered, or when we desire, we shall complete the RFP process to address needs. Complete RFP process, contracting (includes rate setting process and contracting), and credentialing process.

Our 9-county CCS program has developed guidelines for an Evaluation Committee (EC). The EC shall work on the development of any necessary Request for Proposal (RFP) to subcontract for services within the service array that are needed for the region.

We shall hold quarterly Provider Meetings for our 9-county region. During these meetings, we shall provide education on CCS as well as what it means to be a region and how we shall function as a region, including the role of the lead county agency. The RWC recognizes that the relationship we hold with our partners/subcontractors shall be different in this model and we wish to provide a clear and consistent message regarding how we shall work as one program.

Subcontracted providers shall be a fully integrated part of our CCS program. Providers shall be offered participation in the core training sponsored by state-level DHS and the counties. The goal of this process is to ensure that we have a consistent recovery-based model and all team members are working from the same set of principles.

Access Plan:

A consumer may access CCS services through any of the primary or branch offices.

Applications/Referrals shall be accepted from a variety of sources: consumers, providers, other county divisions, etc. We want the community to be aware of the program and, in turn, increase access to services. We will be educating the community on the application process and how it differs from the "referral" process. Although we will conduct outreach following request by providers or other county divisions, an application needs to be initiated and signed by the interested consumer, not a referent.

CCS shall be available to provide outreach support to consumers who are discharged from a non-CCS related program, facilities that serve youth and adults with Mental Health and/or Substance Abuse issues i.e. inpatient psychiatric and nursing homes, and the extended (both within and outside) community, day treatment providers, CBRFs or jails. Outreach support shall consist of educating interested parties and referents, about the CCS program and its concepts and how to engage with a potential consumer. Requests for outreach shall be coordinated by the Mental Health and Substance Abuse Operations Administrator and/or the On-site Administrator, who shall be responsible for receiving and assigning an appropriate staff member to conduct the outreach activities.

Our plan is for children and families CCS staff to receive ongoing supervision from an assigned CCS Clinical Coordinator. We believe that this approach shall foster a strong and ongoing understanding of the role of CCS in the children and families service delivery system. We understand the importance of a clear, comprehensive, and unified program across the lifespan.

We recognize that substance abuse needs historically have not been served in a comprehensive, community-based model. For this reason, we plan to provide outreach and education within the community. We shall utilize provider meetings, visits to providers in the community, providing of information to the Alcoholics Anonymous, Narcotics Anonymous, and other support systems (e.g. clergy, probation/parole, community organizations) that are accessed by persons in need of support around substance abuse issues. We want to assure that providers understand the role of CCS in the substance abuse service delivery system. As indicated above, we shall be providing outreach to area inpatient facilities. We have active participation on our CCS Coordinating Committee by one of the area inpatient facilities and our primary detoxification facility. Our goal is to assure access to a variety of substance use services and do so in a way that supports high-quality existing providers.

Services within the service array are expected to be provided throughout the region. The type of service shall define the need for actual office space or service provision in the community. The Service Facilitator shall work collaboratively with providers to assure that services are accessible according to the needs of the consumer. Transportation cannot be an obstacle for the consumer to receive the service.

Non-Emergency Medical Transportation, which is provided by an agency contracted through the State of Wisconsin, shall be used when appropriate and reimbursable to meet the transportation needs of consumers within the CCS program. As always, natural supports are the first choice to meet transportation needs.

The service array details provided by MA and the CCS Coordinating Committee shall provide guidance on services to be provided. Consumer choice shall be an integral part of the ongoing development of services within the array.

Comprehensive Community Services (CCS) shall be incorporated within the Mental Health and Substance Abuse Services Section of each participating county's Department of Human Services (DHS) or Department of Health & Human Services (DHHS). The program shall be closely coordinated with the other county-based MH/SA programming as well as the family and children's service units, incorporating existing staff between these sections.

CCS program staff shall determine initial eligibility for the CCS benefit and assist interested consumers with application to the program.

CCS shall build upon the consortium's commitment to recovery and principles of empowerment. The "Core Values" for the CCS program shall include the following:

- Collaboration
- Person/Family Centered
- Recovery Orientated
- Effective Leadership

CCS Plan Updates/Amendments/Revisions

Updates/Amendments/Revisions to the CCS plan shall be made when there are substantive changes to the CCS, when policies and procedures of the program are added or revised, and/or when recommended by the CCS Coordinating Committee.

Staff Functions

Policy addresses: DHS 36.07 (1) (a)

The CCS Mental Health and Substance Abuse Operations Administrator and/or a designee, shall verify that all individuals hired possess the required degrees, licenses, certifications, qualifications and training required for each particular position to ensure that all CCS staff are qualified (meeting education and training recommendations) for the positions in which they are providing services. The job classification review form shall document that a person meets the qualifications and training of their respective role.

It is expected that staff offer and provide services in a way that matches the philosophy and culture of the program.

Program Administrator function shall be fulfilled by the Mental Health and Substance Abuse Operations Administrator of the RWC and shall hold one of the qualifications listed in DHS 36.10 Staff Qualifications and Credentials policy under 1) a) (1) through (14). This position shall include overall responsibility for CCS including compliance with DHS 36, as well as developing and implementing policies and procedures.

Service Director function shall be fulfilled by the designated county staff that shall hold one of the qualifications listed in DHS 36.10 Staff Qualifications and Credentials policy under 1) a) (1) through (8). Within the RWC, this function shall be combined with the Mental Health Professional function and be referred to as the "Clinical Coordinator."

Mental Health Professional function shall be fulfilled by the county staff that shall hold one of the qualifications listed in DHS 36.10 Staff Qualifications and Credentials policy under 6) a) (l) through (8). Within the RWC, this function shall be combined with the Service Director function and be referred to as the "Clinical Coordinator."

Substance Abuse Professional function shall be fulfilled by a Substance Abuse Counselor. "Substance abuse counselor" or "counselor" means any of the following:

- DHS 75.02(84)(a) **(a)** A clinical substance abuse counselor as defined in s. SPS 160.02 (5).
- DHS 75.02(84)(b) **(b)** A substance abuse counselor as defined in s. SPS 160.02 (26).
- DHS 75.02(84)(c) **(c)** A substance abuse counselor-in-training as defined in s. SPS 160.02 (27).
- DHS 75.02(84)(d) **(d)** An individual who holds a clinical social worker, marriage and family therapist, or professional counselor license granted under ch. 457, stats.

Service Facilitation function shall be conducted by county or contracted staff that are assigned to CCS and shall hold one of the qualifications listed in DHS 36.10 Staff Qualifications and Credentials policy under 1) a) (1) through (22).

A Job Classification Review Form shall document an individual's credentials, degree, and experience. It shall note the staff functions to be completed by the employee.

Procedure:

1. Upon hire and whenever a change in job classification occurs, the on-site administrator and/or provider shall complete the Job Classification Review Form.

2. After completion, the Job Classification Review Form shall be submitted to the Mental Health and Substance Abuse Operations Administrator via RWC SharePoint site.
3. The Mental Health and Substance Abuse Operations Administrator shall retain the Job Classification Review Form on the RWC SharePoint site and the Lead County Agency Fiscal Department shall have access to the document.

Required Forms:
Job Classification Review Form

Contracting and Recruiting Providers

Contracts/Agreements with Agencies Providing Psychosocial Rehabilitative Services

Provider Contracting Process

Policy addresses: The process in which a potential new provider receives RWC CCS information, goes through the RWC contracting process and ongoing expectations of RWC providers.

Introductory Statement:
The RWC is committed to ensuring our contracted providers have the information, knowledge and understanding needed to complete the contracting process and have a strong understanding of CCS services in order to be an effective and successful service provider. It is essential that providers have a strong understanding of the recovery process and treatment modalities as well as an understanding of the contracting, billing and documentation side of CCS

Procedure:

Prior to Contract Finalization

1. Upon an agency's request for information on becoming a CCS provider Chippewa County, the RWC Lead County, will send them the following documents:
    a. Provider Packet
    b. Potential New Provider Questionnaire.
2. Prospective provider will complete Questionnaire and return to Chippewa County
3. The Lead County will make determination of initial approval to continue in the contracting process based on the following criteria:
        i. Proposed service appears to be CCS billable upon initial information provided (thorough review will be conducted in the next steps)
        ii. An existing RWC CCS consumer is requesting to work with the provider and the county of their residence has assessed a need for this service. The service being requested falls under a CCS billable service array.
        iii. One of the RWC counties has reached out to the Lead County indicating this is a needed service in their region and the service falls under a CCS billable service array.
        iv. The following may result in the RWC not pursuing a contract with a requesting provider:
            1. Potential oversaturation of that service in the county(s) the agency wished to serve.
                a. This will be determined by the Clinical Coordinator team based on their review of the RWC Mapping System within SharePoint.

2. The service being offered by the prospective agency does not align with one of the specified Medicaid billable service arrays for CCS.
3. The agency is not able to meet all contracting requirements outlined within the Provider Packet (including but not limited to insurance, audit and DHS 36 certification requirements)

4. If the above stated initial requirements are met the potential new provider will meet with the Operations Administrator, or designee, to have a thorough discussion regarding CCS service delivery, certification requirements and general discussion regarding the services the agency would like to provide.
5. If after this discussion both the Operations Administrator, or designee, and the potential provider believe they would be a good fit for the RWC CCS Program the Operations Administrator will then connect the potential provider with the RWC Fiscal Team to begin the rate setting and contracting process.
6. Provider will be notified when all contracting requirements have been met and they can begin providing CCS services. At this time all RWC counties will be notified of the new provider and be given a brief description of services they provide.

After Contract Finalization

7. Chippewa will notify all RWC counties of the new provider availability
8. Provider shall ensure all future staff are trained per CCS requirements (see CCS Subcontractor Orientation Checklist)
9. Provider shall ensure they notify the RWC of any staff leaving their agency or leaving their role as a CCS provider in order for Chippewa County to discontinue access to SharePoint

Forms that will be provided to the prospective new provider:
Provider Packet
Contracting Procedure
CCS Subcontractor Personnel File Checklist
Provider To Do Checklist

Forms needed to be completed by the prospective new provider:
Questionnaire

Contracts When Needed Services Are Not Available In Existing Service Array

Policy addresses: DHS 36.07 (1) (d), DHS 36.07 (3) (e), DHS 36.07 (3) (f)

Introductory Statement:

A primary goal of the CCS program is to provide evidence-based, best practice, and promising practice services that meet the needs of consumers. The CCS program subcontractors shall acknowledge expectations by signing a purchase of service contract.

When an evidence-based practice does not coincide with the target population, service, or individual consumer, the CCS shall work with the consumer and/or provider to establish services with relevant outcomes.

Providers shall be expected to provide services in concert with the guiding principles outlined in this manual.

Procedure:

1. The RWC CCS program, under advisement of the CCS Coordinating Committee, shall develop a service array and seek out appropriate providers to meet the service needs of consumers and/or families in the program.
2. When a needed service is not available, the CCS shall establish contracts to meet the need.
3. When a service needs to be expanded throughout the region, but requires recruitment, training, and service planning, the coordinating committee shall be informed of the plan and process to complete the expansion.
4. The service array shall be updated and expanded dependent upon the needs of the consumers.
5. The CCS Coordinating Committee shall review the initial and ongoing service array and make any recommendations.
6. The provider network shall include both supports and services that are available via the CCS benefit as well as the person's own resources such as their MA card.
7. Consumers shall be provided information about the identity, location(s), qualifications, and availability of these supports and services.
8. Formal contracting with providers shall occur when the agreed upon process requires it and there is a monetary exchange for services.
9. Informal Interagency Agreements with providers shall occur when there is not a need for a formal contract, yet there is a need to outline CCS values, principles, mission and responsibilities of providers/partners as part of the organizational support of the CCS program.
10. Providers shall agree to the following:
    a. Incorporation of CCS service plan goals, participating as necessary on teams, protecting consumer rights, and incorporating the "CCS Guiding Principles."
    b. Incorporation of court requirements and other legal mandates into CCS service plans, when applicable and desired by the consumer.
    c. Provision of services that meet the guidelines for Psychosocial Rehabilitation Services (PRS).
    d. Identify outcomes related to Quality Improvement indicators.
11. Providers of services are required to participate in programming activities which shall include, but are not limited to:
    a. Participation on recovery teams as requested
    b. Compliance with the supervision and training requirements outlined in Orientation and Training policy/procedure
    c. Compliance with RWC policies and procedures regarding discrimination, staff credentialing, background checks, misconduct reports and investigations, staff employment records, assessment and service planning and delivery

d. Consumer records and rights
e. Timely exchange of information
f. Provision of services that respect cultural heritage and primary language
g. Service documentation requirements
h. Service invoicing requirements
i. Participation in required programming activities for providers determined to be supports or secondary providers.

12. Support providers shall participate in required programming activities determined to be supports for the consumer.
13. Upon the addition of any service to the array, the Mental Health and Substance Abuse Operations Administrator and/or a designee, shall inform the Wisconsin Department of Health Services of the change.
14. The Consumer shall be made aware of the grievance process if any services are denied or not available.

Required Forms:
N/A

Conflict of Interest

Introductory Statement:
The Recovery & Wellness Consortium and their providers shall work to avoid a conflict of interest.

Conflict of Interest: A conflict of interest (COI) occurs when an individual or organization is involved in multiple interests, one of which could *possibly* influence the motivation.

The presence of a conflict of interest is independent of the occurrence of impropriety. Therefore, a conflict of interest may be discovered and voluntarily defused before any corruption occurs. A widely used definition is: "A conflict of interest is a set of circumstances that creates a risk that professional judgment or actions regarding a primary interest shall be unduly influenced by a secondary interest."

- *Primary interest* refers to the principal goals of the profession or activity, such as the protection of consumers, the health of patients, the integrity of research, and the duties of public office.
- *Secondary interest* includes not only financial gain but also such motives as the desire for professional advancement and the wish to do favors for family and friends, but conflict of interest rules usually focus on financial relationships because they are relatively more objective and quantifiable.

The secondary interests are not treated as wrong in themselves, but become objectionable when they are believed to have greater weight than the primary interests.

The *conflict* in a conflict of interest exists whether or not a particular individual is actually influenced by the secondary interest. It exists if the circumstances are reasonably believed (on the basis of past experience and objective evidence) to create a risk that decisions may be unduly influenced by secondary interests.

Procedures:

1. Upon hire, all persons providing services (both direct and indirect) within the RWC are required to certify that they have reviewed this policy and that they disclose personal, financial, and other interests that could raise potential conflicts of interest.
2. If it is shown that a person providing services (both direct and indirect) within the RWC has a potential conflict of interest, he or she shall obtain administrative approval to continue employment despite conflicts, or, he or she may be required to eliminate the conflict.
3. Additional disclosure shall be made whenever a person providing services (both direct and indirect) within the RWC has a new personal, financial or other interest that raises a potential conflict of interest. This information is reviewed by the respective administrator to determine whether or not those interests pose a real or potential conflict.
4. Documentation of the review shall be maintained in an individual's personnel file.
5. Any person providing services (both direct and indirect) within the RWC who fails to comply with this policy are subject to disciplinary action, which may include termination.

Required Forms:

- None

Contracted Provider Background Check and Consumer Safety

Policy addresses DHS 12

Introductory Statement:
The CCS program shall ensure consumer safety is priority.

Procedure:

1. Provider shall comply with the provisions of DHS 12, Wis. Admin Code.
2. Provider shall conduct background checks at its own expense of all employees assigned to do work, with direct client contact, for the RWC under this contract.
3. Provider shall conduct background checks at its own expense of anyone above the age of eleven residing on the property where CCS services are being provided, excluding individuals receiving services.
4. Provider shall conduct background checks with other states where the employee has lived, any time an employee required to have a background check, has lived out of state within the last 3 years.
5. Provider shall retain in the RWC consortia's SharePoint site all pertinent information, to include a Background Information Disclosure Form, search results from the Department of Justice, the Department of Health Services, and the

Department of Regulation and Licensing as well as out of State records, tribal court proceedings and military records.

