COMMUNITY SUPPORT PROGRAMS PROCEDURE

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Procedure Name:	CSP HISTORY
Procedure Number:	101
Domain:	CSP
Approved By:	Tita Yutuc, LCSW, President/ CEO
Created/Written By:	Kathy Rohr, Coordinator of Community Services
Effective Date:	1/4/2018
Date(s) of Revision:	
References:	

STATEMENT OF PURPOSE

This procedure outlines the history of Community Support Programs with Family & Children's Center

AREAS OF RESPONSIBILITY

All staff involved with Community Support Programs with Family & Children's Center are responsible for knowing this information.

PROCEDURE

Family & Children's Center began providing Community Support Program services in Vernon County in 1994, when FCC merged with the Douglas Mental Health Center. Douglas Mental Health Center had previously been providing CSP services, for a lengthy period of time. FCC has continued to hold this contract for 23 years, serving up to 60 consumers. Family & Children's Center has become known within Wisconsin as a quality provider of Community Support Program services and as such, the agency has grown these services, as additional contracts have been awarded.

In 2004, FCC expanded CSP services to Jackson County and has held the contract there for 13 years since.

In 2007, FCC expanded again to provide CSP services in La Crosse County in 2007. The agency has successfully held the contract for ten years, serving up to 150 clients.

In 2010, FCC's CSP programs began to provide Peer Support Specialist services within the array of services. Between 2007 and 2014, FCC's CSP programs also developed other best practices, such as implementing Dialectic Behavioral Therapy (DBT) – at the Vernon CSP location only, Person Centered Planning, Motivational Interviewing, Integrated Tobacco Cessation and Individual Placement and Support (IPS) Supported Employment.

In 2014, FCC expanded again to provide CSP as a regional CSP provider, when awarded the contract for the Western Region Integrated Care Consortium (WRIC) CSP, to provide CSP services in La Crosse, Jackson and Monroe counties as a regional provider. Thus, Family & Children's Center provides CSP services in four Wisconsin counties. When considering the four counties and large budgets involved with FCC's CSP programs, CSP is the largest program of the agency.

GETTING HELP

For questions, call the Clinical Coordinator of the Community Support Program you are interested in.

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Procedure Name:	SERVICE PHILOSOPHY, MODALITIES, AND INTERVENTIONS
Procedure Number:	102
Domain:	CSP
Approved By:	Tita Yutuc, LCSW, President/ CEO
Created/Written By:	Kathy Rohr, Coordinator of Community Services
Effective Date:	1/4/2018
Date(s) of Revision:	
References:	HFS 63, Tool for Measurement of Assertive Community Treatment (TMACT), CSP Orientation Checklist, Behavioral Support Manual, CSP Agreement, CSP Medication Consent

STATEMENT OF PURPOSE

This procedure outlines the service philosophy, modalities, interventions, evidence based practice foundation, and funding sources of Family & Children's Center's Community Support Programs.

AREAS OF RESPONSIBILITY

All staff involved with Community Support Programs with Family & Children's Center are responsible for knowing this information.

PROCEDURE

Community Support Programs provide services to adults with serious and persistent mental illness, to help them achieve their highest level of self-sufficiency and recovery through gains in personal empowerment, hopefulness and competency. Services are provided to assist clients to live in the community, avoiding hospitalization, institutionalization, and incarceration, to the fullest extent possible. In addition, services are provided to assist clients in attaining their personal goals.

Community Support Programs in Wisconsin are certified according to the standards of HFS 63. Family & Children's Center's CSP programs provide a higher level of services than required by state statutes, guided by the evidence-based practice of Assertive Community Treatment (ACT), guided by the Substance Abuse and Mental Health Administration's Evidence Based Practice Toolkit for ACT and the Tool for Measurement of Assertive Community Treatment (TMACT). Fidelity to the model is assessed on a yearly basis, with internal use of the TMACT tool.

Family & Children's Center's CSP programs do not utilize any non-traditional or unconventional practices, such as hypnosis, acupuncture, or treatment modalities involving physical contact, restraints or seclusion. The programs do not utilize any of the following: Corporal punishment,

the use of aversive stimuli, interventions that involve withholding nutrition or hydration or that inflict psychological or physical pain, the use of demeaning, shaming or degrading language or activities, forced physical exercise, unwarranted use of invasive procedures, punitive work assignments, punishment by peers, or group punishment or discipline for individual behavior. Please see the Behavior Support Manual (BSM) for further information. CSP program staff are trained in the use of Nonviolent Crisis Prevention through Crisis Prevention Institute (CPI) training, with the goal of preventing crises through the use of de-escalation techniques and strategies. If a client becomes aggressive or threatens aggression, CSP staff will call the police immediately and take action to protect themselves and other clients, with nonphysical intervention. Family & Children's Center is a No Hit Zone. Please see the Family & Children's Center's No Hit Zone Procedure for further information on this.

Services provided within Family & Children's Center's CSP programs are guided by the assessment and prescribed by the recovery plan. Each recovery plan and the interventions for each client are individualized. Service modalities/interventions provided within CSP programs include:

- Assessment
- Treatment planning
- Case management
- Crisis intervention
- Symptom management
- Supportive psychotherapy and psychoeducation
- Medication prescription, administration, monitoring, and documentation
- Psychiatric evaluation
- Employment services
- Social recreational skills training
- Activities of daily living services- including individualized support, problem solving, skills training, and supervision
- Transportation
- Representative payeeship
- Peer specialist

CSP program interventions are discontinued immediately if they produce substantiated problematic adverse side effects or are deemed unacceptable according to prevailing professional standards. The decision to discontinue interventions is made in consideration of an examination of benefit/risk ratio.

Family & Children's Center's CSP programs provide all clients with information regarding the potential benefits and potential risks of all treatment modalities/interventions proposed/used in their treatment. All CSP clients are presented with information about the program as a whole through the use of the CSP Agreement Form. This form is completed within the first 30 days of treatment and annually thereafter. The majority of CSP clients are involved with the program voluntarily, but a small minority of clients are involved involuntarily, as the result of a court order for treatment. In these cases, all consent information is given, but the client may not sign the form, and this would not preclude treatment. Information about specific treatments are addressed individually, on an as-needed basis. Information about the potential risk/benefits of psychiatric medications prescribed within the program are provided through the use of the CSP Medication Consent Form. This form is completed within the first 30 days of treatment, annually thereafter, and upon start of new medications.

CSP program staff are trained to provide modalities of service and interventions within the scope of their role within the program, as indicated by HFS 63. Bachelor level and master level staff with required hours of experience provide case management services, nurses must have their registered nurse (RN) licensure, clinical coordinators must have masters degrees and required hours of experience, mental health technicians provide support services as nondegreed professionals, prescribers must be licensed psychiatrists or APNP's, and peer specialists may meet any level of provider, depending on degree and experience.

QUALIFICATIONS.

(a) CSP staff shall have the following qualifications:

1. A CSP professional shall have a bachelor's degree in a behavioral science or a related field with 1,000 hours of supervised post-degree clinical experience with chronically mentally ill persons, or a bachelor's degree in a field other than behavioral sciences with 2,000 hours of supervised post degree clinical experience with persons with chronic mental illness;

2. A psychiatrist shall be a physician licensed under Ch. 448, Stats., to practice medicine and surgery and shall have satisfactorily completed 3 years' residency training in psychiatry in a program approved by the American medical association;

3. A clinical psychologist shall be licensed under Ch. 455, Stats.

4. A clinical social worker shall have a master's degree from a graduate school of social work accredited by the council on social work education;

5. A registered nurse shall hold a current certificate of registration under Ch. 441, Stats. and shall have experience or education related to the responsibilities of his or her position;

6. Occupational therapists and recreational therapists shall have bachelor's degrees in their respective professions;

7. A rehabilitation counselor shall be certified or eligible for certification by the commission on rehabilitation counselor certification;

8. A vocational counselor shall possess or be eligible for a provisional school counselor certificate and shall have a master's degree in counseling and guidance; and

9. A mental health technician shall be a paraprofessional who is employed on the basis of personal aptitude. A mental health technician shall have a suitable period of orientation and in-service training and shall work under the supervision of a clinical coordinator under sub. (2) (c).

(b) When volunteers are used, they shall be supervised by professional staff under par. (a) 1. to 8. The CSP shall have written procedures for the selection, orientation and in-service training of volunteers.

CSP program staff receive orientation and training that allows them to provide quality services. This orientation is outlined in the CSP Orientation Checklist. New employees complete their orientation within 3 months of their start date, under the supervision of the CSP clinical coordinator.

All cited documents, statutes, and manuals in this procedure can be referenced through hyperlink available in the references section of this procedure.