6. Provider shall not assign any individual to conduct work under this contract who does not meet with requirement of this law.
7. Provider shall train its staff to immediately report all allegations of misconduct to their immediate supervisor, including abuse and neglect of a client or misappropriation of client's property. Staff shall also report to their immediate supervisor, as soon as possible, but no later than the next working day, when they have been convicted of any crime or have been, or are being investigated by any government agency for any act or offense (DHS 12.07(1)).
8. The Provider shall notify the RWC Lead County (Chippewa), as soon as possible, but no later than the next business day, when any of the following occurs with regard to its personnel pursuant to DHS 12.07(2):
    a. The person has been convicted of any crime
    b. The person has been or is being investigated by any governmental agency for any other act, offense or omission, including an investigation related to the abuse or neglect, or threat of abuse or neglect, to a child or other client, or an investigation related to misappropriation of a client's property.
    c. The person has a governmental finding substantiated against them of abuse or neglect of a client or of misappropriation of a client's property.
    d. In the case of a position for which the person must be credentialed by the department of regulation and licensing, the person has been denied a license, or the person's license has been restricted or otherwise limited.
    e. A Registered Sex Offender is employed or residing on the physical premises where the service is being provided.
9. Upon notification from Provider, the RWC will follow its internal procedures.
10. Provider shall complete the Background Verification Form and save it within the consortia's SharePoint site.
11. The RWC will conduct routine and random audits of all provider files to ensure compliance.
12. After the initial background check at the time of employment, licensure or contracting, the Provider must conduct a new Caregiver Background Check every four (4) years, or at any time within that period if the Provider has reason to believe a new check should be obtained.
13. RWC contracted providers shall not have any employees, volunteers or individuals not receiving services residing on the property where CCS services are being provided that are Registered Sex Offenders that have any potential contact with RWC consumers, even if only incidental.

Required Forms:

Background check verification form

3/23/2021

Complete for each staff member, with direct client contact, including clinical student and volunteers. The caregiver backgrounds are documented through Background Information Disclosure (BID) forms, Department of Justice, and DHS/DCF response letters and require updating every four (4) years.	Caregiver Misconduct Background Checks (enter Month/Day/Year)						
Name	Position Description	Credential License Number (if applicable)	BID (date)	WI DOJ (date)	WI DHS/DCF IBIS (date)	OTHER STATES (date)	Within Last Four Years (Yes or No)

System of Services and Service Interface

Policy addresses: DHS 36.07 (3)

Introductory Statement: The RWC CCS program shall interface and enhance the existing programs within each county.

The Consumer's needs shall be the first priority whenever care coordination is facilitated between county departments or divisions within county departments. The goal of the CCS program is to offer a fully-integrated system of care where the consumer is at the center.

Procedure:
Each county shall provide and/or coordinate the following services to consumers.

Current Services:

Intake: Phone and walk-in coverage for persons in need seeking information and/or help. Intake staff provides an assessment of need and refers Consumers to appropriate department service teams or community agencies.

Crisis: A 24-hour crisis response as well as information and referral services.

Adult Protective Services: Staff provides investigation and case management services for vulnerable persons with disabilities or infirmities of aging.

Alcohol and/or Drug Abuse Programs: AODA services range from community-based to out-of-home options, based on need. Services may be provided "in-house" or under contract.

Mental Health Programs: Each county provides community mental health treatment services.

Aging and Disability Resource Center (ADRC): The ADRC provides services to the elderly and disabled population.

Children's Services: The family is viewed as the expert in the development of the plan of care. Families and youth are offered a continuum of supports and services in order for the youth to remain in their home or community or within the least restrictive environment that is clinically and educationally appropriate. Services may include: Child Protection, Juvenile Justice, or children with disabilities.

Inpatient Services: RWC counties contract with providers for mental health and detoxification inpatient admissions. We also offer respite/emergency stays at a licensed CBRF.

Vocational Services: Vocational services include extended employment, supported work, sheltered employment and enclave opportunities.

Alternate Care Team/Residential Services: The department contracts for a number of CBRF, Adult Family Home, Group Home for youth, and Respite resources on behalf of consumers with mental illness, co-occurring disorders, infirmities of aging, and related needs. Services are intended to promote recovery and return to less restrictive settings at the earliest opportunity possible.

Recovery Court Services: When the county provides Recovery Court services and a consumer chooses to engage with CCS, the two entities (CCS and Recovery Court) will be integrated with the Recovery Court worker to meet the needs of the consumer in a comprehensive and consumer-driven way. Examples may include, but are not limited to the following:

- Treatment court and recovery team meeting collaboration.
- One service facilitator providing assistance with the facilitation and planning of services.
- Engagement with the legal system to assist the consumer.

Required Forms:
N/A

Outreach, Referral, Care Coordination

Policy addresses: DHS 36.07 (3) (a)

Introductory Statement:
Comprehensive Community Services shall be available to provide outreach support to consumers who are discharged from a non-CCS related program, facilities that serve youth and adults with Mental Health and/or Substance Abuse issues i.e. inpatient psychiatric and nursing homes, and the extended (both within and outside) community i.e. day treatment providers, CBRFs or jails. Outreach support shall consist of educating interested parties and referents, about the CCS concept/program and how a consumer may apply for services. Requests for outreach shall be coordinated by the Mental Health and Substance Abuse Operations Administrator and/or the On-site Administrator, who shall be responsible for receiving and assigning an appropriate staff member to conduct the outreach activities.

Whenever possible, a consumer shall have one primary assigned Service Facilitator to coordinate care. A secondary Service Facilitator may be part of the Consumer's Recovery Team to provide non-direct service facilitation activities.

Procedure:
1. CCS staff will provide community or consumer outreach as requested or as planned as part of the program process. The On-Site Administrator assigns outreach within each community.
2. An application/referral or interest for services is made to any participating county by the interested person.
3. A service facilitator is assigned by the On-Site Administrator to complete the application screening process with the consumer.
4. RWC staff shall screen individuals interested in CCS by completing a Wisconsin Department of Health Services (DHS) Mental Health/AODA Functional Screen.
5. The staff shall also provide information about a variety of possible programs or services that may be beneficial to the person including, but not limited to: other DHHS programs/services, ADRC services, and broader community services i.e. housing support, Social Security/SSI, support groups, etc.
6. If the individual is found eligible for CCS services by the functional screen, the service facilitator will complete the necessary documentation including but not limited to: informed consents, releases, agreements, physician prescription and non-clinical sections of the comprehensive assessment.
7. The Service Facilitator shall arrange for any necessary immediate service referrals needed to complete the assessment (examples: substance abuse, nursing).
8. The Clinical Coordinator shall complete the Mental Status Exam (MSE) which includes a diagnosis as well as the Determination of Need and authorize services.
9. Upon completion of the clinical assessment, if the person continues to be appropriate for CCS services and a physician prescription was obtained, then the person begins CCS services and the development of a Recovery Team.
10. The On-Site Administrator, shall assign a CCS staff member to function as the liaison with non-community-based settings, such as inpatient facilities or jail settings, when requested and

appropriate, to coordinate discharge planning of an individual that is seeking admission to CCS. The purpose of this outreach activity is three-fold:

a. to determine eligibility for the program, and
b. to facilitate a seamless transition from an inpatient setting to community services, if found eligible,
    i. Service Facilitators and Providers shall bill Medicaid under the Service Array: Service Planning, as part of the discharge planning process when the consumer has an active Medicaid status and the service is not duplicative of services provided within the inpatient facility. See Discharge Planning in a Non-Community Based setting section below.
c. and to provide alternative treatment options and community resources as appropriate to meet their needs, if found ineligible.

11. Outreach to families and children shall occur through both the mental health and substance abuse services unit and the children & family service units within each county and with community partners.
12. Staff of each child & family services unit shall be educated on the CCS program, review requests for services and make referrals to the CCS as appropriate.
13. These referrals shall be made directly to the On-Site Administrator, and follow protocol as outlined above. If a staff member within the Family & Children's unit receives a request specifically for CCS services, they shall refer the request directly to the On-Site Administrator who shall follow protocol outlined above.
14. When necessary, crisis services may be utilized for children, families, and adults who are in immediate need of mental health or substance use attention.

***The intake process, including all required steps, is fully outlined under "intake and outreach process."**

Guidance Around CCS Billing for Discharge Planning when Consumer is in a Non-Community Based Setting.

Context: Forwardhealth prevents the billing of CCS services in specific settings, with a few exceptions. This document details these exceptions and outlines requirements when it is allowable. This document also includes guidance around other non-community-based settings that are not listed in ForwardHealth as non-covered settings, but have unique circumstances in regards to billing, such as Jail and juveniles in Detention Centers.

Applicable Forward Health and Statuary Guidance:

Topic #17157 **Non-Covered Services and** DHS 107.13(7)(c)2	The following services are not covered under the CCS benefit • Services provided to a resident of an intermediate care facility, skilled nursing facility or an institution for mental diseases, or to a hospital patient **unless** the services are performed to prepare the member for discharge from the facility to reside in the community

To bill for discharge planning services, the following requirements for all treatment settings listed in the table below must be met:

1. Consumer must have active **Medicaid status**
    - Service facilitator should work with county based fiscal or economic staff to verify consumer's Medicaid status
    - Local RWC county is financially responsible for services provided by a contracted provider during a period when the consumer does not have active Medicaid Status
2. **Documentation** must reflect the need for the service
3. Service must be billed under **service array: Service Planning**
    - This is for both service facilitators and contracted providers providing any type of service to prepare the consumer for a successful return to the community.

Medicaid Eligibility Status Guidance

Treatment Setting		
Institute for Mental Disease (IMD) Traditional IMD settings: such as Winnebago Mental Health Institute, Trempealeau County Health Care Center (TCHCC), Mendota Mental Health Institute.	**Age Guidance:**	An individual between the ages of 21 and 64 who resides in an IMD is not eligible for Medicaid unless the individual resided in the IMD immediately prior to turning age 21. This means it is unlikely billing is allowable for this age group.
		Under the age of 21- If a consumer has institutional MA, Medicaid status is considered active.* Billing would likely be allowable in this situation. *Child would need to have met the institutional level of care need to qualify for institutional MA *Reference: Medicaid Eligibility Handbook 27.1.2.1 Eligibility Age*
	Discharge Timeframe Guidance:	None specified in DHS 36 or ForwardHealth.
Institute for Mental Disease (IMD) ***Substance Use Disorder Treatment Benefit*** **IMD** settings: *Such as Arbor Place, Fahrman Center*	**Age Guidance:**	The Residential SUD Treatment benefit does allow for individuals who reside in an IMD to be eligible for Medicaid if they are receiving Residential SUD Treatment. *Reference: Per the Medicaid Eligibility Handbook 27.1.2.1 IMD residents aged under 21 and over 64 are not eligible (for Medicaid)* ***unless they are receiving RSUD treatment in the IMD****, or were age 21 when admitted and have since turned 22.*
	Specific CCS Guidance & Discharge Timeframe:	**CCS services must be suspended during the member's residential SUD treatment**; however, **service planning and service facilitation may be provided within 30 days before discharge from the residential SUD facility** to support discharge planning. *Reference: ForwardHealth Update 2020-42 Benefit for Substance Use Disorder Treatment*

Intermediate Care Facility, Skilled nursing facility, Hospital	**Age Guidance and Discharge Timeframe Guidance**	None specified in DHS 36 or ForwardHealth.
Jail and Juvenile Detention Centers (JDC)		In most cases, Medicaid eligibility is suspended for enrolled consumers in a jail setting or juvenile detention setting, however, there may be two periods of time a consumer does have an active eligibility status. Typically, this is shortly after incarceration and could be shortly before discharge. *References:* *ForwardHealth Topic #278 Persons Detained by Legal Process* Most individuals detained by legal process who are eligible for BadgerCare Plus or Wisconsin Medicaid benefits will have their eligibility suspended during their detention period. Note: "Detained by legal process" means a person who is incarcerated because of law violation or alleged law violation, which includes misdemeanors, felonies, delinquent acts, and day-release prisoners. Inmates who are released from jail under the Huber Program to return home to care for their minor children may be eligible for full benefit BadgerCare Plus or Wisconsin Medicaid without suspension. ***Suspension Start Date:*** *Per the Medicaid Eligibility Handbook 13.3.3 Existing Members* *Existing health care members who become incarcerated and are determined eligible for the health care suspension will be certified for the suspension from the first of the month after the incarceration is reported.* ***Example:*** *Olivia is open for full-benefit SSI-related Medicaid. On December 23, 2020, Olivia reports she is incarcerated as of December 20, 2020. Olivia's SSI-related Medicaid is suspended starting January 1, 2021.*

		Suspension End Date: *Per the Medicaid Eligibility Handbook 13.4 Suspension End Date When a member in a suspension is released from prison or jail and this information becomes known to the income maintenance agency, full-benefit Medicaid eligibility can be reinstated without a new application for benefits. Upon release, the suspended member's eligibility must be redetermined. If eligible, the member's Medicaid coverage will start the first of the month in which the member is released.* ***Example:*** *Cameron is incarcerated and enrolled in suspended Medicaid. Cameron is released on December 15, 2020. Cameron opens for full-benefit Medicaid starting December 1, 2020.*

Documentation Must Reflect Need for Services

Adequate documentation would need to clearly demonstrate the services provided while the Consumer was in the placement setting, the reason why, and reference the language that provides the authority to do so.

Place of Documentation	**Must Address the following**
Core Assessment	What is the specific service need?
	How will the specific services prepare the member for discharge from the facility to reside in the community?
	How will this service not be a duplication of services? *(Indicate the unique situation this service is being provided through the CCS vs. through the facility the consumer is residing in.)*
	If service is being provided to a person other than the enrolled consumer, the consumer-based need for this must be clearly identified. *(Example: Parenting skills provided to parents to prepare them to appropriately respond to child's behaviors or needs when returned to the home setting.)* *DHS 36.03(7) "Consumer" means an individual who has been determined to need psychosocial rehabilitation services. Note: Family member of the consumer or the consumer's primary caregivers also are considered consumers, and therefore, may receive services related to the consumer's disorder.*
	Objective should be clearly written with a focus on discharge. Must identify if the service is being provided to the consumer or family member.

Individualized Service Plan (ISP)	**Intervention** should be clearly written to reflect what the provider is working on specific to preparing the consumer or family member for a successful return to the community. Should reference the guidance in Topic #17157 **Non-Covered Services and** DHS 107.13(7)(c)2 **Covered Services** **Sample statement added to intervention**: "This service is being provided under the authority in FowardHealth topic #17157 and DHS 107.13(7)(C)2 to prepare the member for a successful return to the community."
	Service array item should be Service Planning
Service Notes (Applies to both Service Facilitator notes and Provider notes)	Must have a clear focus in each note describing the service provided and include how it is preparing the consumer for a successful return to the community. If the service is being provided to a person other than the enrolled consumer, the note must reflect how the service provided to the recipient is preparing for the successful return of the consumer to the community.

Care Coordination for Protectively Placed-Chapter 55

Policy addresses: DHS 36.07 (3) (b)

Introductory Statement:
The adult protective services system shall work side-by-side as a fully integrated services system for the consumer.

Whenever possible, a consumer shall have one assigned Service Facilitator to coordinate care.

Procedure:
1. The CCS and Adult Protective Services staff shall work in collaboration whenever a CCS consumer is the subject of emergency protective placement, protective services or elder abuse investigation.
2. The consumer's protective service needs, any court requirements and legal mandates shall be incorporated into the CCS service plan.

Required Forms:
N/A

Other Care Coordination

Policy addresses: DHS 36.07 (3) (c)

Introductory Statement:
Care coordination is essential to the effectiveness of CCS and other mental health or substance abuse services delivered by the county.

Whenever possible, a consumer shall have one assigned Service Facilitator to coordinate care.

Procedure:

1. When CCS services are provided in conjunction with other care coordination services, the CCS staff shall work collaboratively with those service systems.
2. When the care coordination is provided within any of our existing county divisions, i.e. Adult Protective Services, Child Protective Services, Public Health, CCS staff shall partner with existing teams or services to arrange a fully integrated service system.
3. The CCS Service Facilitator shall coordinate the services for the CCS consumer.
4. For care coordination outside of DHHS, such as school systems, the CCS administrative staff may pursue the development of Partner Agreements to ensure coordination of services and systems. This process shall maximize services through the provision of well-defined roles and responsibilities.
5. The goal is to have CCS Service Facilitator be the primary person coordinating care.

Required Forms:
N/A

Care Coordination for Committed Individuals-Chapter 51

Policy addresses: DHS 36.07 (3) (d)

Introductory Statement:
The CCS program shall engage people in their recovery and service plan.

Whenever possible, a consumer shall have one assigned Service Facilitator to coordinate care.

Procedure:
1. When an individual is placed under Chapter 51 civil commitment, CCS may provide outreach and screening to determine if s/he is eligible for and desires to receive CCS.
2. When CCS is providing services to a consumer, the treatment requirements of the commitment shall be incorporated into the CCS Service Plan.
3. CCS Service Facilitator shall provide an assessment and work collaboratively with the recipient to develop a service plan. All activities shall be in collaboration with the consumer to ensure services are recovery based, conducted in the least restrictive environment, while addressing safety concerns.
4. The CCS Service Facilitator shall advocate for the needs of the consumer with the court system.
5. If and/or when the consumer is unable to lead their care as a result of their mental health and/or substance use needs, the appropriateness of CCS shall be re-considered.

Required Forms:
N/A

Crisis Care Coordination

Policy addresses: DHS 36.07 (3) (g)

Introductory Statement:
The CCS program recognizes that crisis may be a part of a person's recovery.

Procedure:
1. When appropriate, CCS consumers shall be offered the full array of crisis services that are currently provided to county residents.
2. The CCS may be proactive by developing crisis plans (when necessary) as part of the consumer's service planning. The crisis plan shall be strength-based and focus on developing alternative coping skills to manage a crisis situation. All services shall be conducted in the least restrictive environment and promote recovery.
3. Crisis plans shall be developed in collaboration with the consumer and their recovery team. Crisis plans shall be distributed to consumer approved stakeholders to ensure continuity of care.
4. When CCS Service Facilitators are unavailable, the crisis responders shall be contacted and have full access to the consumer's crisis plan in order to resolve the crisis.

5. When it is determined that services from another DHS division are needed, such as Child Protective Services, Adult Protective Services, or Juvenile Justice for the CCS Consumer, protocol shall follow any established service system response planning within that respective division.
6. The consumer's service facilitator shall be informed of all crisis contact so that linkage and follow-up via the CCS program shall be assured.

Required Forms:
N/A

Care Coordination for Recovery Court Participants

Policy addresses: DHS 36.07 (3) (d)

Introductory Statement:
The CCS program shall engage people in their recovery and service plan.

Whenever possible, a consumer shall have one assigned Service Facilitator to coordinate care.

Procedure:

1. When an individual receives Recovery Court services, the CCS may provide outreach and screening to determine if s/he is eligible for and desires to receive CCS.
2. When CCS is providing services to a consumer, the treatment requirements of the Recovery Court shall be incorporated into the CCS Service Plan.
3. CCS Service Facilitator shall provide an assessment and work collaboratively with the recipient to develop a service plan. All activities shall be in collaboration with the consumer to ensure services are recovery based, conducted in the least restrictive environment, while addressing safety concerns.
4. The CCS Service Facilitator shall advocate for the needs of the consumer with the court system.
5. If and/or when the consumer is unable to lead their care as a result of their mental health and/or substance use needs, the appropriateness of CCS shall be re-considered.

Required Forms:
N/A

Duty to Warn

Introductory Statement:

This Recovery & Wellness Consortium policy addresses the legal, moral, and ethical responsibility that RWC staff has in regards to warning an intended victim of specific threats of harm made by another individual. Duty to Warn gives all RWC staff the right and responsibility to breach confidentiality of a consumer if there is a risk posed to another person or themselves.

Procedures:

1. When RWC staff believes they have knowledge of a situation that involves a safety threat made by a consumer to himself or herself, or others; staff needs to assess the situation to see if it poses a threat to the level where confidentiality shall be breached in order to assure safety.

2. If the consumer who is making the threat is available to discuss the situation because the consumer is in the staff's presence or on the telephone; staff shall continue to assess the dangerousness of the situation with the consumer.
3. If it is determined it is likely that the consumer may harm himself, herself, or others; it is the role of RWC staff to try to ensure safety of all individuals involved. This may include, but is not limited to notifying law enforcement, notifying the individual being threatened, and/or the guardian of the individual being threatened, etc.
4. If time permits, staff shall seek guidance from a manager prior to warning a specific person of the threat to them, or contacting law enforcement. The Program Manager or staff may seek input from the respective Corporation Counsel. When the situation is determined to be a credible threat to safety, law enforcement shall be called immediately to intervene. In those situations, staff shall notify their on-site administrator or designee after the fact about the situation and what was done to ensure safety of all individuals.
5. Staff shall document the threat and all actions taken in 'Duty to Warn' situations in the consumer's case record. Staff shall present the documentation to the Program Manager. In situations where the action involves an individual who is not currently open for services, the situation shall be handled as an Emergency Mental Health incident or situation for documentation.
6. A program manager or staff member shall notify the On-Site Administrator by email, in writing, or verbally of all incidents that occur under this policy.

Required Forms:

- None

References:

- See Schuster v. Altenberg, 424 N.W.2d 159, (1988) for discussion of the duty to warn in Wisconsin.

Psychosocial Rehabilitation Service Array and Service Providers

Policy addresses: DHS 36.07 (4)

Introductory Statement:
The CCS program shall, whenever possible, implement evidence-based and best practices within the service array. In addition, consumers shall be informed of the practices that shall support their recovery.

When an evidence-based or best practice does not align with the target population, service, or consumer need, the CCS Service Facilitator shall work with the consumer and/or provider to create outcomes relevant to the service being delivered.

Consumer needs and choice shall be at the center of the service development process.

Procedure:
1. The CCS Coordinating Committee has approved the service. When developing the service array, attention shall be given to following:
    a. Incorporating of evidence-based or best practices.
    b. Addressing the needs of eligible consumers.
    c. Acknowledging similar and different service needs based upon lifespan and target population. Note: Some services may be labeled in the same way, yet their delivery shall be modified based upon the needs and development of the consumer and in alignment with the MA approved service array.
2. The RWC conducted consumer discussions and the themes from those discussions, as well as ongoing consumer input shall assist in the development of the services.
3. Consumer choice shall be respected and integrated throughout the CCS process so as to support the recovery model and determine most appropriate services for the consumer. During service plan development and throughout the consumer engagement process, consumers shall be made aware of available services and the evidence-based and best practices available to support their recovery.
4. The service array, whenever possible shall utilize evidence based or best practices. Services include: screening and assessment, service planning, service facilitation, Diagnostic evaluations, medication management, physical health monitoring, peer support, individual skill development and enhancement, employment-related skill training, individual or family psychoeducation, wellness management and recover/recovery support services, psychotherapy, substance abuse treatment, and psychosocial rehabilitative residential supports,
5. Service providers shall be selected in one of the following ways: consumer request, contract with the CCS lead agency, or through a Request for Proposal or Request for Information process identifying existing and anticipated service needs of current and potential consumers of all ages based upon the assessment domains and treatment needs.
6. In response to the identified consumer's needs, RWC CCS shall be offering services from each category in the service array with at least one provider identified. The ultimate goal is having a minimum of two providers for each item in the CCS service array.

7. Upon agreement by CCS RWC counties, the lead county agency shall engage providers in a Request For Proposal (RFP).
8. When conducting an RFP or RFI, the contracting process shall include requesting, receiving, and reviewing proposals in a systematic fashion by the RWC Evaluation Committee. There shall be special attention paid to the provision of service across the counties, recovery-model, evidence-based practices, and service provision experience. Providers wishing to participate with the CCS shall show that their qualifications meet the program's requirements.
9. CCS Coordinating Committee consumers shall participate in the development and review of outcomes associated with the CCS program.

Required Forms:
N/A

Cultural Competence

Policy addresses: DHS 36.07 (5) (e)

Introductory Statement:
The CCS program shall foster a culture of respect and acceptance.

Procedure:

1. CCS Services shall be provided in a culturally competent manner that considers a consumer's cultural heritage as well as their current cultural preferences, preferred pronouns, and primary language, as factors when developing the consumer's service plan.
2. The RWC recognizes the reality of marginalized populations. Every effort will be made to ensure individuals in such populations receive service delivery that promotes access and equity.CCS services shall be accessible in a language and format in which the consumer is fluent.
3. The diversity of the consortium's CCS service population shall be reflected in the variety of service providers employed and/or contracted by the consortium, and in its referral and outreach efforts.

Required Forms:
N/A

Consumers with Special Needs

Introductory Statement:
In conformance with Title IX of The Civil Rights Act and Section 504 of the Rehabilitation Act, the RWC shall assess for the possibility of consumers receiving the following specialized services: sign language interpreters for the hearing impaired, translators for non-English speaking persons, assistance and adaptive aids for the visually impaired, and physically handicapped individuals receiving wheelchair accessibility and ramp/or elevator accessibility.

Procedures:

1. If a consumer needs any of the above-stated aids in order to benefit from services; please contact your supervisor or designee and arrange for the disability services needed.
2. The RWC shall make all forms, consent forms, releases, and programming, as well as the notification of rights, oral and written, available in a language understood by the consumer, including sign language, foreign language, and simplified language when necessary. (DHS 94.04 (5))

3. RWC staff has access to a list of interpreters and shall assist in locating and contacting persons to provide interpretation or steps for alternate meeting sites to meet physical disabilities.

The following are agreed upon options:
Professional Interpreting Services
6510 West Layton Avenue
Greenfield, WI 53220
Amy Fryman
414-282-8115
amyfryman@pieinc-wi.com

American Sign Language Interpreter
Dawn Koplitz
1244 Vernon Street
Altoona, WI 54720
(715)456-9268
Koplitz5@hotmail.com

Nancy Bose-(Sign Language Interpreter)
3751 Halsey Street
Eau Claire, WI 54701
(715) 833-0272
nancy@programmed.com
WI Sign Language License no. 175150

Connie Wagner-(Spanish)
(715)723-9583
(715)836-0548 (Pager)
wagner1@charter.net

Kathy Dahl
Volunteer Sign Language Interpreter
715-568-2291
Bloomer, WI 54724

4. When a person has a communication need that cannot be met with the above stated options, please consult with your manager. The following on-line option may be feasible. Please note: your manager needs to approve use of this resource. http://www.languageline.com/
5. When a person has a need for services related to visual impairment, please utilize the following potential resources: Center for Independent Living for Western Wisconsin at 715-233-1070 or Al Thompson from the Office for the Blind and Visually Impaired at http://www.dhs.wisconsin.gov/blind.

Prompt and Adequate Treatment

Policy Addresses: DHS.94.08

Introductory Statement:

CCS has grown rapidly every year since the roll out of the Recovery and Wellness Consortium in 2015. With this rapid growth and continual increase in need managing capacity in order to provide prompt and adequate treatment can be a challenge. The RWC is committed to ensuring consumers have timely access to needed services. This Procedure outlines several ways in which we will ensure prompt and adequate treatment.

Proactivity to ensure individuals have prompt treatment:

1. The RWC will engage in State level advocacy to reduce system barriers to CCS expansion
    - The RWC is committed to having representation at the state level to advocate for the mitigation system barriers.
2. Local hiring of staff to support CCS needs
    - The RWC Leadership team will ensure their County Boards are informed of CCS capacity needs
    - Positions will be requested as needed in a proactive way in order to avoid needing to establish a waitlist prior to getting approval to hire additional staff
    - The RWC will ensure that the consortium infrastructure meets the needs of the consortium as a whole. This includes ensuring sufficient staff exists for Service Facilitation, Clinical Coordination, Management, Information Technology (IT), Quality Assurance and Fiscal/Contracts.
3. Recruitment of a robust provider network
    - The Lead county will continually evaluate for unmet need areas within the provider network. The Mapping system will be the primary system utilized to do this, along with consultation from local county teams and CCS Coordinating Committees.
    - If a consumer has an assessed need and requests a specific provider that currently is not contracted with the RWC, the Lead county will reach out to that provider and explore their interest and fit for becoming a new provider.
    - The RWC will ensure that new providers have adequate training and resources to fully understand the philosophies and program structure of CCS.
    - County staff and providers will have adequate training, tools and supports to effectively assist CCS consumers through their recovery journey.
    - The RWC will conduct an assessment annually to evaluate the training needs of the county and provider partners.
    - The RWC is committed to offer at least 8 hours per year of continuing education annually.

- The RWC will continually update trainings to ensure information is current and relevant.

4. Prompt screening and assessment of new referrals
    - The RWC will have initial contact with referring consumers within 2 business days of their inquiry, unless determined to be a crisis situation.
    - A county worker will meet with the inquiring consumer within 5 business days to discuss their needs and options.
    - At the time of this initial meeting the worker will assess for urgent needs to determine if aa abbreviated assessment is needed in order to start services quickly.
    - The RWC will ensure consumers have a full understanding of the CCS program in order to make an informed decision if the program is right for them. The county worker will utilize the RWC Consumer Handbook to guide this conversation. After this initial conversation the consumer will receive the Consumer Handbook.
    - The county staff will conduct a functional screen within 30 business days of initial referral for CCS.
    - The consumer will be enrolled into CCS, to begin the assessment process, within 14 business days of eligible functional screen results.

In the event a waitlist exists:
If an individual expresses interest in CCS in a county where there is a waitlist the following will happen:

- The county will ensure they explore all service options upon referral.
- If CCS is determined to be the consumer's choice a functional screen will be conducted right away to determine eligibility.
- If found eligible:
    - The Clinical Coordinator and Service Facilitator will assess for urgent need in being prioritized to the top of the list. Urgent need will be determined by the following (one of the below does not automatically signify a prioritization, rather a combination and impact to the consumer's stability):
        - Have they ever been to a psychiatric hospital? If so, was it voluntary or involuntary? What was the reason (i.e. suicide attempt, self-harm, suicidal ideation, overdose)
        - Have they had multiple crisis contact recently?
        - Have they had multiple police contact recently?

- Describe any current instability in their life (i.e., housing, child protection or legal system involvement, lack of natural supports)
- What/if any supports are currently in place?
- Are they at risk to harm themselves?
- Are they at risk to harm others?
- Have they been enrolled in CCS in the last year?

- If not prioritized for urgent need:
  - The county will discuss with the consumer community-based resources available while they wait for CCS to begin
  - A CCS worker will be assigned to that consumer and follow up 30 days after they were informed of the need to wait to ensure critical status has not changed and to give the consumer an update on their status.
  - Every 60 days thereafter that worker will reach out to the consumer to ensure their urgent needs are being met and to give them an update on their status. They will ensure the consumer's eligibility has not changed in order to remain on the waitlist.

Screening new CCS referrals

Responding to initial inquiries for mental health and addiction services

- Complete initial referral form in order to gain information to determine which services would be the best fit for the individual to explore
- Utilize RWC First Conversation guide to ensure the consumer has a clear understanding of their options
- Have they tried outpatient mental health psychotherapy? If not, this should be a starting point
- Assess readiness for change
- If interested in CCS utilize the Consumer Handbook to guide a thorough discussion of what the CCS program is

Intake and Outreach Process

Policy addresses: DHS 36.07 (5) (g), (j), (k), (l), (m), (n), (o), (p), (q), & (r)

Introductory Statement:
The CCS program is dedicated to a respectful intake process that meets the needs of consumers as well as program requirements. Consumer friendly communication is an essential part of the care process. Each CCS staff shall be oriented and trained in regards to the following intake process.

The CCS program aims to increase access by offering services for consumers within the geographic area where they reside.