Funding sources for Community Support Programs in Wisconsin are Medical Assistance, county/regional entities, and managed care organizations.

GETTING HELP

For questions about this procedure, call the Clinical Coordinator of the Community Support Program you are interested in.

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Procedure Name:	SCREENING
Procedure Number:	201
Domain:	CSP
Approved By:	Tita Yutuc, LCSW, President/ CEO
Created/Written By:	Kathy Rohr, Coordinator of Community Services
Effective Date:	1/4/2018
Date(s) of Revision:	
References:	State of Wisconsin, Chapter HFS 63, CSP Referral Forms

STATEMENT OF PURPOSE

This procedure outlines the steps that are taken prior to a client's admission to the Community Support Program (CSP), including referral, collaboration with referral sources, outreach, and screening. Family & Children's Centers CSP program aims to provide or recommend the most appropriate and least restrictive or intrusive service alternative to the person, thru this screening procedure. Further, individuals thru the screening process are informed about:

- How well the individual's request matches FCC's services and;
- What services are available to the person and when.

AREAS OF RESPONSIBILITY

The Clinical Coordinator for each Community Support Program is responsible for carrying out the functions of the procedure.

PROCEDURE

The Family & Children's Center Community Support Programs are contracted with counties or multi-county regions. The primary referral sources for the program are the contracted county/multi-county region and family care entities, although occasionally there are self - referrals or referrals from other agencies or community collaborates, such as from inpatient psychiatric facilities or the Veterans Administration.

Outreach for each Community Support Program takes place upon request from community partners, and is infrequent. Outreach provided is information about Family & Children's Community Support Program services, such as admission criteria, list of services, cost and how to make a referral. Community partners who request outreach presentations include family care organizations, clinics, and NAMI. Outreach specifically to clients or potential clients only occurs after a referral has been made.

The steps of the pre-admission process are as follows:

1. **REFERRAL:** The pre-admission process begins with a referral from either the county/region, family care, other provider/entity or rarely the person. When receiving a referral, the Clinical Coordinator will acknowledge receipt of the referral within seven days, if the referral did not occur in person. Typically, the Clinical Coordinator will also request further information about the person referred. The majority of referrals are involved with treatment providers and are being referred for more intensive services. The referral document can be found hyperlinked in this procedure or upon request from the Clinical Coordinator of the CSP program, you are interested in.

2. **PRIORITIZING ADMISSIONS:** The Clinical Coordinator engages in regular meetings with representatives from the counties to discuss potential admissions and to prioritize in collaboration the order of admissions for persons on a wait list.
   The frequency of these meetings is as follows:
   - Vernon CSP- Every other month in person meeting, as needed via phone between
   - WRIC CSP La Crosse location- Weekly in person meeting
   - WRIC CSP Jackson and Monroe locations- Monthly meeting by phone

   The Family & Children's Center's Community Support Programs screening and intake practices ensure that applicants receive prompt and responsive access to appropriate services. At the meetings with counties/regions, potential admissions are discussed, a wait list is maintained, and a plan is made regarding prioritizing and time frames for screening and intake of county/region referrals. Priority is given in cases where there is urgent needs or emergencies. In addition, plans are put in place for resources or services that will be recommended/provided for those who are referred and cannot be served promptly.
   The wait list is reviewed at each meeting.
   Referrals from sources other than the county/region are prioritized by the clinical coordinator.

3. **SCREENING:** Screening of referrals are conducted by the Clinical Coordinator. Information is attained from the referral source and from records. The Clinical Coordinator decides whether an in person screening for admission is required, as records and referral source may indicate the person is clearly eligible and wants CSP services or is required to participate in them. For example, if a client/consumer is involved with the CCS (Comprehensive Community Services) Program and is

repeatedly hospitalized, the client may clearly need services that are more intensive. In this case, the CCS worker may tell the client/consumer about CSP and the client/consumer may agree to CSP services. However, the majority of admissions are screened in person. Based on all information gathered, the Clinical Coordinator determines if the person meets the admission criteria for the program. Community Support Programs recommend the most appropriate and least restrictive or intrusive service alternative for the person.

Referrals to the program will receive equitable treatment in the screening process. Admission or eligibility criteria for Community Support Programs in the state of Wisconsin are clearly defined by HFS Statute 36, the statute governing these services. These criteria are as follows:
Admission to CSP shall be limited to an individual who has severe and persistent mental illness which by history or prognosis requires repeated acute treatment or prolonged periods of institutional care and who exhibits persistent disability or impairment in major areas of community living as evidenced by:

(a) 1. A condition of chronic mental illness and a diagnosis listed in the DSM-IV-TR within one of the following classification codes:
a. 295.1, .2, .3, .6 and .9 -Schizophrenia
b. 296.2, .3, .4, .5, .6 and .7 -Affective Disorders
c. 297.1 – Delusional Disorder; or
d. 295.7 and 298.9 – Other Psychotic Disorder

2. A significant risk of either continuing in a pattern of institutionalization or living in a severely dysfunctional way if CSP services are not provided; and

3. Impairment in one or more of the functional areas: vocational, education, homemaking, social, interpersonal, community, self-care, or independent living or

(b) 1. A condition of severe and persistent mental illness with another diagnosis listed in the DSM-IV-TR provided that documentation in the client records shows that:

a. There have been consistent and extensive efforts to treat the client, such as use of special structured housing, more frequent outpatient appointments combined with proactive efforts such as home visiting when the client does

not come in for appointments, cooperative efforts by various outpatient, housing, vocational and crisis agencies to coordinate and plan treatment and face-to-face crisis intervention services on a regular basis, with or without crisis housing. The efforts have persisted for at least a year, except in unusual circumstances such as a serious and sudden onset of dysfunction, causing the client's condition to move beyond basic outpatient clinical standards of practice; and

b. The client exhibits persistent dangerousness to self or others

2. A significant risk of either continuing in a pattern of institutionalization or living in a severely dysfunctional way if CSP services are not provided; and

3. Impairment in one of more of the following areas: vocational, educational, homemaking, social, interpersonal, community, self-care, or independent living.

4. **RESULTS OF SCREENING:** The Clinical Coordinator notifies the referral source of the result of the screening process. For those persons found ineligible for services, potential other services are discussed. For those persons found ineligible for services, record of the decision and reason is kept on site. The results of the screening will be shared with the referred person either by the clinical coordinator or by the referral source, depending on the situation. The referred person will be informed about whether they met eligibility criteria, and what services will be available and when.

5. **APPROVAL OF ADMISSIOINS:** All admissions must be approved by either the county/region, family care or other payment source prior to admission. In addition, Medical Assistance pays for a share of services and must be verified prior to admission, although a small portion of clients may be approved by the county/region for admission without Medical Assistance.

6. **ADMISSION/INTAKE:** For persons who meet the eligibility criteria for CSP, agree to services or are legally required to participate in services, and whom are approved by a funding source, the admission/intake process begins. This process is reviewed in the Intake Procedure.

GETTING HELP

For questions about this procedure, call the Clinical Coordinator of the Community Support Program you are interested in.

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Procedure Name:	INTAKE
Procedure Number:	202
Domain:	CSP
Approved By:	Tita Yutuc, LCSW, President/ CEO
Created/Written By:	Kathy Rohr, Coordinator of Community Services
Effective Date:	1/4/2018
Date(s) of Revision:	
References:	Chapter HFS 63, CSP Initial Assessment and Plan, CSP Program Agreement, CSP Client Rights, CSP Informed Consent, CSP Cost of Treatment and Grievance Procedure, Family & Children's Center Permission for Communication, Family & Children's Center HIPPA Acknowledgement of Receipt

STATEMENT OF PURPOSE

This procedure outlines the steps that are taken to intake a client to Family & Children's Center's Community Support Programs, once a person has been determined eligible and approved for funding. Family & Children's Center aims at ensuring the intake process is both prompt and responsive to client needs.

AREAS OF RESPONSIBILITY

The Clinical Coordinator for each Community Support Program (CSP) is responsible for carrying out or ensuring the functions of the procedure are carried out.

PROCEDURE

Once a person has been found eligible for the CSP Program and approved for funding, the steps of the admission/intake process are as follows:

1. In collaboration with the county/region, family care entity, or other funding source, an admission/intake date is set.
2. The Clinical Coordinator will assign a case manager to the person.
3. The Clinical Coordinator or Case Manager will attain medical records for the person, to assist with the psychiatric evaluation and in depth assessment. Releases for the information will have been signed at the screening meeting, attained by the referral source, or signed by the client soon after admission. This information will identify critical service needs and will include personal and identifying information, emergency health needs, and safety concerns, including imminent danger or risk of future harm. All information gathered aims to help identify critical service needs and/or to help determine when a more intensive service is necessary. This information could include but is not limited to emergency health needs and safety concerns.

4. The Clinical Coordinator or Case Manager will set up an appointment for the person with the CSP psychiatrist for as quickly as possible after admission, preferably for within 30 days of admission.
5. No clients will be denied admission or services on the basis of age, race, religion, ethnicity, sexual orientation, gender or gender identity, marital status, arrest or conviction record, ancestry, creed, national origin, disability, or physical condition. Admission will not be denied on the basis of the number of previous admissions to any program or service provider.
6. The Clinical Coordinator or Case Manager will inform the person of the general nature of the program, program regulations governing client conduct, the types of issues that may lead to corrective action, and the process for appeal, the hours which services are available, the service costs that may be billed to them, the program's procedures for follow up if a client is discharged, and their client rights as provided under Ch. HFS 94.
7. The client or legal guardian will sign admission paperwork on the first day of treatment or as soon thereafter as possible, and within 30 days. This paperwork includes: CSP Program Agreement, Client Rights, Informed Consent, Cost of Treatment and Grievance Form, Permission for Communication Form, and HIPPA Acknowledgement. These forms can be found hyperlinked in this policy or in Family & Children's Center's electronic health record.
8. On the first day of services, the Initial Assessment and Plan is completed by the clinical coordinator or case manager. This explains need/appropriateness for CSP services and the plan for services for the first 30 days. This form can be found hyperlinked in this policy or in Family & Children's Center's electronic health record.

GETTING HELP

For questions about this procedure, call the Clinical Coordinator of the Community Support Program you are interested in.

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Procedure Name:	ASSESSMENT
Procedure Number:	301
Domain:	CSP
Approved By:	Tita Yutuc, LCSW, President/CEO
Created/Written By:	Kathy Rohr, Coordinator of Community Services
Effective Date:	1/4/20128
Date(s) of Revision:	
References:	Chapter HFS 63, CSP In Depth Assessment CSP Psychiatric Evaluation, CSP Nursing Assessment, State of Wisconsin Adult Mental Health Functional Screen, CSP Psychiatric Evaluation

STATEMENT OF PURPOSE

This procedure outlines the steps that are taken to provide a comprehensive assessment in the Family & Children's Center's Community Support Programs. Family & Children's Centers Assessment process are both strength based and culturally responsive.

AREAS OF RESPONSIBILITY

The Clinical Coordinator for each Community Support Program (CSP) is responsible for carrying out or ensuring the functions of the procedure are carried out.

PROCEDURE

- Once a person has been admitted to the Community Support Program, a comprehensive assessment is completed within 30 calendar days.
- This assessment is comprehensive, individualized, strength-based, family-focused, and culturally responsive.
- The assessment form used is the CSP in Depth Assessment and this format assesses all domains recommended by state statutes for CSP programs, as well as those recommended by the Assertive Community Treatment (ACT) Evidence Based Practice.
- The assessment examines the person's history of serious and persistent mental illness, treatment and response to treatment, as well as alcohol or other drug use/abuse/dependence. In addition, the assessment takes a holistic look at the person's life, looking at domains such as employment, community living skills, and physical health, to best lead to development of a plan and services that will be individualized and helpful for that person, and to determine current strengths, skills, assets and resources. The assessment looks at the person's life span for themes and patterns, which might be missed with a shorter view. The assessment determines if the person could benefit from services that promote the ability to live and function in the environment of their choice. The assessment involves the client/consumer to the fullest extent allowed by the person.

- The assessment also involves review of medical records and information from other sources, as allowed by the client/consumer, such as family and friends.
- The assessment is completed via a series of interviews with the client and other significant persons in their lives.
- The employee who completes the assessment is either the Clinical Coordinator of the program or the assigned case manager.
    - At WRIC CSP, the case manager completes the In Depth Assessment
    - For Vernon CSP, the Clinical Coordinator completes the In Depth Assessment.
- The In Depth Assessment form can be attained by hyperlink from this document or from Family & Children's Center's electronic health records.
- All Clinical Coordinators and Case Managers are qualified by training, skill and experience to complete the In Depth Assessment. All Clinical Coordinators have Master Degrees with a clinical background and required hours of supervised experience. All case managers have bachelor degrees or higher, with required hours of supervised experience.
- Orientation to these positions includes training on completion of the assessment and the form has been developed to include prompts, which allow for thorough and quality completion of the assessment. In addition, orientation for these positions includes training on interviewing and developing a relationship with clients, to the extent appropriate related to the employee's experience.
- Assessments are conducted in a culturally responsive manner to identify resources that can increase service participation and support the achievement of goals.
- All In Depth Assessments are reviewed and approved by both the Clinical Coordinator and the Program Psychiatrist.
- In addition, to the In Depth Assessment, admissions to the program participate in a psychiatric evaluation with the psychiatrist. This assessment is completed within 30 days of admission. The assessment is completed by a licensed/certified psychiatrist. The psychiatrist reviews medical records and conducts an interview of the client/consumer to establish a firm psychiatric diagnosis, using the standardized tools of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, and the International Statistical Classification of Diseases and Related Health Problems. All new clients meet with the program psychiatrist, although some clients may see Advanced Practice Nurse Prescribers within the program for medication management and counseling after the initial psychiatric evaluation, and a few clients may see providers outside of the CSP program due to extenuating circumstances, such as funding. APNP providers in the program work under the supervision of the program psychiatrist.

  - ➢ The psychiatric evaluation form can be found by hyperlink from this document or in Family & Children's Center's electronic health records.
- In addition to the In Depth Assessment and Psychiatric Evaluation, new admissions meet with a CSP nurse for a health assessment. This assessment is completed within 30 days of admission. This assessment is completed by employees who have at least registered nurse licenses. The employees who complete these assessments receive orientation on interviewing and developing a relationship with clients/consumers as part of their orientation, as appropriate to their level of experience. This assessment includes a review of family medical history, the person's medical history across a wide range of domains, and makes recommendations for how the program can help the person with their health needs, such as helping the person acquire a dentist and what support they might need to get to doctor appointments. This assessment lays the groundwork for assistance the program provides the person related to education and skills training related to health/wellness and lifestyle choices.
- In addition, all admissions are assessed using the State of Wisconsin Adult Mental Health Functional Screen. This screen gathers diagnostic and functional information. The case manager completes the functional screen during the screening process or within 30 days of admission. All case managers undergo online training to conduct functional screens.
  - ➢ The Functional Screen form can be found hyperlinked in this policy.

The Assessment is an essential ongoing activity/service of Family & Children's Center's Community Support Programs. Examples of this include symptom assessment, AODA assessment, and suicide assessment. Further description of ongoing assessment is provided in the Services procedure.

GETTING HELP

For questions about this procedure, call the Clinical Coordinator of the Community Support Program you are interested in.

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Procedure Name:	RECOVERY PLAN
Procedure Number:	401
Domain:	CSP
Approved By:	Tita Yutuc, LCSW, President/ CEO
Created/Written By:	Kathy Rohr, Coordinator of Community Services
Effective Date:	1/4/18
Date(s) of Revision:	
References:	Chapter HFS 63, CSP Initial Assessment and Plan, CSP Recovery Plan, CSP Recovery Plan Review, Brief Psychiatric Rating Scale (BPRS), Suicide Assessment Checklist-Revised (SAC-R)

STATEMENT OF PURPOSE

This procedure outlines the steps that are taken to provide a recovery plan in Family & Children's Center's Community Support Programs. These plans include:

- Agreed upon goals, desired outcomes and timeframes for achieving them;
- Services and supports to be provided and by whom; and
- Signatures of the client being served.

During the process, FCC explains available options and the benefits, alternatives, and consequences of planned services

AREAS OF RESPONSIBILITY

The Case Manager for each client/consumer of each Community Support Program is responsible for ensuring there is a current recovery plan in place to guide treatment. The Clinical Coordinator for each Community Support Program (CSP) is responsible for ensuring the functions of the procedure are carried out.

PROCEDURE

The first recovery plan put in place to guide treatment and services in the Community Support Program is established the day of admission and is called the **Initial Assessment and Plan**. This document is completed by either the Case Manager or the Clinical Coordinator and is reviewed and signed by the Clinical Coordinator and the CSP Psychiatrist. This document identifies diagnosis, appropriateness for Community Support Program, functional deficits understood by the initial brief assessment, brief history and presenting problems, and the plan for treatment for the first 30 days in the program. This plan outlines plan for care, types and frequency of services, and notes particular issues the program will begin helping the client/consumer with in the first 30 days, such as homelessness or need for safe housing, and crisis management. Typically, the plan involves establishing a rapport with CSP staff, managing crises, and completing the In Depth Assessment and full Recovery Plan.