Procedure:

1. Outreach Services
    a. CCS shall conduct outreach activities to consumers, service providers, family members and community partners. The purpose is to increase awareness and inform individuals on how to make a referral.
    b. The CCS shall inform community partners, family members, potential consumers, and interested parties that CCS is a voluntary program and criteria for admission is determined via a state sponsored functional screen.
    c. Dissemination of CCS information shall be provided in a number of ways including, but not limited to: e-mail, phone, in-person meetings, presentations, and in-service training.
    d. The CCS staff shall provide specific consultation to community partners and organization regarding potential CCS consumers while maintaining confidentiality pursuant to Wisconsin Administrative Code DHS 92.
2. Application (Detailed under 36.13)
    a. The CCS shall provide information regarding services and admission criteria/procedures to all interested parties.
    b. An application form shall be made available at each office to facilitate communication about the program and the coordinating of applications.
3. Application & Initial Screening (Detailed under 36.13)
    Completion of the consumer application may take place at various points in the intake process. Often times, the following are completed prior to the application: Informed Consent (Financial, Treatment, and Functional Screen), Releases, Functional Screen, and Physician Prescription.
    a. Informed Consent - During the intake and assessment process, consumers shall be informed of their rights and be provided informed consent which includes the following:
        i. Grievance procedure.
        ii. Informed consent for treatment.
        iii. Informed consent for functional screen.
        iv. Informed consent for financial processes.
    b. Release of Information – The consumer authorizes the sharing of information between professional entities to support completion of the Functional Screen.
    c. Functional Screen – The service facilitator, trained in completing the functional screen, will complete the on-line screen to determine initial eligibility, pending the comprehensive assessment.

d. Physician Prescription – Per Medicaid requirements, persons receiving CCS must have a current physician's prescription to receive CCS.
e. Application and Admission/Service Agreement – The Application is completed by the consumer to express their desire to receive CCS. The Application date is the admission date. The Admissions/Service Agreement (Detailed under 36.13)informs consumers of the following:
    i. Services offered within the CCS program.
    ii. Hours of operation for each county.
    iii. Information on how to access crisis services. Staff member titles and responsibilities.
    iv. When transitional or continued services are needed, the Admission/Service Agreement shall authorize the services to be provided via CCS prior to the completion of the individualized service plan.
f. When an individual is engaged in other divisions or services within the county system and interested in CCS, the CCS shall provide outreach and screening to determine if s/he is eligible to receive CCS.

5.

4. Comprehensive Assessment (Detailed under 36.16)
    g. An accurate comprehensive assessment shall be conducted for each eligible applicant of CCS in order to identify strengths, needs and desired outcomes of the consumer and to evaluate progress toward those outcomes to ensure that service plans and services provided to consumers are based on accurate and complete evaluations of the individual strengths, needs and desires of each consumer.
    h. The Service Facilitator shall gather relevant treatment records and conduct necessary assessment meetings with the consumer and collateral parties.
    i. The Service Facilitator shall have assessment participants complete a sign-in form for the assessment process.
    j. The Clinical Coordinator shall complete a Mental Status Exam (MSE) and a Determination of Need, which also authorizes services.
    k. When a person is determined to have a substance abuse diagnosis, the assigned Substance Abuse Professional shall review, provide feedback, and sign the following documents: Determination of Need, Assessment, Individualized Service Plan. For continued or transitional services and when substance use diagnosis exists, the Substance Abuse Professional shall also sign the Admission/Service Agreement.
    l. The Comprehensive Assessment leads to the development of the individualized service plan.
5. Recovery Team Development
    m. The Recovery Team development process begins during the admission and team development meeting after the consumer's admission to the CCS has been established.
    n. The consumer, and when applicable their legal representative, shall be involved in choosing the members of their recovery team.
    o. The Recovery Team shall include all of the following:
        i. The consumer
        ii. A service facilitator

iii. A Clinical Coordinator and/or substance-use professional (If the Consumer has or is believed to have a co-occurring condition, then the team shall include both a mental health professional and a substance-use professional or a person who has the qualification of both)
iv. Service providers, family members, natural supports and advocates, with the consumer's consent, unless their participation is unobtainable or inappropriate
v. If the consumer is a minor or incompetent or incapacitated, a parent or legal representative shall be included on the recovery team.

p. The role of each team member shall be guided by the nature of the member's relationship with the consumer and the scope of the members' practice.
q. Team members shall participate in the assessment process and service planning, in addition to the ongoing monitoring of the service plan and necessary reviews.
r. Team members shall provide information, evaluate input from various sources and make collaborative recommendations regarding outcomes, services and supportive activities. This partnership shall be built on the cultural norms of the consumer.
s. Team members shall complete a recovery team sign-in form demonstrating their participation in the recovery team meeting.

6. Service Planning and Delivery (Detailed under 36.17)
   t. A written individualized service plan/recovery plan (ISP) shall be based upon, and completed in conjunction with the assessment to ensure that a written plan is developed that identifies the psychosocial services to be provided or arranged for a consumer based upon the individualized assessment and choice. The ISP shall be signed by the consumer, service facilitator, Clinical Coordinator, and when a substance abuse diagnosis exists, the Substance Abuse Professional.
7. Service Coordination, Referrals and Collaboration (Detailed under 36.17)
   u. Following service planning, the consumer and service facilitator shall determine the coordination, referral, and collaboration process to be implemented.
8. Advocacy, Support and Mentoring for the Consumer
   v. Our CCS program seeks to ensure that consumers of the CCS are empowered to take an active role in treatment and recovery.
   w. CCS shall promote advocacy through involvement of consumers, family representatives and other advocates within the Coordinating Committee.
   x. The program's Coordinating Committee shall encourage interested, non-member, consumers and advocates to attend meetings as a means for providing feedback and/or voicing concerns.
   y. Service Facilitators shall encourage consumers to invite individuals to participate in recovery teams who they consider to be active advocates or supports on their behalf.
   z. The Service Facilitator, Clinical Coordinator and Substance Abuse Professional shall work to foster appropriate consumer-directed recovery services that are addressed within the consumer's service plan.
   aa. During facilitation and coordination activities, recovery team members teach consumers to communicate effectively with members of their recovery team and others through modeling, skill training and collaboration with other professionals.
   bb. Mentoring shall be part of the role that recovery team members undertake in promoting consumers' recovery.

cc. Recovery team members shall act as positive role models for consumers.
dd. Recovery team members shall enhance consumers' self-advocacy efforts.

2. Discharge planning and facilitation (Detailed under 36.17)- CCS shall be provided to consumers based on the need for psychosocial rehabilitation services. Consumers achieving their recovery goals or wishing to terminate services for other reasons shall be assisted in this process to facilitate a smooth transition for CCS consumers who have attained their identified level of recovery resulting in their completion of the program.

Required Forms:

- CCS Application/ Form

Consumer Rights and Grievance Process

Introductory Statement:

Individuals who receive services via the RWC shall be informed of their rights and the process for conflict resolution that includes the options of using either formal or informal procedures for resolving complaints and disagreements.

The program shall use the RWC Grievance Procedure that meets the requirements under s. 51.61, Stats., and DHS 94.27 for a grievance resolution system.

The RWC shall ensure that no consumer is denied benefits or services or is subjected to discrimination on the basis of age, race or ethnicity, religion, color, sexual orientation, marital status, arrest or conviction record, ancestry, national origin, disability, gender, or physical condition.

Per DHS 94.08, all consumers shall be provided prompt and adequate treatment, habilitation or rehabilitative supports, community services and education services as required under state and federal regulations.

Staff shall further ensure that consumers are engaged in defining their personal plan for recovery, that their health information is protected, and that they are treated with dignity, respect, and in the least restrictive and most integrated manner possible in line with their preferences and needs.

To the extent possible, consumers have choice in the selection of their recovery team members, services, and service providers.

As part of the RWC informed consent and assessment process, consumers shall receive specific, complete, and accurate information regarding their services.

Consumers shall be informed of the following:

- Services offered.
- Costs of services.

- Grievance procedure.
- Informed consent for treatment.
- Confidentiality of records.

A consumer or person acting on the consumer's behalf shall file a grievance within 45 days of the occurrence of the event or circumstance in the grievance or of the time when the event or circumstance was actually discovered or should reasonably have been discovered, of the consumer's gaining or regaining the ability to report the matter, whichever comes last. Modifications to this timeline may be made with good cause.

Procedures:

Informed of Process:

1. Each consumer that receives services from the Recovery and Wellness Consortium shall receive at time of intake a copy of the rights, grievance, and complaint process. The worker shall be responsible to advise the consumer of the steps.
2. Grievances may be presented on behalf of the consumer by appropriate other parties. When this occurs, the consumer may allow that those assisting with the grievance be included in the process.
3. Each site providing program certified services shall have a poster, outlining Consumer Rights, the Grievance Process and the Informed Consent for community programs, visible to consumers.
4. For consumers with Medical Assistance, they shall receive information about the fair hearing process s. DHS 104.01 (5).
5. Each Consumer Rights Specialist receives training in the consumer rights and grievance process.
6. The Consumer Rights Specialist for the RWC is:

   Pauline Spiegel
   Chippewa County Department of Human Services
   711 North Bridge Street
   Chippewa Falls, WI 54729
   Phone: 715-726-7788

7. No sanctions shall be threatened or imposed against any consumer who files a grievance, or any person including an employee of the department, a county department or a service provider, who assists a consumer in filing a grievance.

Informal Process:

8. When an issue arises, the consumer shall attempt to work through and resolve challenges with their assigned worker. The worker shall document the issue and its resolution in the case file.

9. When a resolution cannot be achieved between the consumer and the worker, the worker shall refer the consumer to their On-Site Administrator.

10. The On-Site Administrator shall attempt to informally resolve the issue with the consumer and the assigned worker. When the issue is resolved, documentation of the issue and its resolution shall be placed in the treatment record.

11. When a resolution cannot be achieved between the consumer and the On-Site Administrator, the On-Site Administrator shall refer the consumer to the RWC Operations Administrator.

12. The RWC Operations Administrator shall attempt to informally resolve eh issue with the consumer and the assigned worker. When the issue is resolved, documentation of the issue and its resolution shall be placed in the treatment record.

Formal Process:

13. When an informal resolution cannot be achieved, RWC Operations Administrator shall offer the consumer a RWC Resolution Request form (See appendix A, shall be submitted to CRGC within 45 days of incident) or when a consumer chooses a state level review (provide state level contact information).

14. Within 5 business days (excluding weekends and holidays) from receipt of the RWC Resolution Request form, the Consumer Rights and Grievance Specialist shall contact the consumer acknowledging the receipt of the form and next steps.

15. When a RWC Resolution Request is made by a consumer, the Consumer Rights and Grievance Specialist shall appoint an On-Site Administrator from another county to review RWC Resolution Request and analyze the consumer's concern. The Consumer Rights and Grievance Specialist shall provide a copy of the resolution form to the RWC Operations Administrator.

16. The Consumer Rights and Grievance Specialist shall obtain any case records upon request from the On-Site Administrator from another county in order to assist in making a decision. The On-Site Administrator from another county shall complete the report within 30/5 days (non-emergency/emergency).

17. The On-Site Administrator from another county shall interview all parties associated with the grievance or complaint. Minimally, this includes the Worker, On-Site Administrator, and consumer.

18. The On-Site Administrator from another county shall complete a written summary and recommendation on how to resolve the issue or suggest a next step.

19. The On-Site Administrator from another county shall submit the written summary to the Consumer Rights and Grievance Specialist and the RWC Operations Administrator. Consumer Rights and Grievance Specialist and the RWC Operations Administrator shall share the summary and recommendation or next step with the RWC Operations Administrator of the county which the grievance or complaint originated.

20. If the On-Site Administrator from the originating county supports the recommendation the RWC Operations Administrator shall inform the On-Site Administrator from the different county to proceed with writing a letter to the consumer presenting a summary, the action that shall occur to resolve the issue, and the next step in the grievance/complaint process. The letter shall be copied to On-Site Administrator, Worker, and RWC Operations Administrator.

21. <u>If originating county or consumer does not support different county recommendation:</u> If either the consumer or the On-Site Administrator does not agree with the decision by the On-Site Administrator from another county, then the On-Site Administrator issues his/her own decision within 10/5 days (non-emergency/emergency) and submits to the RWC Operations Administrator.

22. The consumer may appeal to the Mental Health and Substance abuse Operations Administrator within 14 days.

23. When the On-Site Administrator is not in agreement with the On-Site Administrator from another county decision and submits their own decision the RWC Operations Administrator shall review the On-Site Administrator decision and either uphold the initial recommendation of the On-Site from another county or schedule a meeting with both parties to mediate a resolution.

24. RWC Operations Administrator shall evaluate, review, analyze and issue a decision to the consumer and/or On-Site Administrator within 30/10 days (non-emergency or emergency) of receiving the written request.

25. RWC Operations Administrator's response is considered final unless a state level review of the decision may be requested under DHS 94.43. Under DHS 94.43 any consumer shall have 14 days from the date the consumer receives a county director's decision to request a state level review.

<u>State Level Review:</u>

26. At any time in the grievance process, the consumer may choose to contact the appropriate state level agency responsible to hear rights, grievances, or complaints. For some services, the consumer has the right under sec. 51.61 (7) Stats to take the matter to court.

27. In addition, following the county level determination, a consumer may submit a request for state-level review. If needed, the county shall assist the consumer in requesting this state-level review.
28. A request for administrative review of the RWC Administrators decision shall state the basis for the grieving's objection and include a proposed alternative solution.
29. All relevant information shall be provided to the Administrator of the Division of Mental Health and Substance Abuse Services to conduct a desk review of the previous level decision and all earlier documentation. In non-emergency situations, this shall be completed within 7 days of receiving the request. In emergency situations, overnight mail shall be used and submitted within 3 days of the request.
30. Any recipient of **state or county funding** in an inpatient facility who is receiving services for mental illness, a developmental disability, or substance abuse may file a grievance. This includes Hospitals, Outpatient clinics, AODA providers, Vocational and Day Services, Crisis Programs, Community Support Programs, Residential Settings, Group and Foster Homes, Nursing Homes, Day Treatment, In-Home Programs, and any other program that provides services for mental illness, developmental disabilities, or substance abuse or for people protectively placed under Sec. 55.06, Wis. Stats. In such cases the CRGC shall follow the steps as outlined in DHS 94 Community Grievance Resolution Procedures available at: http://dhs.wisconsin.gov/clientrights/docs/main/flowChart.pdf.

NOTE: There are additional rights within sec. 51.61(1) and DHS 94, Wisconsin Administrative Code. They are not mentioned here because they are more applicable to inpatient and residential treatment facilities. A copy of sec. 51.61, Wis. Stats. and/or DHS 94, Wisconsin Administrative Code is available upon request.

Required Forms:

- Consumer Bill of Rights and the Grievance Procedure
- Informed Consent
- DHS 94 – Patient Rights and Resolution of Patient Grievances

Limitation or Denial of Rights

Limitation or denial of rights applies only to residential and/or inpatient facilities.

Within residential and/or inpatient facilities, good cause for denial or limitation of a right exists only when the director or designee has reason to believe the exercise of the right would create a security problem, adversely affect the consumer's treatment, or seriously interfere with the rights or safety of

others. At the time of denial and/or limitation, written notice shall be provided to the consumer and the guardian, if any, and a copy of that notice placed in the person's treatment record.

A facility shall notify the county department when an individual is ready for placement in a less restrictive setting.

After an inpatient or residential treatment facility notifies the county department that the placed patient is ready for placement in a less restrictive setting, the county department then shall act in accordance with S. 51.61 (1)(e), Stats., to place the patient in a less restrictive setting.

Consumer Informed Consent

Introductory Statement:

Individuals who receive services via the RWC shall be informed of their rights and be provided with a treatment informed consent and financial informed consent.

Except in an emergency, when it is necessary to prevent serious physical harm to self or others, no medication may be given to any patient or treatment performed on any patient unless the patient has been found not competent to refuse medication and treatment under s. 51.61(1)(g), Stats., and the court orders medication and/or treatment.

In the case of a patient found incompetent under ch.880, Stats., the informed consent of the guardian is required.

In the case of a minor, the informed consent of the parent or guardian is required. Except as provided under an order issued under s. 51.14(3)(h) or (4)(g), Stats., if a minor is 14 years of age or older (mental health) or if a minor is 12 years of age or older (substance use), the informed consent of the minor and the minor's parent or guardian is required. Informed consent for treatment from a patient's parent or guardian may be temporarily obtained by telephone in accordance with s. DHS 94.03(2m).

Procedures:

1. The RWC staff person shall provide a treatment informed consent to the consumer(s) and/or guardian(s) both orally and in writing.
2. The treatment consent shall include the following:
    a) treatment alternatives.
    b) possible outcomes and side effects of treatment recommended in the treatment plan.
    c) treatment recommendations and benefits of the treatment recommendations.
    d) approximate duration and desired outcome of treatment recommended in the treatment plan.

e) the rights of a consumer receiving outpatient mental health services, including the consumer's rights and responsibilities in the development and implementation of a recovery plan.
f) the general nature and purpose of the services that shall be offered under the plan.
g) how to use the grievance procedure under ch. DHS 94.
h) the way by which a consumer may obtain emergency mental health services during periods outside the normal operating hours.
i) The clinic's discharge policy, including circumstances under which a patient may be involuntarily discharged for inability to pay or for behavior reasonably the result of mental health symptoms.
j) The consumer's right to withdraw informed consent at any time, in writing.