- The Initial Assessment and Plan document can be found hyperlinked to this procedure or in Family & Children's Center's electronic health records.

A full recovery plan is created within 30 days of admission. Recovery planning is done with full client/consumer involvement and with the involvement of family/friends/support system, to the fullest extent allowed by the client/consumer. Recovery plans are created with the use of an in-person recovery plan meeting, with the CSP team, client/consumer and any support persons the client/consumer wishes to invite. Clients/consumers do not need to participate in the meeting if they do not wish, and can create their plan with their case manager individually, which the case manager will then share with the CSP team.

The recovery plan is created using information and themes from the assessment, as well as input from the recovery plan meeting or individual meeting. The recovery plan supports agreed upon goals, improvement in the person's quality of life and ability to manage within the community, and the development of desired skills. Recovery plans are person centered and strength-based, identifying strengths and barriers toward an over-arching life goal, with 3 month and 6 month objectives which are identified steps toward achieving the person's over-arching life goal or toward improving their quality of life or skill development. The recovery plan identifies the plan for services, including who provides the services, type of services, and frequency of services. The recovery plan identifies the current situation, the goals/outcomes and how they can be objectively measured in terms of completion, and the interventions provided to work toward those goals/outcomes. The recovery plan is completed by the person's case manager. CSP case managers are trained in person centered planning and motivational interviewing, which are vital tools in developing recovery plans.

CSP Recovery Plans are completed and reviewed every 6 months or sooner if needed, due to dramatic changes in the person's circumstances or goals. The electronic health records system provides prompts and reminders when recovery plans are due and the Clinical Coordinator schedules the recovery plan meetings. Recovery plans are reviewed and signed by the client/consumer/guardian, the case manager, the Clinical Coordinator and the psychiatrist.

- The CSP Recovery Plan document can be found hyperlinked to this procedure or in Family & Children's Center's electronic health records.

The review of the current plan is completed at the recovery plan meeting or individual meeting, and includes specifically reviewing each objective(3 month and 6 month), with a rating of met, partially met, and not met, with a required explanation of the situation/circumstances/reasoning related to the rating. The recovery plan review document is completed by the case manager and is reviewed and signed by the Clinical Coordinator.

- The recovery plan review document can be found hyperlinked to this procedure or in Family & Children's Center's electronic health records.

The Vernon Community Support Program completes a Brief Psychiatric Rating Scale (BPRS) Assessment and Suicide Assessment Checklist-Revised (SAC-R) every 6 months, at the time of recovery planning. These activities are not required by CSP certification standards but are extra assessment procedures put in place by the program. The BPRS and SAC-R are completed by the case manager. These documents can be found hyperlinked to this procedure or in Family & Children's Center's electronic health records.

GETTING HELP

For questions about this procedure, call the Clinical Coordinator of the Community Support Program you are interested in.

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Procedure Name:	CRISIS PLAN
Procedure Number:	402
Domain:	CSP
Approved By:	Tita Yutuc, LCSW, President/ CEO
Created/Written By:	Kathy Rohr, Coordinator of Community Services
Effective Date:	1/4/2018
Date(s) of Revision:	
References:	Chapter HFS 63, CSP Crisis Plan

STATEMENT OF PURPOSE

This procedure outlines the steps that are taken to provide a crisis plan for each client/consumer in Family & Children's Center's Community Support Programs.

AREAS OF RESPONSIBILITY

The Case Manager for each client/consumer of each Community Support Program is responsible for ensuring there is a current crisis plan in place to guide treatment and assist clients/consumers in managing crises. The Clinical Coordinator for each Community Support Program (CSP) is responsible for ensuring the functions of the procedure are carried out.

PROCEDURE

- A crisis plan for each client/consumer of Family & Children's Center's Community Support Programs is created within 30 days of admission.
- Crisis planning is done with full client/consumer involvement and with the involvement of family/friends/support system, to the fullest extent allowed by the client/consumer.
- Crisis plans are created at the in-person client/consumer recovery plan meeting or via individual meeting between case manager and client/consumer.
- The crisis plan is created using information and themes from the assessment, as well as input from the recovery plan meeting or individual meeting. The crisis plan examines what may cause the client/consumer to be in crisis, the person's support system for crises, the person's skills for managing crises, what may be helpful to the person while in crisis and any specifics the person chooses regarding services/providers they'd prefer to use or not use in a crisis.
- This crisis plan is available via electronic health records to CSP staff of that team/program, to use to assist the person when in crisis.
- Each CSP program provides its own after-hours phone crisis service to clients/consumers.
- Efforts are made to introduce all staff who are on call to clients/consumers who use or may use the after-hours crisis line.

The goal is for clients/consumers to be assisted by staff who know them, using plans developed ahead of time with full client/consumer involvement, to best help clients/consumers manage their crisis. This should help manage and minimize crises, hopefully preventing psychiatric hospitalizations. The Crisis Plan document can be found hyperlinked to this policy or in Family & Children's electronic health records.

GETTING HELP

For questions about this procedure, call the clinical coordinator of the Community Support Program you are interested in

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Procedure Name:	SERVICE ELEMENTS-COMMUNITY SUPPORT PROGRAM (CSP)
Procedure Number:	501
Domain:	CSP
Approved By:	Tita Yutuc, LCSW, President/ CEO
Created/Written By:	Kathy Rohr, Coordinator of Community Services
Effective Date:	1/4/2018
Date(s) of Revision:	
References:	HFS 63, CSP Crisis Plan

STATEMENT OF PURPOSE

This procedure outlines the service elements of Family & Children's Center's Community Support Programs.

AREAS OF RESPONSIBILITY

All staff involved with Community Support Programs with Family & Children's Center are responsible for knowing this information.

PROCEDURE

Community Support Programs provide services to adults with serious and persistent mental illness, to help them achieve their highest level of self-sufficiency and recovery through gains in personal empowerment, hopefulness and competency. Services are provided to assist clients to live in the community, avoid hospitalization, institutionalization, and incarceration, to the fullest extent possible. In addition, services are provided to assist clients in attaining their personal goals.

Services provided within Family & Children's Center's CSP programs are guided by the assessment and prescribed by the recovery plan. Each recovery plan and the interventions for each client are individualized. Service elements provided within CSP programs include:

Assessment- this service element is primarily provided by the psychiatrist/prescriber and case manager, although it may also be provided by the clinical coordinator and other staff, as assigned in the recovery plan or in the case of crisis. See the Assessment policy for more information.

Treatment planning- this service is primarily provided by the case manager, with full client involvement and invitation for involvement of the client's support system. See Recovery Plan policy for more information.

Case management- this service element is primarily provided by the case manager, with the frequency/intensity of services guided by the assessment and recovery plan. Case management involves assisting the client to attain and coordinate needed resources/services.

Housing assistance (not in the form of financial assistance)- is a service element provided by the case manager, with the goal of assisting the client to live in the safe, affordable housing of their choice.

Crisis intervention- this service element is provided by the case manager, by any staff person available during work hours, and by on call staff after hours. On call, staff are case managers with at least a bachelor degree and whom are assigned on call duty and whom receive a stipend to provide the service. Clients reach on call staff by calling an answering service in La Crosse and Vernon counties, leaving their name and number, and on call staff returning their call within 10 minutes. Clients reach on call staff by directly calling a cell phone carried by on call staff in Jackson and Monroe counties. All on call staff are able to access client crisis plans in electronic health records and help clients according to their plans. The goal is to avoid hospitalization and other adverse outcomes as possible. Knowing the client from the program and knowing the crisis plan typically, helps avoid crises from escalating.

Symptom management- this service element is provided by the case manager, psychiatrist/prescriber and all other staff who provide clinical services. CSP staff provide psychoeducation and Illness Management and Recovery (IMR) services to assist clients in coping with, managing and improving their symptoms.

Supportive psychotherapy and psychoeducation- this service element is provided by the case manager, psychiatrist/prescriber, and other clinical staff, as indicated by the recovery plan. Therapy and psychoeducation are provided on both an individual and group basis. Therapy is provided by master degreed staff.

Medication prescription, administration, monitoring, and documentation- prescription is provided by the psychiatrist/prescriber only, medication administration is provided by nurses only, monitoring and documentation are provided by any clinical staff of the program. Medication monitoring takes place according to the needs of the client and includes several potential modalities- including the client setting up their medications in a weekly reminder box with staff verbal support only, clients coming in to the office and taking medication, nurses providing injections, and CSP staff delivering medications to clients who take the medications independently, or CSP staff delivery medications to clients and requesting clients take their

medications in their presence. Medication monitoring may be a required part of a treatment order. If a client is required to take medications by court order, all efforts are made to respect client wishes, create compromise, and work together. See Medication Proceudre for more information.

Psychiatric evaluation- is a service element provided by the psychiatrist/prescriber.

Prevocational, vocational, and education services- is a service element provided by all clinical staff, but particularly by the IPS employment specialist at the La Crosse, Black River Falls, and Sparta locations. In these programs, all clients who are interested in work are referred to the IPS program and are assigned an employment specialist within 7 days. The employment specialist completes a career profile and meets with the client at least weekly to assist them in determining their career goal, attain competitive employment in the community, and provides ongoing supports to assist them in maintaining employment. In Vernon County, employment services are provided by the case manager.

Social recreational skills training- is a service element provided by case managers, mental health technicians and/or peer specialists. CSP staff assist clients to identify and meet their goals of community involvement, particularly providing skills training in building relationships, effective communication, and wellness.

Activities of daily living services- is a service element provided by case managers, mental health technicians and/or peer specialists. Activities of daily living includes individualized support, problem solving, skills training, and supervision in completing tasks such as home care, personal care, laundry, grocery shopping, driving, and money management.

Transportation- assistance with transportation or planning for transportation is provided by case managers, mental health technicians, and/or peer specialists. Transportation assistance is guided by the assessment and plan. Assistance varies from none at all for those who drive themselves independently, to assisting persons in navigating the bus system in La Crosse, to assistance in brainstorming other potential transportation options, assistance coordinating with Medical Transport, and providing transportation and support directly.

Representative payeeship- is a service element provided by the assigned team member, who may be a full time representative payee (La Crosse), a case manager or another staff member assigned. See Representative Payee policy for more information.

Peer support specialist services- is a service element provided by peer specialists, based on their lived experience, and offering hope and support to persons in developing their own recovery.

Integrated Tobacco Cessation services- is a service element provided by case managers or other assigned staff, using the “Bucket Approach” to provided integrated tobacco cessation services. Full teams at La Crosse and Viroqua received training on tobacco cessation services and aides and each CSP program has at least one assigned staff specialist on tobacco cessation services.

These core services are provided at each Community Support Program. In addition, each Community Support Program specializes in additional service elements. At CSP Vernon, Dialectic Behavioral Treatment (DBT) is offered, following the guidelines of Marsha Linehan. At WRIC CSP La Crosse, Illness Management and Recovery services are offered, following the guidelines of the evidence based practice curriculum. At WRIC CSP in La Crosse, Jackson, and Monroe counties, Individual Placement and Support (IPS) Supported Employment services are provided, with exemplary fidelity to the evidence based practice and participation in the state IPS learning collaborative.

The programs work with clients to identify and use natural resources and peer support to create a supportive community. An example of peer support services available in La Crosse and Vernon county are the Drop In Centers available in these locations and the collaboration FCC’s CSP programs have with the Drop In Centers. CSP staff meet with clients at the Drop In Centers and assist clients in getting involved with the Drop In Centers. The Drop In Center in Vernon County is operated by Family & Children’s Center and located in the same building as CSP. The Drop In Center in La Crosse is operated by another agency but located only a few doors away from CSP.

Core service elements of the CSP programs focus on helping individuals improve and manage the quality of their lives through:
Development of self-care and independent living skills
Medication adherence and an understanding of how to manage their illnesses
Socialization and use of leisure time
Housing, education, and family support services
Vocational development
The program offers clients a variety of opportunities to achieve their goals through individual, group and/or milieu activities, within a culturally sensitive framework that allows each individual to:
Learn how to relate to others

Anticipate and control behaviors that interfere with inclusion in the community
Experience peer support and feedback
Build on strengths and enhance self-reliance and productivity
Celebrate competence and success

Some examples of group services include:

- DBT group at CSP Vernon
- Tobacco Cessation group at WRIC CSP La Crosse, Jackson, Monroe and Vernon
- Activity Group at CSP Vernon
- Artists Supporting Artists Group at CSP Vernon
- Coffee Group at WRIC CSP Jackson
- Bowling Group at WRIC CSP La Crosse
- IMR Group at WRIC CSP La Crosse
- Craft Group at WRIC CSP La Crosse
- Chess Club at WRIC CSP La Crosse, led by clients

Each Community Support Program directly provides, coordinates, or arranges for:

- 24 Hour Crisis Intervention
- Medical/dental treatment
- Medication management
- Integrated mental health and substance use services
- Substance use education and treatment
- Public assistance and income maintenance
- Work-related services and job placements
- Financial services
- Legal advocacy and representation
- Transportation

Each CSP program provides 24-hour crisis intervention services. These services are provided during the workday by appropriately trained staff and after hours via phone crisis services. Phone crisis services are provided by CSP staff, so that clients will have a rapport with the person they talk with. All clients are given a refrigerator magnet and/or business card with information on how to reach CSP after hours phone crisis services. The intention of crisis services is to provide crisis assistance, information and referral. The staff person may provide supportive psychotherapy, crisis intervention, symptom management and/or coordination for other services and supports, such as having a friend stay with them, mobile crisis, CARE Center,

police welfare check or hospitalization. When a crisis service is provided, it is recorded in the electronic health record and the provider lets the client's case manager know of the contact and the outcome as soon as possible and within the next business day.

CSP programs assist clients with crisis planning in addition to crisis intervention. With assistance, each client develops a Crisis Plan, which clarifies what may trigger a crisis for them, what/who they find helpful and not helpful in a crisis, their coping skills, and what services might be indicated or should be avoided, as possible, for them. CSP Crisis Plans are completed within the first 30 days of treatment and annually thereafter, or as needed. These plans are available to the CSP staff on call and are also shared with county collaborators/contractors, in La Crosse, Jackson and Monroe counties, where the county provides mobile EMHS crisis services. See the Crisis Plan policy for more information.

Another after hours service that may be provided by the CSP program is weekend medication delivery/monitoring. This service is offered by the WRIC Jackson and WRIC La Crosse programs. Decisions regarding providing weekend medication monitoring will be made on an individual basis and will be directed by the assessment and recovery plan, and potentially by court order.

CSP programs recognize the benefit of involving the client's family, friends and other support system in their treatment, as allowed by the client. CSP staff reach out to family and support people, as allowed, to gain information for the assessment, be involved in recovery planning, and work together collaboratively to benefit the client. CSP staff utilize appropriate informed consents for the release of information. CSP staff also provide referral and psychoeducation to family members, as allowed by clients, as well as linkage to community services. CSP programs work in collaboration with the National Alliance on Mental Illness (NAMI) and staff are actively involved with NAMI activities. CSP staff refer family members to NAMI for support, education and advocacy. In both La Crosse and Vernon, the NAMI Family Support Group takes place in Family & Children's Center's buildings, so referrals are exceptionally easy.

Community Support Programs in Wisconsin are required to provide at least 50% of services in the community and the Family & Children's Center CSP programs meet this requirement.

All cited documents, statutes, and manuals in this procedure can be referenced through hyperlink available in the references section of this procedure.

GETTING HELP

For questions about this procedure, call the Clinical Coordinator of the Community Support Program you are interested in.

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Procedure Name:	HUNGER TASK FORCE
Procedure Number:	502
Domain	CSP, Healthy Families, Stepping Stones, Sandcastles, Youth Home, Hope Academy
Approved By:	Tita Yutuc, CEO/ President
Created/Written By:	Mary Jacobson, Wisconsin Director of Programs
Effective Date:	3/15/2019
Date(s) of Revision:	
References:	Meal Tracking Log, Pantry Monthly Report Cover Sheet, Pantry Register Spreadsheet, Meal & Shelter Monthly Cover Sheet, Hunger Task Force Contract Agreement

STATEMENT OF PURPOSE

This procedure describes how to properly utilize the Hunger Task Force (HTF) food pantry.

AREAS OF RESPONSIBILITY

All programs that utilize the HTF food pantry in serving meals and/or allowing clients to obtain food through our pantry. The Hunger Task Force food pantry can and should be utilized by any client being served by an FCC program. Current programs using this service include CSP, Healthy Families, Stepping Stones, Sandcastles, Youth Home and Hope Academy.

PROCEDURE

Each program that wants to participate in receiving food from HTF needs to appoint a staff or volunteer that will be responsible for all training and paperwork associated with HTF. Once appointed, the Director of Wisconsin Programs will be notified. Programs can distribute food in two ways:

1. Program staff can escort clients to the food pantry located across from the lunchroom on first floor at GVC. The key is located with the front desk receptionist. The Pantry Clientele Register needs to be filled out for each client that takes items from the pantry. There is no real limit, but clients should only take what they can use.
2. Program staff can utilize food from HTF to cook a meal or provide snacks for clients served. This can be for a meeting, regularly scheduled mealtime (Youth Home, Hope Academy) or an event we are hosting for clients. When this occurs, the Meal Tracking Log would be utilized.