3. The consumer shall receive a copy of the treatment informed consent.
4. In emergency situations or where time and distance requirements preclude obtaining written consent before beginning treatment and a determination is made that harm shall come to the patient if treatment is not initiated before written consent is obtained, informed consent for treatment may be temporarily obtained by telephone from the parent of a minor patient or the guardian of a patient. Oral consent shall be documented in the patient's record, along with details of the information verbally explained to the parent or guardian about the proposed treatment. Verbal consent shall be valid for a period of 10 days, during which time informed consent shall be obtained in writing.
5. A patient may refuse medications and any other treatment except as provided under s. 51.61 (1) (g) and (h), Stats., and this section.
6. Any patient who does not agree with all or any part of his or her treatment plan shall be permitted a second consultation for review of the treatment plan as follows:
   a) An involuntary patient may request a second consultation from another staff member who is not directly providing treatment to the patient, and the treatment facility shall make the designated staff member available at no charge to the patient; and
   b) Any patient may, at his or her own expense, arrange for a second consultation from a person who is not employed by the treatment facility to review the patient's treatment record.
   c) Service providers may pay for some or all of the costs of any second consultation allowed under par.
   d) Service providers may also enter into agreements with other service providers to furnish consultations for each other's clients.
7. A voluntary patient may refuse any treatment, including medications, at any time and for any reason, except in an emergency, under the following conditions:
   a) If the prescribed treatment is refused and no alternative treatment services are available within the treatment facility, it is not considered coercion if the facility indicates that the patient has a choice of either participating in the prescribed treatment or being discharged from the facility; and
   b) The treatment facility shall counsel the patient and, when possible, refer the patient to another treatment resource prior to discharge.
   c) However, the goal of the program is to engage the consumer and work toward the recovery plan whenever possible.

8. If a consumer is prescribed medication as part of the recovery plan the prescribing provider shall obtain a separate medication informed consent. The medication informed consent indicates that the prescriber has explained to the consumer, or the consumer's legal representative, if the legal representative's consent is required, the nature, risks and benefits of the medication and that the consumer, or legal representative, understands the explanation and consents to the use of the medication.
9. The treatment informed consent shall be reviewed and signed annually.
10. Following the initial appointment, a fiscal staff person, or their designee, shall meet with the consumer and provide financial informed consent to include the following:
    a. The fees that the consumer or responsible party shall be expected to pay for the proposed services.
    b. Consumers receiving Medicaid covered services may not be charged any amount in connection with services other than the applicable cost share, if any, specified by the Wisconsin Medicaid Program.

Required Forms:

- Treatment Informed Consent
- Financial Informed Consent

Emailing/Texting For Service Facilitators

PURPOSE: To define methods of communication for Service Facilitation when email or texting is the mode of communication used by the consumer, providers and Service Facilitator.

POLICY: It is the policy of the RWC CCS Program to assure that consumers receive the best possible care when enrolled in CCS. In order to fulfill that objective communication with consumers and providers is essential. While face to face communication is best practice, many factors may prevent that from occurring. These include but are not limited to consumer preference, weather and illness.

An essential role in CCS is Service Facilitation. Such is defined in the CCS Service Array (WI DHS Chapter 36).

> 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.

For a Service Facilitator to support a member in an effective and efficient manner, many modes of communication are available, including electronic forms such as texting, emailing and voicemails. Email, text and voice mails are not a means of providing services, rather a means of communication. They are ways to prepare and respond to consumers and those providing collateral information that is necessary for service planning, implementation and monitoring. All means of electronic communication will be HIPAA complaint.

PROCEDURE:

1. The only service on the CCS Service Array billable when using texting, emailing or voicemail as a form of communication is Service Facilitation, Service Planning or Screening and Assessment.
2. Providers of other services are not able to bill for time when emailing, texting or leaving voicemails.
3. Compliance to the definition of Service Facilitation as defined in WI DHS Chapter 36 will be maintained.
4. Service Facilitators shall use the same procedure for documenting services performed, and time spent doing such, as when the service is face to face or via electronic communication.
5. If a county has additional policies that address electronic communication, CCS staff at that county will follow county acceptable practices.
6. Service Facilitators may communicate via emailing or texting consumers, providers and others as granted by a signed release of information by the consumer.
7. Confidentiality of records will be maintained as required in other applicable laws, 42 CFR Part 2, HIPAA
8. Not all emails are needed in the consumer file. Service Facilitators will use clinical judgement to determine if an email should be placed in the consumer file. If the Service Facilitator has a question, they will contact the Mental Health Professional or onsite County Manager to obtain further direction.
9. RWC Treatment Informed Consent Form shall be completed prior to use of email or texting.

CCS Coordinating Committee

Policy addresses: DHS 36.07 (1) (c) & 36.09

Introductory Statement: Consumers shall be involved at all levels of RWC - CCS including program planning, design and quality improvement.

It is the intent of the RWC to have consumer input be at the core of program development and ongoing programming. This is fostered through the administrative processes of the consortium as well as the establishment of the coordinating committee.

Procedure:

1. The RWC – CCS Coordinating Committee shall consist of the following representatives:
   - Consumers and family members and interested citizens. (At least 1/3 of the CC)
   - County or tribal departments or service providers. (No more than 1/3 of CC)
   - Community mental health advocates.
   - Community substance use advocates.
   - Community mental health and substance use advocates.

2. The Coordinating Committee shall be responsible for all of the following:
   - Serve in an advisory role to RWCC CCS.
   - Review and make recommendations regarding the initial and any revised CCS plan required under s. DHS 36.07, the CCS quality improvement plan, personnel policies, and other policies, practices or information that the committee deems relevant to determining the quality of the CCS and protection of consumer rights.
   - Maintain written minutes of meetings.
   - Maintain a current membership list.
   - Meet at least quarterly and more frequently as needed.

3. Documentation of Coordinating Committee meetings is contained on the RWC SharePoint site.

Required Forms:
N/A

Resources:
- CCS Coordinating Committee Roster

Staff Qualifications and Credentials

Policy addresses: DHS 36.10

Introductory Statement:
The Mental Health and Substance Abuse Operations Administrator (CCS Program Administrator) and/or a designee (On-Site Administrator and/or Network Provider) shall verify that all individuals hired possess the required degrees, licenses, certifications, qualifications and training required for each particular position.

In order to ensure that subcontracted providers are verifying that all individuals hired possess the required degrees, licenses, certifications, qualifications and training required for each particular position, the Provider shall submit verification of credential and training by means of the Job Classification Review Form.

Procedure:

a. Each staff member and subcontracted provider shall be trained in the recovery model and be a practitioner of its concepts.

b. Each staff member and subcontracted provider shall have the interpersonal skills, training and experience needed to perform the staff member's assigned functions, and each staff member providing psychosocial rehabilitation services shall meet one of the following minimum qualifications.

    a. Psychiatrists shall be physicians licensed under Chapter 448, Statutes, to practice medicine and surgery and shall have completed 3 years of residency training in psychiatry or child psychiatry in a program approved by the accreditation council for graduate medical education and be either board-certified or eligible for certification by the American board of psychiatry and neurology.

    b. Physicians shall be persons licensed under Chapter 448, Statutes, to practice medicine and surgery who have knowledge and experience related to mental disorders of adults or children; or, who is certified in addiction medicine by the American Society of Addiction Medicine, certified in addiction psychiatry by the American Board of Psychiatry and Neurology or otherwise knowledgeable in the practice of addiction medicine.

    c. Psychiatric residents shall hold a doctoral degree in medicine as a medical doctor or doctor of osteopathy and shall have successfully completed 1500 hours of supervised clinical experience as documented by the program director of a psychiatric residency program accredited by the accreditation council for graduate medical education.

d. Psychologists shall be licensed under Chapter 455, Statutes, and shall be listed or meet the requirements for listing with the national register of health service providers in psychology or have a minimum of one year of supervised post-doctoral clinical experience related directly to the assessment and treatment of individuals with mental health issues or substance-use issues.

e. Licensed Independent Clinical Social Workers shall meet the qualifications established in Chapter 457, Statutes, and be licensed by the examining board of social workers, marriage and family therapists and professional counselors with 3000 hours of supervised clinical experience where the majority of Consumers are children or adults with mental health issues or substance-use issues.

f. Professional Counselors and Marriage and Family Therapists shall meet the qualifications required established in Chapter 457, Statutes, and be licensed by the examining board of social workers, marriage and family therapists and professional counselors with 3000 hours of supervised clinical experience where the majority of Consumers are children or adults with mental health issues or substance-use issues.

g. Adult Psychiatric and Mental Health Nurse Practitioners, Family Psychiatric and Mental Health Nurse Practitioners or Clinical Specialists in Adult Psychiatric and Mental Health Nursing shall be board certified by the American Nurses Credentialing Center, hold a current license as a registered nurse under Chapter441, Statutes, have completed 3000 hours of supervised clinical experience; hold a master's degree from a national league for nursing accredited graduate School of nursing; have the ability to apply theoretical principles of advanced practice psychiatric mental health nursing practice consistent with American Nurses Association scope and standards for advanced psychiatric nursing practice in mental health nursing from a graduate school of nursing accredited by the national league for nursing.

h. Advanced Practice Nurse Prescribers shall be adult psychiatric and mental health nurse practitioners, family psychiatric and mental health nurse practitioners or clinical specialists in adult psychiatric and mental health nursing who are board certified by the American Nurses Credentialing Center; hold a current license as a registered nurse under Chapter 441, Statutes; have completed 1500 hours of supervised clinical experience a mental health environment; have completed 650 hours of supervised prescribing experience with Consumers with mental illness and the ability to apply relevant theoretical principles of advance psychiatric or mental health nursing practice; and hold a master's degree in mental health nursing from a graduate school of nursing from an approved college or university.

i. Advanced Practice Nurses are not qualified to provide psychotherapy unless they also have completed 3000 hours of supervised clinical psychotherapy experience.

j. Certified Social Workers, Certified Advance Practice Social Workers and Certified Independent Social Workers shall meet the qualifications established in

Chapter 457, Statutes, and related administrative rules, and have received certification by the examining board of social workers, marriage and family professional counselors.

k. Psychology Residents shall hold a doctoral degree in psychology meeting the requirements of s. 455.04 (1) (c), Statutes, and shall have successfully completed 1500 hours of supervised clinical experience as documented by the Wisconsin psychology examining board.

l. Physician Assistants shall be certified and registered pursuant to ss 448.05 and 448.07 Statutes, and Chapters Med 8 and 14.

m. Registered Nurses shall be licensed under Chapter 441, Statutes,

n. Occupational Therapists shall be licensed and shall meet the requirements of s.448.963 (2), Statutes

o. Master's Level Clinicians shall have a master's degree and coursework in areas directly related to providing mental health services including master's in clinical psychology, psychology, school or educational psychology, rehabilitation psychology, counseling and guidance, counseling psychology or social work.

p. Other professionals shall have at least a bachelor's degree in a relevant area of education or human services.

q. Alcohol and Drug Abuse Counselors shall be certified by the Wisconsin certification Board as defined in s. DHS 75.02 (94).

r. Specialists in specific areas of therapeutic assistance, such as recreational and music therapists, shall have complied with the appropriate certification or registration procedures for their profession as required by State Statute or administrative rule or the governing body regulating their profession.

s. Certified Occupational Therapy Assistants shall be licensed and meet the requirements of s.448.963 (3), Statutes

t. Licensed Practical Nurses shall be licensed under Chapter 441, Statutes

u. A peer specialist, meaning a staff person who is at least 18 years old, shall have successfully completed 30 hours of training during the past two years in recovery concepts, consumer rights, consumer centered individual treatment planning, mental illness, co-occurring mental illness and substance abuse, psychotropic medications and side effects, functional assessment, local community resources, adult vulnerability, consumer confidentiality, a demonstrated aptitude for working with peers, and a self-identified mental health issues or substance use issues.

v. A rehabilitation worker, meaning a staff person working under the direction of a licensed mental health professional or substance abuse professional in the implementation of rehabilitative mental health, substance use disorder services as identified in the consumer's individual treatment plan who is at least 18 years old shall have successfully completed 30 hours of training during the past two years in recovery concepts, consumer rights, consumer-centered individual treatment planning, mental illness, co-occurring mental illness and substance abuse, psychotropic medications and side effects, functional assessment, local community resources, adult vulnerability, and consumer confidentiality.

w. Clinical students shall be currently enrolled in an accredited academic institution and working toward a degree in a professional area identified in this subsection and providing services to CCS under the supervision of a staff member who meets the qualifications under this subsection for that staff member's professional area.

2. Staff Credentials

   a. Staff members and subcontracted providers providing services within CCS shall have the professional certification, training, experience and abilities to carry out prescribed duties as outlined in their respective position description.

3. Documentation of Staff Qualifications

   a. Copies of staff degrees, licenses, certifications and completed training shall be maintained in the personnel file and supplied to the Lead County Agency via the RWC SharePoint site.

   b. Copies of degrees, licenses, certifications and completed training shall be maintained in the personnel file for subcontracted staff and supplied to the Lead County Agency via the RWC SharePoint site.

   c. Credentials of each CCS provider (county staff and subcontracted providers) shall be maintained and shall be available for review by consumers (and parents or legal representatives of consumers if parental or legal representative consent to treatment is required).

4. Hiring Qualified Staff (Applies to county-based staff and subcontracted providers)

   a. An applicant for employment shall provide references regarding professional abilities from at least 2 people and, if requested by the program, references or transcripts from any post-secondary educational institution attended and employment history reports or recommendations from prior employers.

   b. References and recommendations shall be documented either by letter or in a signed and dated record of a verbal contact.

c. Application information shall be reviewed and investigated to determine whether employment of the individual is in the best interests of the program's consumers. This shall include a check of relevant and available conviction records. The provisions of s.111.335, Wis. Statute, shall be utilized in determining if an arrest record (regarding a pending charge) or a conviction is an appropriate basis for denial of employment.

d. An applicant's current professional licensure or certification shall be reviewed, if that licensure or certification is a condition of employment.

e. Consideration shall be given to each applicant's competence, responsiveness, sensitivity toward, and training in serving the characteristics of the consumer population, including gender, age, cultural background, sexual orientation, developmental, cognitive or communication barriers and physical or sensory disabilities.

5. Staff Records

a. Records of staff members who provide services within the CCS shall be maintained in the Primary or Branch offices of each County Department of Health and Human Services (DHHS) personnel file. Records of subcontracted providers who provide services within the CCS shall be maintained at the designated subcontracted provider location. Records shall include:

i. References for job applicants obtained from at least 2 people, including previous employers, educators or post-secondary educational institutions attended if available, and documented either by letter or verification of verbal contact with the reference, dates of contact, person making the contact, individuals contacted and content of the contact.

ii. Confirmation of an applicant's current professional license or certification, if that license or certification is necessary for the staff member's prescribed duties or position.

iii. The results of the caregiver background check including a completed background information disclosure form for every background check conducted, and the results of any subsequent investigation related to the information obtained from the background check.

iv. A completed Job Classification Review Form which outlines a person’s credentials, degrees, and experience.

d. The Lead County Agency shall be provided and retain a copy of the most up-to-date, completed Job Classification Review Form for each county-based staff. This document shall verify credential and experience and supplied to the Lead County Agency via the RWC SharePoint site.

Staff Functions

a. Administrator shall be fulfilled by the designee from the RWC management team who shall hold one of the qualifications listed in this policy under 1) a) (1) through (14). The Lead Agency employed Mental Health and Substance Abuse Operations Administrator shall serve as the CCS Program Administrator.

b. Service Director shall be fulfilled by the staff who meet the qualifications listed in this policy under 1) a) (1) through (8). The Clinical Coordinator shall serve as the Service Director.

c. Mental Health Professional shall be fulfilled by the staff who meet the minimum qualifications listed in this policy under 6) a) (l) through (8). The Clinical Coordinator shall serve as the Mental Health Professional.

d. Substance Abuse Professional duties shall be fulfilled by the Substance Abuse Counselor or other qualified designee who meets the minimum qualifications listed in this policy under 1) a) (16).

e. Service Facilitation shall be conducted by various RWC and contracted staff who are assigned to CCS and who meet one of the minimum qualifications listed in this policy under 1) a) (1) through (22).