The appointed staff will need to shadow an existing person that currently handles the HTF paperwork. Shadowing will consist of physically going to HTF, being introduced to the staff there, being given a tour of the facility, picking up needed items for their program, and filling out the proper documentation required at HTF for items taken.

All HTF appointed staff are required to fill out the Pantry Clientele Register for people that utilize our food pantry and the Meal Tracking Log for people that we provide a meal/snack to with food we acquire from HTF for their program areas. Both reports are maintained throughout the month and submitted to the Wisconsin Director of Programs by the fifth of the following month.

The Wisconsin Director of Programs will gather all program information and compile the data into the Pantry Monthly Report Cover Sheet and Meal Program and Shelter Report Cover Sheet. All reports are submitted to the HTF via email to lacrossehunger@gmail.com by the 10th of each month.

GETTING HELP

If you have questions regarding this procedure, please contact:

1. Program Supervisor
2. Program Coordinator
3. Director of Wisconsin Programs

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Procedure Name:	NO-MEDICAID PROCEDURE
Procedure Number:	503
Domain:	CSP
Approved By:	Tita Yutuc, President/CEO
Created/Written By:	Liam Bailey, Regional Coordinator Paul Brown, Regional Coordinator
Effective Date:	9/16/2019
Date(s) of Revision:	4/15/2020
References:	

STATEMENT OF PURPOSE

Describes and delineates the steps to be taken when a CSP client loses his/her Medicaid funding.

AREAS OF RESPONSIBILITY

All CSP staff members are responsible for knowing this information. Further details on individual position responsibilities follow in the "Procedure" section of this document.

PROCEDURE

The following personnel/positions are responsible for the described tasks:

CSP case managers are kept informed when Medicaid expiration dates draw near and subsequently engage clients or guardians in the steps necessary to keep Medicaid effective without a coverage lapse. The status of the renewal process is discussed during weekly supervision meetings. Potential problems are identified and managed by the Clinical Coordinator, Case Manager, the affected beneficiary/client, with help from Economic Assistance.

- Medicaid status checks are completed each month by Administrative Assistants via the Forward Health Portal.
- Administrative Assistants provide Forward Health Portal results to the Clinical Coordinators, the Regional Coordinators, and to Revenue Cycle when concerns about potential or actual Medicaid lapses are identified.
- Under the direction of the Regional Coordinator, the Clinical Coordinator informs the client's Case Manager whenever potential or actual Medicaid interruptions occur or are about to occur.
- If the client's Medicaid can be reinstated, the Clinical Coordinator works with the Case

Manager to reinstate Medicaid within 30 days of the Medicaid expiration date and arranges for Medicaid eligibility to be reinstated retroactively. This will include direct consultation between Economic Assistance and the client's Authorized Representative (usually the CSP Case Manager).

- If Medicaid cannot be reinstated, the county, the Medical Director, and the client/guardian will be informed, via written communication that the client has lost funding for CSP services.

- If the county/FCC contract has a provision for non-funded clients, said client can fill a non-funded opening via agreement between the Clinical Coordinator and the county.

- Within 30 days after Medicaid loss, the Case Manager helps the client reinstate Medicaid, helps find alternative funding for CSP, or helps the client obtain an alternative service provider. Within this time frame, the following shall occur:

    - The CSP team staffs the client's medical and psychiatric stability and level of services needed. The case is staffed a minimum of once weekly. Clients deemed unstable continue to be served and the county responsible pays the agreed upon rate, pending Medicaid reinstatement.

    - The plan for services shall be clearly defined, including type of service, hours/frequency of services, and the duration of services. This includes a provision for psychiatric medication prescribing, as needed. The plan is developed by the Clinical Coordinator and the designated county agent. Services are monitored with county agreement by the Clinical Coordinator with oversight by the Regional Coordinator

- If reinstatement of Medicaid remains unsuccessful, and the client's county does not agree to provide funding, then the Clinical/Regional Coordinator will inform the client/guardian within five business days prior to the 30 days expiring that the client is no longer eligible for CSP.

- If Medicaid or alternate funding is not obtained, and the client's needs cannot be met with abbreviated services, the client will be discharged from CSP within 30 days Medicaid ends or, in cases where the client is prescribed psychiatric medications, within five days of having an appointment with a medical prescriber, whichever comes later, and must be within the thirty day limit. An aftercare plan is provided to the entities indicated above.

- The Family & Children's Center's President and CEO may grant exceptions to this

procedure on a case-by-case basis.

GETTING HELP

- Medicaid Checks: CSP Administrative Assistant—La Crosse, (608) 785-0001, #260; CSP Administrative Assistant--Black River Falls, 608-369-6398, #3; CSP Administrative Assistant--Viroqua (608) 637-7052, #200
- General Questions: La Crosse/Jackson Regional Coordinator (608) 785-0001, #287 Viroqua Regional Coordinator (608) 637-7052, #233)
- Individual Cases: Clinical Coordinator—La Crosse, (608) 785-0001, #237; Clinical Coordinator—Jackson/Monroe, (608) 785-0001, #287; Clinical Coordinator--Viroqua, (608) 637-7052, #233.
- Exceptions and waivers: CEO, (608) 785-0001, #252
- Procedure #701, CSP Case Closing Procedure

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Procedure Name:	TELEHEALTH SERVICES
Procedure Number:	103
Domain:	Client Rights All FCC Programs
Approved By:	Leah Morken, Clinical Director
Created/Written By:	Mary Jacobson, Director of Programs Vanessa Southworth, Director of Programs
Effective Date:	6/15/2020
Date(s) of Revision:	
References:	APA Telehealth Training Informed Consent for Telehealth Services form Procedure 407: Case Record Overview Revenue Cycle Homepage Provider Assurance Statement for Telemedicine Telephonic Telemedicine Provider Assurance Statement

STATEMENT OF PURPOSE

Telehealth services have been approved through the end of the State of Emergency related to COVID-19. The agency anticipates that telehealth will remain an important method of service delivery throughout the COVID-19 pandemic and beyond. As such, we will stay abreast of rules and regulations regarding telehealth and update this procedure accordingly. This procedure outlines the roles, responsibilities and processes related to providing telehealth services.

AREAS OF RESPONSIBILITY

All staff proving telehealth services are responsible for knowing and understanding the information in this procedure. All staff providing telehealth services must participate in the online APA telehealth training or other telehealth training approved by the Clinical Director.

PROCEDURE

Telehealth is the practice of health care delivery of services, diagnosis, consultation, or treatment of medical data by means of audio, visual, or data communication. Telehealth services must be provided through a 2-way, real-time, interactive method of communication. This excludes voicemails, texting, emailing, faxing, and chat rooms.

Telehealth is not a “check-in”. It is a purposeful and intentional service that is medically needed as determined by a licensed medical professional or mental health professional. Services must be clinically appropriate for the consumer’s needs.

Methods of Telehealth:
Providers are expected to use HIPAA compatible modalities to protect consumer rights. Family & Children's Center complies with established state and federal regulations for telehealth.

Family & Children's Center prefers the use of doxy.me for secure telehealth services and has provided a select number of accounts for providers in need of a secure platform that allows for screen sharing capabilities. Providers are responsible for ensuring the platform they are using is an approved platform by confirming with the Clinical Director. Approved platforms may vary with time based on regulations.

FCC expects all providers to adhere to the requirements of Health Insurance Portability and Accountability Act (HIPAA). This requires taking necessary steps to protect the privacy of clients and the confidentiality of information related to providing services via telehealth. Providers should refer to agency procedures related to HIPAA as well as the APA telehealth training or other approved training if they have questions. For additional help, they should contact the Clinical Director.

Telehealth Process:
Prior to providing any telehealth services, providers must obtain consent from clients via the Informed Consent for Telehealth Services form. Signed and written consumer consent is preferred; however, if written consent is unable to be obtained, then verbal consent is allowable while documenting the efforts to obtain written consent. This can be done via email or regular mail. If verbal consent is utilized, it must be obtained at the start of every session after the risks of telehealth to privacy are discussed.