6. Volunteers

When CCS uses volunteers to support the activities of staff members:

a. Before a volunteer may work independently with a consumer or family member, CCS shall conduct a background check on the volunteer.

b. Each volunteer shall be supervised by a staff member meeting one of the qualifications listed in this policy under 1) a) (1) through (17).

c. Each volunteer shall receive the required orientation and training.

Supervision and Clinical Collaboration

Policy addresses: DHS 36.11

Introductory Statement:

To ensure that RWC CCS provides each staff member with the supervision and clinical collaboration necessary to perform their respective functions and ensure that consumers are afforded appropriate care within RWC CCS.

Staff within RWC CCS qualified under s. DHS 36.10 (2) (g) 1-8 shall comply with the supervision and clinical collaboration requirements as outlined in agency policy and procedure for DHS 35.14.

Staff within RWC CCS qualified under s. DHSDHS 36.10 (2) (g) 9-22 shall receive clinical supervision, as well as day-to-day consultation from a staff qualified under s. DHS 36.10 (2) (g) 1-8.

The supervision and/or collaboration shall foster the implementation of recovery concepts and person-centered planning throughout the service delivery system.

Procedure:

1. Staff qualified under s. DHS 36.10 (2) (g) 1-8 shall receive at least 1 hour of either supervision or clinical collaboration per month or for every 120-clock hours of face-to-face psychosocial rehabilitation or service facilitation they provide via individual sessions for case review, clinical collaboration and weekly joint, multi-disciplinary staffing.

2. Each staff member qualified under s. DHS 36.10 (2) (g) 9-22 shall receive, from a staff member qualified under s. DHS 36.10 (2) (g) 1-8, day-to-day supervision and consultation and at least one hour of supervision per week or for every 30 clock hours of face-to-face psychosocial rehabilitation services or service facilitation they provide through a combination of weekly joint, multi-disciplinary staffing and separate weekly CCS clinical staffing. Day-to-day consultation shall be available during CCS hours of operation.

3. Clinical supervision and clinical collaboration log shall be dated and documented in the form of a supervisory record signed by appropriate personnel. The supervisory record shall be located within each branch or primary office.

4. When consumer-specific feedback is provided, the clinical record shall address the following:
    a. Focus area
    b. Existing strengths as applicable, or pertinent, newly assessed strengths
    c. Barriers, met and unmet
    d. Objectives, met and unmet
    e. Progress towards meeting identified objectives, and

f. Recommendations

5. The Clinical Coordinator, based upon direct knowledge, or at the recommendation of another supervisory staff, may direct a CCS staff person to participate in additional hours of supervision or clinical collaboration beyond the minimum identified in this subsection in order to ensure that consumers of the program receive appropriate psychosocial rehabilitation services.

6. A staff member qualified under s. DHS 36.10 (2) (g) 1-8 who provides supervision or clinical collaboration may not deliver more than 60 hours/week of face-to-face psychosocial rehabilitation services, clinical services and supervision or clinical collaboration in any combination of clinical settings.

7. The Clinical Coordinator, in collaboration with the Substance Abuse Professional and Service Facilitator shall determine the frequency of consumer review at supervision meetings.

8. The Clinical Coordinator and/or the Substance Abuse Professional shall review individualized service plans and authorize services based upon consumer need.

9. The Clinical Coordinator shall determine the method and structure of supervisory sessions with staff.

Orientation & Training

Policy addresses: DHS 36.07 (5) (i) & DHS 36.12

Introductory Statement:

It shall be the policy of the RWC Comprehensive Community Services to provide orientation and ongoing training to staff members, providers, volunteers and Coordinating Committee members to ensure the delivery of competent, quality services to consumers. Available trainings may consist of materials created by the RWC, an outside entity, or a combination of the two.

The orientation and ongoing training process shall foster the implementation of recovery concepts, trauma aware service delivery, person-centered planning, and integrated mental health and substance use services.

Procedure:

Orientation

1. The RWC CCS Administrator and/or a designee, shall assure the organization, delivery and documentation of the following training program for:

County and Subcontracted Provider staff:

a. At least 40 hours of orientation training within 3 months of beginning employment for each staff member who has less than 6 months experience providing psychosocial rehabilitation services to children or adults with mental health or substance-use issues.

b. At least 20 hours of orientation training within 3 months of beginning employment for each staff member who has 6 months or more experience providing psychosocial rehabilitation services to children or adults with mental health or substance-use issues.

Volunteers:

a. At least 40 hours of orientation training for each regularly scheduled volunteer before allowing the volunteer to work independently with consumers or family members.

Coordinating Committee Members:

a. Orientation and training shall be provided to the committee members as deemed necessary, to ensure that they not only have a level of awareness but are informed and educated to the level that allows them to adequately guide and direct the work of the CCS.

2. Orientation training shall minimally include the following: staff members, providers, and volunteers working directly with consumers, along with Coordinating Committee members when applicable, shall be able to apply all of the following at either a level of awareness, knowledge or skill application as identified in the objectives listed below.

a. Staff, Providers, Volunteers and Committee Members shall have an awareness of recovery concepts and principles which ensure that services and promote consumer hope, healing, empowerment and connection to others and to the community; and are provided in a manner that is respectful, culturally appropriate, collaborative between consumer and service providers, based on consumer choices and goals and protective of consumer rights.

d. Staff, providers, volunteers and committee members shall have knowledge of parts of DHS 36 services they provide and be able to apply this knowledge.

e. Staff members, providers, and volunteers working directly with consumers shall know and apply the policies and procedures pertinent to the services they provide.

f. Committee members shall have an awareness of the policies and procedures of the CCS.

g. Staff members, providers, and volunteers working directly with consumers shall know their own job responsibilities and be aware of roles and responsibilities of other providers.

h. Staff members, providers, and volunteers working directly with consumers shall know and apply applicable parts of Chapters 48, 51 and 55, Statutes, and any related administrative rules and know how to access said documents.

i. Staff members, providers, and volunteers working directly with consumers shall know the basic provisions of Civil Rights laws including the American with Disabilities Act of 1990 and Civil Rights act of 1964 as the laws apply to staff providing services to individuals with disabilities.

j. Staff members, providers, and volunteers working directly with consumers shall know and apply current standards regarding documentation and the provisions of HIPPA, s. 51.30 Stats., Chapter DHS 92 and, if applicable, 42 CFR Part 2 regarding confidentiality of treatment records.

k. Staff members, providers, and volunteers working directly with consumers shall know and apply the provisions of s.51.61, Statutes, and Chapter DHS 94 regarding patient rights.

l. Staff members and providers shall have the skill to apply current knowledge about mental health issues and substance-use issues and co-occurring disabilities and treatment methods. Volunteers and Committee members shall have an awareness of current knowledge about mental health and substance-use issues and co-occurring disabilities.

m. Staff members and providers shall have the knowledge and skill to apply current principles and procedures for providing services to children and adults with mental health and substance-use issues and co-occurring disabilities. Areas addressed shall include recovery-oriented assessment and services, principles of relapse prevention, psychosocial rehabilitation services, age-appropriate assessments and services for individuals across the lifespan, trauma assessment and treatment approaches, including symptom self-

management, the relationship between trauma and mental health and substance-use issues, and culturally and linguistically appropriate service.

n. Staff members, providers, and volunteers working directly with consumers shall have the knowledge and skill to apply techniques and procedures for providing non-violent crisis management, including verbal de-escalation, methods for obtaining backup and acceptable methods for self-protection and protection of the individual and others in emergency situations. Staff members shall have skills for suicide prevention and management beyond suicide assessment.

o. Staff members, providers, and volunteers working directly with consumers shall have the specific knowledge and skills necessary for the position for which they are hired, beyond the clinical skills necessary as defined in (j), yet necessary for their specific position.

Ongoing Training Program

1. The CCS Administrator and/or a designee shall ensure that each staff member receives at least 8 hours of in-service training a year.

   a. Training shall be designed to increase the knowledge and skills received by staff members in the orientation training provided under paragraph (b)

   b. Staff shared with other community mental health, substance-use or addiction programs, may apply documented in-service hours received in those programs toward this requirement if that training meets the requirements under this Chapter.

   c. Ongoing in-service shall include one or more of the following:
      i. Time set aside for in-service training, including discussion and presentation of current principles and methods of providing psychosocial rehabilitation services.
      ii. Presentations by community resource staff from other agencies, including Consumer operated services.
      iii. Conferences or workshops.

3. Volunteers shall receive annual training as needed related to changes in practice and policy related to CCS.

4. Updated, written copies of the orientation and ongoing training programs and documentation of the orientation and ongoing training received by staff members, subcontractors, and volunteers shall be provided to the Mental Health and Substance Abuse Operations Administrator via the RWC SharePoint site.

Consumer Application

Referral

Screening

Service Facilitation

Recovery Team Development

Policy addresses: DHS 36.13

Purpose

To provide a process for application and screening that shall ensure that eligible applicants are admitted to the RWC-CCS, while also initiating and fostering the development of the recovery team.

Policy

RWC - CCS shall provide and have procedures in place for receiving consumer applications, functional and financial screening, clinical assessment and recovery team development for individuals enrolled in CCS.

Procedure:

Application and Screening-Children, Youth, and Adults:

1. Any person may apply for CCS services.
2. The application process can begin in a number of ways:
    a. Consumer application
    b. Outreach request
    c. Delivery of another service
3. The county-based on-site administrator shall assign a service facilitator to complete the process.

4. The CCS Service Facilitator reviews the information provided and sets up an initial outreach meeting. During this outreach meeting, the following may occur, but in no particular order:

    a. The consumer's application for CCS services is reviewed.
    b. The Service Facilitator completes consumer outreach as needed.
    c. The Service Facilitator may complete the following steps:
        i. Informed Consent (Financial, Treatment and Functional Screen) and Releases.

   ii. Physician Prescription (An allowable, Medicaid enrolled prescriber such as an MD, DO, PA or APNP, working within their scope of practice, needs to provide a prescription for CCS to be billed to Medicaid.)
   iii. Service/Admissions Agreement.
   iv. Functional Screen.
   v. Need for immediate services is reviewed and determined.

4. During the intake and assessment process (functional screen and comprehensive assessment), team members, including natural supports and providers if they are able, participate in the assessment process.

5. Once all necessary information has been obtained, the Service Facilitator completes the Functional Eligibility Screen.

6. Upon completion of the functional eligibility screen and when the consumer is indicated to be an appropriate CCS participant, per the functional eligibility, the assessment process continues to include a comprehensive assessment, Mental Status Exam and Determination of Need.

7. If the consumer is deemed appropriate for services via the functional screen, comprehensive assessment and determination of need, then she/he will collaborate with the service facilitator to develop an individualized service plan.

8. If the person does not meet requirements for CCS, during any of the steps, then the following applies:
   i. No additional psychosocial rehabilitation services shall be provided to the consumer through CCS.
   ii. The consumer and team members shall discuss appropriate referrals to other non CCS services as needed and/or identify how the consumer's needs may be met by use of informal supports.
   iii. The consumer shall be provided information on their right to submit a written request for a review of determination of need for psychosocial rehabilitation services to the Bureau of Mental Health and Substance Abuse Services.

9. If CCS is deemed necessary and appropriate the consumer is eligible for CCS services then the following occurs:

   a. The service planning process is explained and initial planning for the Recovery Team begins.
   b. Within 30 days of admission to CCS (admission date is considered to be the application date), one or more recovery team meetings shall be scheduled and the written comprehensive assessment shall be completed.

Recovery Team Development:

1. The Recovery Team development process begins during the admission and team development meeting is held after the consumer's admission to the CCS has been established.

2. The consumer and their legal representative (when applicable) shall be involved in choosing the members of their recovery team.

3. The Recovery Team shall include all of the following:
   a. The consumer

   b. A service facilitator

   c. A clinical coordinator and/or substance-use professional (If the consumer has or is believed to have a co-occurring condition, then the team shall include both a mental health professional and a substance-use professional or a person who has the qualification of both)

   d. Service providers, family members, natural supports and advocates, with the consumer's consent, unless their participation is unobtainable or inappropriate

   e. If the consumer is a minor or incompetent or incapacitated, a parent or legal representative shall be included on the recovery team.

4. The role of each team member shall be guided by the nature of the member's relationship to the consumer and the scope of the members' practice

5. Team members shall participate in the assessment process and service planning, in addition to the ongoing monitoring of the service plan and necessary reviews.

6. Team members shall provide information, evaluate input from various sources and make collaborative recommendations regarding outcomes, services and supportive activities. This partnership shall be built on the cultural norms of the consumer.

Criteria for Determining the Need for Psychosocial Rehabilitation Services

Policy addresses: DHS 36.14

Introductory Statement:
Psychosocial rehabilitation services shall be available to individuals who are determined to require more than outpatient counseling but less than the services provided by a community support program (DHS 63) and as a result of the functional screen. The consumer shall meet all of the following criteria:

1. Has a diagnosis of a mental disorder or a substance use disorder.
2. Has a functional impairment that interferes with or limits one or more major life activities and results in needs for services that are described as ongoing, comprehensive and either high-intensity or low-intensity. Determination of a qualifying functional impairment is dependent upon whether the applicant meets one of the following descriptions:
   a. "Group 1" – Persons in this group include children and adults in need of ongoing, high-intensity, comprehensive services who have diagnosis of a major mental disorder or substance use disorder, and substantial needs for psychiatric, substance abuse, or addiction treatment.
   b. "Group 2" – Persons in this group include children and adults in need on ongoing, low-intensity comprehensive services who have a diagnosed mental or substance use disorder. These individuals generally function in a fairly independent and stable manner but may experience acute psychiatric crises.
3. If the department-approved functional screen cannot be completed at the time of the consumer's application, the CCS shall conduct an assessment of the applicant's needs pursuant to the DHS 36.16 (3) and (4) assessment process.
4. If an applicant is determined to not need psychosocial rehabilitation services, no additional psychosocial rehabilitation services may be provided to the applicant by the CCS program.
5. If an applicant is determined to need psychosocial rehabilitation services, a comprehensive assessment shall be conducted under s. DHS 36.16 (3) and (4) unless the following conditions are present:
   a. A comprehensive assessment was conducted and completed.
   b. The consumer qualifies for an abbreviated assessment under s. DHS 36.16 (5).

Service Authorizations

Policy addresses: DHS 36.15

Introductory Statement:
The RWC CCS shall provide services in accordance with an individuals assessed need as well as consumer choice.

Procedure:

1. A service authorization may be provided after the development of the individualized service plan (ISP) or when there is an immediate need for services, but only after the following steps have been taken:
    - **a.** Informed Consent (Treatment, Functional Screen, Financial)
    - **b.** Physician Prescription
    - **c.** Functional Screen – Deemed eligible for CCS
    - **d.** Application and Service Agreement
2. Unless there is an immediate need, the Clinical Coordinator shall do all of the following:
    a. Complete a Mental Status Exam.
    b. Review the parts of the comprehensive assessment completed by the service facilitator.
    c. Review and attest to the consumer's need for psychosocial rehabilitation services via the Determination of Need.
    d. Authorize services via the Determination of Need as well as the assessment and service plan.
    e. Review and attest to the services outlined in the Individualized Service Plan (ISP), per their signature.
3. When an immediate need for services exists, the service facilitator shall assure that the steps outlined in #1 have been completed and review the consumer's need with the clinical coordinator during supervision or consultation. The service/admissions agreement shall be signed by the clinical coordinator indicating the need for immediate services. This assures that the consumer does not experience an interruption in necessary services.
4. If the applicant has or may have a substance-use disorder, a substance abuse professional shall also sign assessment and service plan which functions as the authorization for services.

Assessment

Policy addresses: DHS 36.16

Introductory Statement:

To ensure that individualized service plans and services provided to consumers are based on accurate and complete evaluations of the individual strengths, needs and desires of each consumer, a comprehensive assessment shall be conducted for each eligible applicant of RWC - CCS in order to identify strengths, needs and desired outcomes of the participant and to evaluate progress toward those outcomes.

Procedure:

1. Facilitation

    a. The assessment process shall be explained to the consumer and, if appropriate, a guardian or legal representative.

    b. The Service Facilitator shall carry out the assessment process in collaboration with the Consumer, their Recovery Team, the designated Clinical Coordinator, and when applicable the Substance Abuse Professional.

    c. The Service Facilitator shall have assessment participants complete an assessment sign-in form.

    d. The Service Facilitator may recommend/suggest the use of advocacy services if no social supports are available to the consumer.

    a. In circumstances where there may be a substance-use issue, a qualified substance abuse professional shall;

        i. Establish if a substance-use diagnosis exists; and

        ii. Conduct an assessment of the consumer's substance-use, strengths and treatment needs

    b. The assessment shall be completed within 30 days of the consumer’s application for service.

2. Assessment Criteria

    The assessment shall be comprehensive and accurate and conducted within the context of the domains listed in this policy. The assessment shall be consistent with all of the following:

- Be based upon known facts and recent information and evaluations and include assessment for co-existing mental health issues, substance-use issues, physical or mental impairments and medical problems.
- Be updated as new information becomes available.
- Address the strengths, needs, recovery goals, priorities, preferences, values and lifestyle of the Consumer.
- Address the influence of age and developmental factors upon the identified goals and desired outcomes, and address preferred methods for achieving the identified goals given these influences.
- Identify the impact of cultural and environmental supports upon identified goals and desired outcomes, and address preferred methods for achieving the identified goals given this impact.
- Identify the Consumer's recovery goals and his/her understanding of options for treatment, psychosocial rehabilitation services and self-help programs to achieve those goals.

3. Assessment Domains. The assessment process shall address all of the following domains of functioning:
    a. Life satisfaction

    b. Basic needs

    c. Social network and family involvement (Family involvement means the activities of a family member to support a Consumer receiving psychosocial rehabilitation services. Except where rights have been terminated, the family of a minor shall always be included. The family of an adult Consumer may be involved only when the adult has given written permission.)

    d. Community living skills

    e. Housing issues

    f. Employment

    g. Education

    h. Finances and benefits

    i. Mental health

    j. Physical health

    k. Substance use

    l. Trauma and significant life stressors

m. Medications

n. Crisis prevention and management

o. Legal status

p. Any other domain identified by CCS

4. Abbreviated Assessment

a. The assessment may be abbreviated if the Consumer has signed an application and one of the following circumstances applies:

i. The consumer's health or symptoms are such that only limited information may be obtained immediately; or

ii. The consumer chooses not to provide information necessary to complete a comprehensive assessment at the time of application; or

iii. The consumer is immediately interested in receiving only specified services that require limited information.

a. An abbreviated assessment shall meet the requirements of the assessment criteria to the extent possible within the context that precluded a comprehensive assessment.

b. The Assessment Summary and/or a progress note shall include the specific reason for abbreviating the assessment.

c. An Abbreviated Assessment shall be valid for up to 3 months from application.

d. Prior to the expiration date, a comprehensive assessment shall be conducted to continue psychosocial rehabilitation services.

e. If upon expiration of the abbreviated assessment period, the consumer chooses not to participate in a comprehensive assessment or a comprehensive assessment is not possible due to lack of information and/or completion by the consumer, the consumer shall be given written notice of a determination that the consumer does not qualify for psychosocial rehabilitation services.

5. Assessment Summary - Documentation

The Assessment Summary shall be prepared by the Service Facilitator and shall include all of the following:

a. The period of time within which the assessment was conducted. Each meeting date shall be included.

b. A summary of the information on which outcomes and service recommendations are based.

c. Outcomes and measurable goals desired by the consumer.

d. The names and relationship to the consumer of all individuals who participated in the assessment process.

e. Significant differences of opinion, if any, which are not resolved among members of the recovery team.

f. Signatures of persons present at meetings being summarized.

g. Shall be documented as a summary.

Service Planning and Delivery Processes, including Discharge

Policy addresses: DHS 36.17

Introductory Statement:

In order to ensure that a written plan is developed and identifies the psychosocial rehabilitation services to be provided or arranged for a consumer based upon the individualized assessment, a written service plan shall be based upon and completed in conjunction with the comprehensive assessment.

Procedure:

1. Service Plan Process

   The service planning process shall be explained to the consumer and, if appropriate, their legal representative.

   a. The service facilitator, in collaboration with the consumer and recovery team, shall carry out the service planning process.

   b. Service planning shall address the needs and recovery goals identified in the assessment.

   c. The initial service plan shall be completed within 30 days of the consumer's application (CCS admission date).

2. Service Plan Documentation

   The service plan shall include a description of all of the following:

   a. Service Facilitation - The service facilitation activities that shall be provided to the consumer or on the consumer's behalf.

   b. Psychosocial rehabilitation and treatment services - The psychosocial rehabilitation and treatment services to be provided or arranged for the consumer, including the schedules and frequency of services provided.

   c. Service Providers And Natural Supports - The service providers and natural supports that are or shall be responsible for providing the consumer's treatment, rehabilitation, or support services and the payment source for each.

   d. Goals - Measurable goals and type and frequency of data collection that shall be used to measure progress toward desired outcomes.

   e. Attendance Roster - An attendance roster shall be signed by each person, including recovery team members in attendance at each service planning meeting.

f. The roster shall include:

   i. The date of the meeting.
   ii. The name, address, and telephone number of each person attending the meeting

g. The completed service plan shall be signed by the consumer, a mental health professional (Clinical Coordinator) and/or substance abuse professional, the service facilitator and any other identified recovery team members.

h. Documentation of the service plan shall be available to all members of the Recovery Team.

i. The service facilitator shall obtain appropriate authorizations to release information to the recovery team members who are not staff members of the respective Department of Health and Human Services (DHHS) or Department of Human Services (DHS).

j. The service plan document shall be maintained in the consumer treatment record. Each original, updated and partially completed service plan shall be maintained in the consumer treatment record.

3. Service Plan Review

The service plan for each consumer shall be reviewed and updated at least every 6 months.

a. A service plan that is based on an abbreviated assessment shall be reviewed and updated upon completion of a comprehensive assessment.

b. The service plan for each consumer shall be reviewed and updated if the needs of the consumer change.

c. The review shall include an assessment of the progress toward goals and consumer satisfaction with services.

4. Service Delivery

a. Psychosocial rehabilitation and treatment services shall be provided in the most natural and least restrictive manner and most integrated settings. Services shall be delivered with reasonable promptness and build upon the natural supports available in the community

b. Services shall be provided with sufficient frequency to support achievement of goals identified in the service plan.

c. Documentation of the services shall be included in the service record of the Consumer under the requirements in s. DHS 36.18.

5. Discharge - Consumers shall enter into CCS services with the idea that they shall recover and at some point in time, no longer be in need of formalized psychosocial rehabilitation services.

6. A consumer's service plan shall identify recovery goals.

   a. Service facilitators shall recognize that discharge criteria may change over time and shall work with consumers and their recovery teams to review criteria at regular plan review intervals

7. Discharge from CCS shall generally be a planned process involving the consumer in the decision to terminate services. The primary reason for discharge shall be because the consumer is no longer in need of psychosocial rehabilitative services.

8. Discharge from the CCS may also occur when:

   a. The consumer chooses another path for recovery and no longer wants and/or needs psychosocial rehabilitation services through CCS.

   b. The whereabouts of the consumer have been unknown for at least three months despite diligent efforts to locate the consumer.

   c. The consumer refuses services from CCS for at least three months despite diligent outreach efforts to engage the consumer.

   d. A consumer is placed in a long-term facility such as a nursing home. Potential for discharge to independent community living shall be reviewed with the Recovery Team and Service Director at 30-day intervals for a period not to exceed 90 days.

   e. The consumer is incarcerated for an extended period. Potential for release to independent community living shall be reviewed with the Recovery Team and Service Director at 30-day intervals for a period not to exceed 90 days.

   f. If during the course of care, a consumer's actions become a significant danger to the Recovery Team, such as repeated threats or assaultive behaviors. Each situation shall be dealt with on a case-by-case basis. Recommendations could include police involvement i.e. emergency detention, charges filed or mediation with CCS staff. These cases shall be staffed with the consumer's Recovery Team and clinical coordinator for treatment recommendations prior to implementing an administrative discharge.

   g. If an AODA assessment is refused or is completed and the consumer and the AODA counselor cannot come to a mutual acceptance of the need for treatment and/or proper

AODA treatment for recovery; or if the consumer's continued abuse of alcohol and/or other drugs interferes with their ability to engage in their CCS services. These cases shall be staffed with the consumer's Recovery Team and Clinical Coordinator/Service Director for treatment recommendations.

h. If a consumer has maximized their ability to develop and invest in recovery focused goals, or has increased their capability to rely on developed natural community supports or partners in hope for recovery, or is unable to recognize their capabilities (e.g. not open minded regarding discussion of discharge), which in turn limits their awareness of recovery possibilities.

i. A consumer is determined functionally ineligible for CCS services as calculated by the State of Wisconsin DHS Mental Health/AODA Functional screen or Children's LTS Functional screen.

j. The consumer moves out of the service area.

k. The consumer is deceased.

9. When a consumer is discharged from CCS, whether voluntarily or involuntarily, the consumer shall be given written notice of the discharge (Discharge Summary), to include:

    i. The reason for the discharge.
    ii. Consumer status and condition at discharge including the consumer's progress toward the outcomes specified in the service plan.
    iii. An outline of the conditions that would indicate renewed participation in the program and need for psychosocial rehabilitation services.
    iv. A list of recommended service options that may be available to the consumer.
    v. Written procedures on how to re-apply for CCS services.
    vi. Information regarding post-discharge follow-up by the QI team.

10. If a consumer is discharged from CCS voluntarily, the following shall occur:

    a. The consumer, Service Facilitator and Mental Health (Clinical Coordinator) or Substance Abuse Professional shall sign the discharge summary when discharge has been planned.

    b. With consumer consent, the discharge summary shall be shared with providers who shall subsequently be providing further support or services.

11. If a consumer is discharged from CCS involuntarily, the consumer shall hold the right to appeal the decision of termination and shall be given information on how to submit a written request for review of the discharge to the Department's Client Rights Specialist.

Required Forms:

- N/A

Reporting of Consumer/Patient Death Attributable To Suicide, Restraint, or Psychotropic Medication

Introductory Statement:
The RWC shall report the death of any consumer receiving services when there is reasonable cause to believe that the death is related to the use of physical restraint, psychotropic medications, or suicide.

Procedures:

1) It is the responsibility of any staff member who has become aware of a reportable death to notify the Medical Director, Program Administrator, Program Manager or Agency Director, or his/her designee and prove an initial verbal report of the death.
    a. Northwest Connections Director shall also be notified if Northwest Connections was a service provider of the consumer.
    b. When the service is part of the consortium, the RWC Program Administrator/Mental Health and Substance Abuse Operations Administrator needs to be informed of the death to complete the report on behalf of the lead agency.
2) The Consumer/Patient Death Determination Guidelines as outlined on page 3 of form F62470 shall be utilized to assist in determining if there is reasonable cause to believe the consumer death is due to use of restraint, seclusion, psychotropic medications or suicide.
3) The Medical Director, Program Administrator, Program Manager or Agency Director who was notified of the death shall designate a staff member to complete the "Consumer/Patient Death Determination Form" (F 62470). If Northwest Connections was a service provider of this consumer they may assist.
4) Within 24 hours after the death of a consumer, or learning of a death, notification shall be made to the Wisconsin Department of Health and Family Services. The Consumer/Patient Death Determination Form shall be faxed to the DQA Director Section Chief at (608) 261-0655.for the respective program reporting a death.
5) Within two weeks of submitting Consumer/Death Determination Form, the medical director, Program Manager, Emergency Services Director, behavioral health staff directly involved in care of consumer and their Lead Worker shall conduct a clinical review of the death that shall be documented in the chart on Form DQA-2486 (Report and Summary Consumer/Patient Death Quality Improvement Event Analysis). NWC shall be included in clinical review if they participated in consumer care. Additional input may be obtained from a mental health professional not directly involved in the individual's treatment.

6) A plan for contacting family members of the consumer shall be developed with the DHS Reportable Death Review Coordinator.

References:
Form F-62470 Consumer/Patient Death Determination

Suicide Debriefing

Introductory Statement:
In addition to the completion of the DHS reporting requirements, the RWC shall provide support to staff and families following the suicide of a consumer.

Procedures:

1. As soon as possible following the suicide of a consumer, but no later than seven (7) days following the death, the staff involved may participate in a postvention. The postvention shall generally be conducted by a clinical supervisor or designee. The purpose of the postvention is to allow the staff to process their reactions and gain support.
2. Within one month following a consumer suicide, a clinical review of the record shall be completed. Assignment of the staff person or team to complete the review shall be done by the On-site Administrator in collaboration with the Clinical Coordinator. Assignment shall be made to someone not directly involved in the treatment of the consumer. The purpose of the review is to assure quality care and appropriate documentation.
3. Active efforts shall be made to refer family members or other concerned persons following a consumer suicide to other providers for debriefing or other services. Where appropriate the RWC shall provide this service.
4. It is noted that a person's legal rights do not stop when they die, thus, there may be no release of confidential information without proper legal authorization. Any requests for information should follow the release of information procedure with legal consultation as needed.

Technology User Request

Introductory Statement:

This procedure addresses the process used to obtain authorization and in turn gain access to RWC technology systems.

Applies to the following technology systems:

- RWC SharePoint site
- Netsmart- AVATAR Electronic Health Record (EHR)

Employees, Providers, or Partners that are pre-approved for Remote Access include:

- RWC Governance Partners
- Subcontractors providing crisis services
- Subcontractors providing Comprehensive Community Services

Procedure:

1. The On-Site Administrator/Manager shall determine the specific needs of the employee and/or vendor/provider.
2. After determining the individual's needs, the On-Site Administrator/Manager shall complete the JotForm "SharePoint Changes JotForm, or the "Avatar User Maintenance JotForm" which is located on the RWC SharePoint site
3. The Lead Agency IT Staff person shall complete the necessary processes to provide access to AVATAR and the SharePoint site as appropriate, based on request submitted via the JotForm.
4. The Lead Agency IT Staff person shall communicate to contracting to assure that the costs associated with the technology are appropriately allocated.
5. Upon termination of the need for access (last date of employee service or last date of provider service). If termination date is known in advance, please provide as much advanced notice as is possible. The same JotForm is completed by the county onsite manager or contracted provider agency

Remote Access

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Contractual Expectations:

To establish guidelines and define standards for remote access to the Western Region Recovery and Wellness Consortium's information resources (networks, systems, applications, and data including but not limited to, electronic protected health information (ePHI) received, created, maintained or transmitted by the organization). Remote access is a privilege, and is granted only to remote users who have a defined need for such access, and who demonstrate compliance with the Western Region Recovery and Wellness Consortium's established safeguards which protect the confidentiality, integrity, and availability of information resources. These safeguards have been established to address HIPAA Security regulations including:

- Workforce Clearance Procedures [45 CFR §164.308(a)(3)(ii)(B)]
- Access Authorization [45 CFR §164.308(a)(4)(ii)(B-C)],
- Automatic Logoff [45 CFR 164.312(a)(2)(iii)],
- Supervision [45 CFR §164.308(a)(3)(ii)(A)],
- Termination Procedures [45 CFR §164.308(a)(3)(ii)(C)].
- Security Management Process (164.308a1i);
- Security Incident Procedures (164.308a6i-ii);
- Sanction Policy (164.308a1iiC); and
- Health Information Technology for Economic and Clinical Health Act (HITECH), revisions to 45 C.F.R. Parts 160, 162, & 164

Responsible for Implementation:

HIPAA Security Officer

Applicable To:

All users who work outside of the Organization's environment, who connect to the organization's network systems, applications and data, including but not limited to applications that contain ePHI, if applicable, from a remote location.

Violation of these expectation and its procedures by workforce members may result in corrective disciplinary action, up to and including termination of employment. Violation of these expectations and procedures by others, including providers, providers' offices, business associates and partners may result in termination of the relationship and/or associated privileges. Violation may also result in civil and criminal penalties as determined by federal and state laws and regulations.