Providers must adequately address client safety before, during, and after the telehealth service is rendered. This may include but is not limited to a review of client records to identify history of safety risks, creation of a safety plan and protocol for staff members, on-going assessment of client's symptoms and potential safety risks via question and aftercare referral and submission of the created safety plan to the next provider.
The following information must be communicated and discussed with the client at the start of every session:

- An understanding that others may hear the conversation in the background
- Staff's location and environment (ex: working from home with dogs that may bark in the background)

- An understanding that the platform used may not be confidential (e.g., if the platform is not HIPAA compatible, such as Skype, data storage, 3rd party recordings, internet security breaches, etc.)
- An understanding that the consumer has the right to refuse or stop the session at any time
- An understanding that the provider may end the session if the connection is poor or for other reasons that should be explained to the client

Requirements for Documentation:
Staff documentation expectations remain in effect, including the use of the SIRP method of documentation. However, additional requirements must be clearly documented in every case note. This information includes:

- Method/mode of transmission used for session (e.g., Skype, telephone call, etc.)
- A description of the provider's basis for determining that telehealth is an appropriate and effective means for delivering service to the client (e.g., due to COVID-19, due to Safe at Home Order, due to client being unable to come into the office, due to client not having internet connection—in the case of a telephone session, etc.)
- Type of service provided (e.g., outpatient counseling session, supervised visit, etc.)
- Location of consumer (as confirmed by provider) and location of provider (e.g., "Due to consumer self-quarantine, writer called from office to consumer in their home", etc.). This is also known as the location of the originating and the distant site.
- That risks were reviewed and provider received consent for telehealth (Ex: "Current signed consent for telehealth", "Verbally reviewed risks and received verbal consent to conduct session via telehealth", etc.)
    - Ask and document assurance that the client is in a place with privacy, and if they are not, who else is present?
    - Ask and document that the client moved their camera around so you can see the physical setting of the room they are in.
    - Review and document the procedures for disconnection (sign back into the telehealth platform, and if that does not work what number to call by telephone to reconnect with the client) and your safety plan for emergency contact if needed.

- Time the service began and ended, with a.m. and p.m. designations

Addressing How and When to Discontinue Telehealth Services:

The following criteria should be utilized to address how and when telehealth services should end:

- Evaluation of service (intervention used and client's response): Daily review of progress notes
- Evaluation of on-going needs of the client: Clinical consultation of client cases either weekly, monthly, or as needed depending on circumstances
- Evaluation of scope of practice and client's needs: Clinical consultation of client cases either weekly, monthly, or as needed depending on circumstances
- If it is determined a client is not a fit for telehealth services, then an option may be to initiate in person services.

Process for discontinuation:

Context

- Client demonstrates deterioration or a need for higher level of care
- Client has on-going missed appointments or cancellations over a 3-week period
- Client decides to discontinue services
- Client's additional community providers report concern due to client's deterioration in functioning

Protocol

- Staff will consult with Clinical Supervisor
- Staff will consult with outside providers (e.g., County Case Manager)
- Staff will make 3 attempts to discuss potential discharge with client
- Staff will complete a discharge summary
- Staff will provide a referral for aftercare and follow-up

Billing Requirements:

There are no changes to service note billing requirements. However, invoices must add an indicator for telehealth services. For information on how to bill for telehealth services by payer, please go to the Revenue Cycle Homepage on the Depot. This can be accessed by going to Directory > By Department > Revenue Cycle Management > Click here to visit the Revenue Cycle Homepage!

In Minnesota, billable provides must complete the Provider Assurance Statement for Telemedicine, which is submitted to Medicaid and other payers as required, by the Revenue Cycle Department. Also, in Minnesota if any provider offers telephonic services, they must complete the Telephonic Telemedicine Provider Assurance Statement.

GETTING HELP

If you have questions regarding this procedure, please contact your Program Supervisor, Coordinator, Director or Clinical Director.

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Procedure Name:	REHABILITATION TEAM
Procedure Number:	601
Domain:	CSP
Approved By:	Tita Yutuc, LCSW, President/ CEO
Created/Written By:	Kathy Rohr, Coordinator of Community Services
Effective Date:	1/4/2018
Date(s) of Revision:	
References:	HFS 63, Tool for Measurement of Assertive Community Treatment (TMACT)

STATEMENT OF PURPOSE

This procedure outlines the rehabilitation team of Family & Children's Center's Community Support Programs.

AREAS OF RESPONSIBILITY

All staff involved with Community Support Programs with Family & Children's Center are responsible for knowing this information.

PROCEDURE

Family & Children's Center's Community Support Programs provide services to adults with serious and persistent mental illness, to help them achieve their highest level of self-sufficiency and recovery through gains in personal empowerment, hopefulness and competency. Services are provided to assist clients to live in the community, avoiding hospitalization, institutionalization, and incarceration, to the fullest extent possible. In addition, services are provided to assist clients in attaining their personal goals.

Community Support Programs in Wisconsin are certified according to the standards of HFS 63, which directs the makeup of the rehabilitation team. Qualifications for staff are as follows:

Required staff. A CSP shall employ:

(a) A director, who shall have overall responsibility for the program. The director shall meet the qualifications for any of the program staff listed under sub. (4) (a) 1. to 8.;
(b) A psychiatrist on a full-time, part-time or consulting basis to provide necessary psychiatric services. The psychiatrist shall meet the qualifications specified under sub. (4) (a) 2.; and
(c) A clinical coordinator who shall have overall responsibility for and provide direct supervision of the CSP's client treatment services and supervision of CSP clinical staff. The clinical coordinator shall be a psychiatrist or psychologist or have a master's degree in social work, clinical psychology or psychiatric mental health nursing or have met equivalent requirements. The coordinator shall have either 3,000 hours of supervised clinical experience in a practice

where the majority of clients are adults with chronic mental illness or 1,500 hours of supervised clinical experience in a CSP.

(3) Staffing ratios. The client-to-staff ratio may not exceed 20 clients to one full-time equivalent staff person, except that the department may permit, in accordance with a request for a waiver under s. DHS 63.05, that the ratio may not exceed 25 clients to one full time equivalent staff person. Only staff who meet the qualifications under subs. (2) and (4) (a) may be counted in the staff-to-client ratio.

(4) Qualifications.

(a) CSP staff shall have the following qualifications:

1. A CSP professional shall have a bachelor's degree in a behavioral science or a related field with 1,000 hours of supervised post-degree clinical experience with chronically mentally ill persons, or a bachelor's degree in a field other than behavioral sciences with 2,000 hours of supervised postdegree clinical experience with persons with chronic mental illness;

2. A psychiatrist shall be a physician licensed under ch. 448, Stats., to practice medicine and surgery and shall have satisfactorily completed 3 years' residency training in psychiatry in a program approved by the American medical association;

3. A clinical psychologist shall be licensed under ch. 455, Stats.;

4. A clinical social worker shall have a master's degree from a graduate school of social work accredited by the council on social work education;

5. A registered nurse shall hold a current certificate of registration under ch. 441, Stats., and shall have experience or education related to the responsibilities of his or her position;

6. Occupational therapists and recreational therapists shall have bachelor's degrees in their respective professions;

7. A rehabilitation counselor shall be certified or eligible for certification by the commission on rehabilitation counselor certification;

8. A vocational counselor shall possess or be eligible for a provisional school counselor certificate and shall have a master's degree in counseling and guidance; and

9. A mental health technician shall be a paraprofessional who is employed on the basis of personal aptitude. A mental health technician shall have a suitable period of orientation and in-service training and shall work under the supervision of a clinical coordinator under sub. (2) (c).

(b) When volunteers are used, they shall be supervised by professional staff under par. (a) 1. to 8. The CSP shall have written procedures for the selection, orientation and inservice training of volunteers.

(5) Clinical supervision.

(a) Each CSP shall develop and implement a written policy for clinical supervision of all staff who provide treatment, rehabilitation and support services to CSP clients.

(b) Clinical supervision of individual CSP staff shall include direct clinical review, assessment and feedback regarding their delivery of treatment, rehabilitation and support services to individual CSP clients and teaching and monitoring of the application of CSP principles and practices.
(c) Clinical supervision shall be provided by a clinical coordinator meeting the qualifications under s. DHS 63.06 (2) (c) or by staff who meet the qualifications under s. DHS 63.06 (2) (c) and who are designated by the clinical coordinator to provide clinical supervision.
(d) Clinical supervision shall be accomplished by one or more of the following means:
1. Individual, face-to-face sessions with staff to review cases, assess performance and give feedback;
2. Individual, side-by-side sessions in which the supervisor accompanies an individual staff member to meet with individual clients in regularly scheduled sessions or crisis situations and in which the supervisor assesses, teaches and gives feedback regarding the staff member's performance regarding the particular client; or
3. Regular client report or review staff meetings and treatment planning staff meetings to review and assess staff performance and provide staff direction regarding individual cases.
(e) For every 20 clients or every 40 hours of direct service in the CSP, the clinical supervisor shall spend at least 4 hours a week providing supervision.
(f) Clinical supervision provided to individual CSP staff shall be documented in writing.
(6) Orientation and training.
(a) Each CSP shall develop and implement an orientation and training program which all new staff and regularly scheduled volunteers shall complete. The orientation shall include:
1. Review of the applicable parts of this chapter;
2. Review of CSP policies;
3. Review of job responsibilities specified in the job description;
4. Review of ch. DHS 94, patient rights; and
5. Review of ch. DHS 92, confidentiality of treatment records.
(b) Each CSP shall develop and implement a training plan for all staff, including:
1. Use of staff meeting time which is set aside for training;
2. Presentations by community resource staff from other agencies;
3. Attendance at conferences and workshops; and
4. Discussion and presentation of current principles and methods of treatment, rehabilitation and support services for chronically mentally ill persons.