Purpose:

The purpose of these expectations is to establish uniform security requirements for all authorized users who require remote electronic access to the Western Region Recovery and Wellness Consortium's network and information assets. The guidelines set forth in these expectations are designed to minimize exposure to damages that may result from unauthorized use of the Western Region Recovery and Wellness Consortium's resources and confidential information.

Scope:

These expectations apply to all authorized system users, including members of the workforce, business associates, and vendors, desiring remote connectivity to the Western Region Recovery and Wellness Consortium's networks, systems, applications, and data. Users are frequently categorized in one of these user groups:

1. **Workforce members with permanent remote access.** These users are often Information Services (IS), executive, or specific administrative staff, business staff, providers, or teleworkers who require 24-hour system availability and are often called upon to work remotely or who travel often. Their remote access offers the same level of file, folder and application access as their on-site access.

2. **Workforce members with temporary remote access.** These users typically request short-term remote access due to an extended time away from the office most frequently as a result of a short-term medical or family leave. Access for these users is typically restricted to only that which is necessary for task completion during time away from the office and may be limited.

3. **Contractors and Vendors offering product support with no access to PHI.** These users have varied access depending upon the systems needed for application or system support, but do not have access to any PHI in the applications or systems. These users access the system on an as needed, or as called upon basis for system troubleshooting.

4. **Contractors and Vendors offering product support and other Business Associates with access to PHI.** These users have varied access to PHI depending on the application or system supported and/or accessed. Appropriate Business Associate Agreements must be on file prior to allowing access, and all such access must be audited on a regular basis.

Key Definitions:

Defined Network Perimeter. Refers to the boundaries of the Western Region Recovery and Wellness Consortium's internal computer network.

Electronic Protected Health Information (ePHI). Protected health information means individually identifiable health information that is: transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.[1]

[1] 45 CFR § 164.503.

Firewalls. A logical or physical discontinuity in a network to prevent unauthorized access to data or resources. A firewall is a set of hardware and/or related programs providing protection from attacks, probes, scans and unauthorized access by separating the internal network from the Internet.

Information Resources. Networks, systems, applications, and data including but not limited to, ePHI received, created, maintained or transmitted by the Western Region Recovery and Wellness Consortium.

Protected Health Information (PHI). Individually identifiable health information that is received, created, maintained or transmitted by the organization, including demographic information, that identifies an individual, or provides a reasonable basis to believe the information can be used to identify an individual, and relates to:

- Past, present or future physical or mental health or condition of an individual;
- The provision of health care to an individual;
- The past, present, or future payment for the provision of health care to an individual.

Privacy and Security Rules do not protect the individually identifiable health information of persons who have been deceased for more than 50 years.[2]

Privileged Access Controls. Includes unique user IDs and user privilege restriction mechanisms such as directory and file access permission, and role-based access control mechanisms.

Remote Access. Remote access is the ability to gain access to a <Organization's> network from outside the network perimeter. Common methods of communication from the remote computer to the Western Region Recovery and Wellness Consortium's network includes, but is not limited to, RWC SharePoint site web-based Netsmart-AVATAR electronic health record, and other methods which employ encrypted communication technologies.

Role-Based Access. Access control mechanisms based on predefined roles, each of which has been assigned the various privileges needed to perform that role. Each user is assigned a predefined role based on the least-privilege principle.

Teleworker. An individual working at home (or other approved location away from the regular work site) on an established work schedule using a combination of computers and telecommunications.

Virtual Private Network (VPN). A private network that connects computers over the Internet and encrypts their communications. Security is assured by means of a tunnel connection in which the entire information packet (content and header) is encrypted. VPN technology should use accepted standards of encryption, based, for example, on FIPS 140-2.

Web-based Portal. A secure website offering access to applications and/or data without establishing a direct connection between the computer and the hosting system. Web-based portals most often use 128-bit or higher SSL encryption.

Workforce Member. Workforce means employees, volunteers (board members, community representatives), trainees (students), contractors and other persons whose conduct, in the

[2] § 164.502(f).

performance of work for a covered entity, is under the direct control of such entity, whether or not they are paid by the covered entity.[3]

Procedures:

1) Gaining Remote Access
   A) Refer to "IT User Request" procedure for definition of roles preapproved for remote access.
   B) Workforce members shall apply for use of RWC technology solutions by completing a "Technology User Request" jotform (refer to the IT User Request Procedure). Remote access is strictly controlled and made available only to workforce members with a defined business need, at the discretion of the workforce member's manager, and with approval by the Security Officer or designee.
   C) The workforce member is responsible for adhering to all of the Western Region Recovery and Wellness Consortium's policies and procedures, not engaging in illegal activities, and not using remote access for interests other than those for the Western Region Recovery and Wellness Consortium.[4]
   D) Business associates, contractors, and vendors may be granted remote access to the network, provided they have a contract or agreement with the Western Region Recovery and Wellness Consortium which clearly defines the type of remote access permitted (i.e., stand-alone host, network server, etc.) as well as other conditions which may be required, such as virus protection software. Such contractual provisions must be reviewed and approved by the Security Officer and/or legal department before remote access will be permitted. Remote access is strictly controlled and made available only to business associates and vendors with a defined business need, at the discretion of and approval by the Security Officer or designee.
   E) All users granted remote access privileges must sign and comply with the "Information Access & Confidentiality Agreement" kept on file with the Human Resources Department or other department as determined by the Western Region Recovery and Wellness Consortium.
   F) It is the remote access user's responsibility to ensure that the remote worksite meets security and configuration standards established by the Western Region Recovery and Wellness Consortium. This includes configuration of personal routers and wireless networks

2) Equipment, Software, and Hardware
   A) The organization will not provide all equipment or supplies necessary to ensure proper protection of information to which the user has access. The following assists in defining the equipment and environment required.
      i) RWC Provided:
         (1) SharePoint- Web based, secure information sharing site
         (2) Netsmart - AVATAR

[3] 45 CFR § 164.103.
[4] All P&Ps need to consider remote access.

ii) Contractor Provided:
(1) Encryption of any end user devices where PHI is stored
(2) Anti-Virus Protection
(3) Broadband connection and fees
(4) Paper shredder (Cross-Cut or Confetti Style)
(5) Printer (if needed)
(6) Phone (if needed)
(7) Secure office environment isolated from visitors and family
(8) A lockable file cabinet or safe to secure documents when unattended

B) Remote users will be allowed access through the use of equipment owned by or leased to the entity, or through the use of the workforce member's personal computer system provided it meets the minimum standards developed by the Western Region Recovery and Wellness Consortium, as indicated above. (The Organization must determine minimum standards based on FIPS 140-2 or its successor.)

C) Remote users utilizing personal equipment, software, and hardware are:
i) Responsible for remote access. The Western Region Recovery and Wellness Consortium will bear no responsibility if the installation or use of any necessary software and/or hardware causes lockups, crashes, or any type of data loss.
ii) Responsible for remote access used to connect to the network and meeting the Western Region Recovery and Wellness Consortium requirements for remote access.
iii) Responsible for the purchase, setup, maintenance or support of any equipment not owned by or leased to the Western Region Recovery and Wellness Consortium.

D) Continued service and support of the Western Region Recovery and Wellness Consortium owned equipment is completed by IS workforce members. The Western Region Recovery and Wellness Consortium will provide documentation of setup processes. When possible, the Western Region Recovery and Wellness Consortium will provide support for the technology solutions named in Section A (i). Troubleshooting of telephone or broadband circuits installed is the primary responsibility of the remote access user and their Internet Service Provider. It is not the responsibility of the Western Region Recovery and Wellness Consortium to work with Internet Service Providers on troubleshooting problems with telephone or broadband circuits not supplied and paid for by the Western Region Recovery and Wellness Consortium.

E) The ability to print a document to a remote printer is not supported without the organization's approval. Documents that contain confidential business or ePHI shall be managed in accordance with the Western Region Recovery and Wellness Consortium's confidentiality and information security practices.

3) Security and Privacy

A) Only authorized remote access users are permitted remote access to any of the Western Region Recovery and Wellness Consortium's computer systems, computer networks, and/or information, and must adhere to all of the Western Region Recovery and Wellness Consortium's policies.

B) It is the responsibility of the remote access user, including Business Associates and contractors and vendors, to log-off and disconnect from the Western Region Recovery

and Wellness Consortium's network when access is no longer needed to perform job responsibilities.

C) Remote users shall lock the workstation and/or system(s) when unattended so that no other individual is able to access any ePHI or organizationally sensitive information. In addition, remote users will implement a screen saver lock automatically after 15 minutes of no activity.

D) .

E) It is the responsibility of remote access users to ensure that unauthorized individuals do not access the network. At no time will any remote access user provide (share) their user name or password to anyone, nor configure their remote access device to remember or automatically enter their username and password.

F) Remote access users must take necessary precautions to secure all of the Western Region Recovery and Wellness Consortium's equipment and proprietary information in their possession.

G) Virus Protection software is installed on all the Western Region Recovery and Wellness Consortium's computers and is set to update the virus pattern on a daily basis. This update is critical to the security of all data, and must be allowed to complete, i.e., remote users may not stop the update process for Virus Protection, on organization's or the remote user's workstation. Virus scan should be completed weekly.

H) A firewall shall be used and may not be disabled for any reason.

I) Copying of confidential information, including ePHI, to personal media (hard drive, USB, cd, etc.) is strictly prohibited, unless the organization has granted prior approval in writing.

J) Electronic Data Security
   i) Backup procedures have been established that encrypt data moved to an external media. If there is not a backup procedure established or if the Western Region Recovery and Wellness Consortium has external media that is not encrypted, contact the IS Department or Security Officer for assistance.
   ii) Transferring data to the Western Region Recovery and Wellness Consortium requires the use of an approved secure connection to ensure the confidentiality and integrity of the data being transmitted. Users may not circumvent established procedures when transmitting data to the Western Region Recovery and Wellness Consortium.
   iii) Users may not send any ePHI via e-mail unless it is encrypted. If PHI or ePHI needs to be transmitted through email, IS or the Security Officer must be contacted to ensure an approved encryption mechanism is used.

K) Paper document security
   i) Remote users are discouraged from using or printing paper documents that contain PHI.
   ii) Documents containing PHI must be shredded before disposal consistent with the "Device, Media and Paper Record Sanitization for Disposal or Reuse" expectations and procedures.

4) <u>Enforcement</u>

A) Remote access users who violate this expectation are subject to sanctions and/or disciplinary actions, up to and including termination of employment or contract.

Termination of access by remote users is processed in accordance with the Western Region Recovery and Wellness Consortium's termination expectation.

B) Remote access violations by Business Associates and vendors may result in termination of their agreement, denial of access to the Western Region Recovery and Wellness Consortium's network, and liability for any damage to property and equipment.

Applicable Standards and Regulations:

- 45 CFR §164.312(a)(2)(iii) – HIPAA Security Rule Automatic Logoff
- 45 CFR §164.308(a)(3)(ii)(B) – HIPAA Security Rule Workforce Clearance Procedures
- 45 CFR §164.308(a)(3)(ii)(C) – HIPAA Security Rule Termination Procedures
- 45 CFR §164.308(a)(4)(ii)(B-C) – HIPAA Security Rule Access Authorization

References

Federal Information Processing Standard (FIPS) Publication 140-2

Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS),"HIPAA Security Guidance" (12/28/2006)
http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/remoteuse.pdf

SANS (SysAdmin, Audit, Network, Security) Institute
The Health Information Technology for Economic and Clinical Health Act (HITECH), part of the American Recovery and Reinvestment Act of 2009 (ARRA)

Treatment Records

Introductory Statement:
Treatment records shall be kept confidential as required under s.51.30, Stats., ch. HFS 92, and 45 CFR Parts 160, 162, and 164, and 42 CFR Part 2.

- The RWC programs shall maintain accurate records of services provided to consumers.
- All treatment records shall be maintained in a secure manner to ensure that unauthorized persons do not have access to the records.
- Maintenance, release, retention and disposition of consumer service records shall be kept confidential.
- The treatment record shall be maintained in an electronic format. The Electronic Health Record (EHR) shall be confidential and meet all state and federal requirements.

A treatment record shall include the following:

- A specific statement of the diagnosis and an explicit description of the behaviors and other signs or symptoms exhibited by the patient;
- Documentation of the emergency when emergency treatment is provided to the patient;
- Clear documentation of the reasons and justifications for the initial use of medications and for any changes in the prescribed medication regimen; and
- Documentation that is specific and objective and that adequately explains the reasons for any conclusions or decisions made regarding the patient.

Procedures:

1. The RWC Mental Health and Substance Use Operations Administrator is responsible for the maintenance and security of consumer service records.
2. Contracted providers shall submit service documentation to the lead county, when services are provided under a county-based certification.
3. Contracted provider service records shall be attached to the Electronic Health Record and be accessible as part of the treatment record for those parties with authorized access.
4. The RWC shall act as the custodian of the consumer records for the required retention period or until the records have been transferred to a new program.

Record Retention

Per DHS 92.12, treatment records shall be retained for at least 7 years after treatment has been completed, unless under this section they are to be retained for a longer period of time.

The following additional situations are listed under DHS 92.12:

- In the case of a minor, records shall be retained until the person becomes 19 years of age or until 7 years after treatment has been completed, whichever is longer.
- Any record undergoing federal or state audit shall be maintained until completion of the audit.
- Records relating to legal actions shall be maintained until completion of the legal action.
- Records relating to billing or collections shall be maintained for periods of time specified in s. DHS 1.06.

1. RWC – Lead Agency Office Associate shall be responsible for annual record retention and destruction.
2. By January 31 of each calendar year, OA shall identify, pull, and destroy division records according to the guidelines and retention period set forth in Appendix A. (These records include applicable paper and electronic copies.)

3. Upon termination of a staff member's association with the RWC, the treatment records for which the staff member was responsible shall remain in the custody of the RWC.
4. In the event of the RWC closing, the lead county agency shall continue to hold the treatment records.

Quality Assurance (QA) Monitoring

Introductory Statement:

The CCS – Leadership Committee has decided to use a Quality Assurance Monitoring process for documentation requirements associated with CCS. The QA checkpoints will be determined utilizing the requirements of the CCS – Medicaid Handbook and the DHS 36 Administrative Code, as well as the specific direction provided by DHS.

Procedure:
QA Process:

Clinical File Review

1. Initial implementation of a QA monitoring process began in February of 2017. Full implementation of a QA monitoring process, including existing consumer files, will be completed by: 08/01/2019. After that time, all files will be engaged in the QA monitoring process.
2. Each county has an assigned QA person, who is a member of the RWC QA Team.
3. Each QA person is trained in the completion of the QA process and attends meetings with the Program Administrator and QA team.
4. The QA person reviews each consumer file utilizing the QA checklist.
5. Each county has an established communication plan which outlines who provides QA feedback to their staff.
6. Each consumer file is engaged in the QA monitoring process.
7. The service facilitator assigned to a consumer initiates each level of QA file review.
8. The levels of QA review include: Billable Review, 30-day Review, 6-month Review, Annual Review, Discharge, and Transfer Review.
9. Each county maintains the QA on the shared RWC SharePoint site.
10. In the event clinical files have been deemed adequate for a period of time, the RWC will move from 100% compliance review to a sampling of files.
11. In the File Sampling Process, the following situations will require submission of files for a QA checkpoint review
    a. All new service facilitators will submit for all checkpoints for their first year of employment with the CCS
    b. All new consumers being enrolled in CCS will have files reviewed by QA for their initial review and 30 day review
    c. If a file has compliance issues identified in the 30 day review, it will be reviewed at the 6 month checkpoint. The file will continue through the QA checkpoints until it is free of compliance issues. Once is has been reviewed and has been free of compliance issues, it will enter the sampling pool.
    d. One file will be reviewed in the sampling pool per month for each CCS service facilitator

e. Managers may direct service facilitators who experience consistent errors to submit file reviews to QA for as long as the Manager determines necessary.

Provider Service Note Review

1. RWC Lead County provides Quality Assurance monitoring of Provider service notes and required staff documentation such as background checks, training and orientation, etc.
2. As new providers engage in contracts with the RWC, their documentation is reviewed by QA staff to ensure certification requirements are met.
3. Initial providers begin with 100% of their service notes being reviewed by QA staff and will progress to having a sampling percentage based on the number or infractions identified.
4. This process allows QA staff to see trends in errors which leads to an opportunity for training, ultimately improving service and program quality.

Required Forms:

- QA Checklist