To summarize, the Community Support Program rehabilitation team is a multi-disciplinary team that is made up of the clinical coordinator (supervisor of the program), psychiatrist (and potentially also an APNP prescriber who works under the supervision of the psychiatrist),

nurse(s), case managers, and peer specialist(s) as clinical staff. Each location utilizes an administrative assistant, although in Viroqua this is shared with other programs. Some locations (Black River Falls and Viroqua) also include a Mental Health Technician, a non-degreed support staff. In addition, some locations include an IPS employment specialist (La Crosse, Black River Falls, and Sparta). Some locations provide weekend medication monitoring (Black River Falls and La Crosse). In La Crosse, a full time representative payee is part of the team.

In addition to meeting the requirements of HFS 63, Family & Children's Center's CSP programs follow the higher standards of Assertive Community Treatment (ACT), as guided by the Tool for Measurement of Assertive Community Treatment (TMACT). The CSP rehabilitation team has a low clinical staff to client ratio with at least one full time clinical staff person (includes nurses, coordinators, case managers, peer specialists and mental health technicians) for every 10 clients.

The CSP team coordinates services and involves the client and/or guardian, family/support people, medical, clinical vocational, educational and activity personnel in planning and implementing services. Responsibility for coordination of services and involvement of collateral parties lies with the case manager, who coordinates with collateral parties and invites collateral parties to recovery team meetings to the fullest extent allowed/desired by the client.

The CSP program is the primary provider of treatment, rehabilitation, and social services and works with the person to support recovery, reduce symptoms and to encourage membership in the community through an individualized, coordinated service approach.

Each client of the Community Support Program is assigned a case manager. A full caseload is 12 clients. The case manager is the person's primary contact and completes the recovery plan, which guides treatment. However, it is each CSP program's goal for the entire team to know each client and work as a team to provide services, with multiple team members involved in providing services. For example, a client may see their case manager once a week, see the nurse once a week for in-office medication monitoring, health education, or injection, and attend one group at CSP facilitated by another case manager, and call CSP for crisis assistance, talking to another case manager.

Each CSP program is available on call 24 hours a day for phone crisis services. Each program has a rotation of case managers who are on call. The clinical coordinator coordinates the rotation.

Each CSP provides services to the person as often as needed, guided by the recovery plan and as assessed on an ongoing basis, with visits increased as needed to assist clients in crisis or when symptoms are increased.

Each CSP is involved in hospital admission and discharge decisions. In general, it is the goal of the Community Support Program to assist clients to avoid hospitalization, but at times hospitalization is needed and helpful. It is usually the case manager or case manager on call who is involved in hospital and discharge decisions and planning, but the psychiatrist is often involved as well. This involves assessment, crisis counseling, determination of need for hospitalization, involvement with police in the case of request for welfare check or emergency detention, assistance with plan for transportation to/from the hospital, and assistance with planning for either alternate ways of ensuring support for the crisis period (instead of hospitalization) or planning for logistics related to hospitalization (such as pet care).

All cited documents, statutes, and manuals in this procedure can be referenced through hyperlink available in the references section of this procedure.

GETTING HELP

For questions about this procedure, call the Clinical Coordinator of the Community Support Program you are interested in.

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Procedure Name:	CASE CLOSING
Procedure Number:	701
Domain:	CSP
Approved By:	Tita Yutuc, LCSW, President/ CEO
Created/Written By:	Kathy Rohr, Coordinator of Community Services
Effective Date:	1/4/2018
Date(s) of Revision:	
References:	HFS 63, CSP Discharge Summary, CSP Discharge Survey, Program Participation System (PPS) Form, WI Mental Health/AODA Functional Screen

STATEMENT OF PURPOSE

This procedure outlines the guidelines followed when clients are discharged from the Family & Children's Center's Community Support Programs.

AREAS OF RESPONSIBILITY

All staff involved with Community Support Programs with Family & Children's Center are responsible for knowing this information.

PROCEDURE

Discharge planning in CSP programs begins at intake, with identification of what criteria may indicate CSP services are no longer needed. Discharge criteria are individualized and clients, guardians and other support people are involved with identifying discharge criteria, as allowed by the client. Discharge criteria are clearly defined in the client's recovery plan and reviewed every six months or as needed. The case manager is the primary staff member responsible for establishing discharge criteria with the client, although other staff may also be involved, such as the psychiatrist/prescriber.

Reasons for discharge from CSP include:

- Move to less intensive or no services due to improvement in condition/recovery
- Client choice/disengagement from services
- Move from the area
- Long term nursing home, incarceration, institutional, or other non-community setting stay
- Direction of the contractor or payer
- Death

A continuum of community mental health services are available in each county served by Family & Children's Center's Community Support Programs. Thus, clients are assessed for ability to be treated in a less intensive treatment setting on a regular basis. This assessment occurs at least

every six months upon recovery planning and once a year upon completing the Wisconsin adult Mental Health/AODA Functional Screen, a screening tool that determines eligibility for CSP services. When clients may be able to be treated in a less intensive treatment setting, this is discussed with both the client and the county, and a comprehensive plan for transition is planned. The plan addresses a taper of CSP services to match less intensive services and how needed services will be met in new ways. This includes potential transfer of representative payeeship, establishment with a new prescriber, plan for other needed services (such as transportation/grocery assistance/crisis management) and plan for medication, particularly if the person receives injectable medication. Part of the transition plan will include a warm hand-off, including introductions to new providers and tour of new provider settings. It is the responsibility of the case manager to coordinate the transition plan.

In some cases, voluntary clients decide themselves that they no longer wish to be involved with CSP services. In these cases, attempts will be made to re-engage the client for a period of time, to be decided on an individual basis, in collaboration with the county/agency of contract. Multiple outreach strategies will be utilized, such as letters, calls and visits. Services will be discontinued when the time period is met if the client still does not wish for services. All attempts will be made to refer the client to other services or providers, in case they may be a better fit for the person.

Upon discharge, the case manager notifies any collaborating service providers, including the courts, as appropriate.

Clients who are discharged from CSP will be asked to provide feedback about their CSP services by completing a client satisfaction survey. The case manager provides the survey in paper form to the client either in person or by mail, with a request to complete and return it. Surveys are turned in to the clinical coordinator. Information from CSP discharge surveys is analyzed on a yearly basis by the clinical coordinator and included in the Annual Report. This is one method the program uses to monitor client satisfaction.

CSP program staff make all efforts to assist clients in keeping their health insurance benefits, but occasionally there are times when third-party insurance ends. In these cases, program staff work with the client and contracting agency to determine how to proceed. Contracting agencies may pay the full cost for CSP treatment, Family & Children's Center may continue treatment for a period of time without reimbursement, or the client may be transitioned to other services. Ultimately, it is the county/region/payer who determines how long someone can remain in services after insurance lapses.

When a client is discharged, a discharge summary is completed as quickly as possible and within seven days of discharge, by the case manager or the clinical coordinator. The discharge summary is signed by the case manager, the psychiatrist, and the clinical coordinator. The summary will document the reason for discharge, the client's status and condition at discharge, a summary of the client's progress toward treatment goals, and the aftercare/referral plan. The full team is notified of the discharge, the FCC revenue department is notified of the discharge, the payer/contracting agency is notified and a Program Participation System (PPS) form is completed, by the case manager or clinical coordinator.

In the rare occasion that a CSP client is asked to leave the program, program staff make every effort to link the person with appropriate services and assist in planning with the client and referral/payment source.

All cited documents, statutes, and manuals in this procedure can be referenced through hyperlink available in the references section of this procedure.

GETTING HELP

For questions about this procedure, call the clinical coordinator of the Community Support Program you are interested in.

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Procedure Name:	AFTERCARE AND FOLLOW UP
Procedure Number:	801
Domain:	CSP
Approved By:	Tita Yutuc, LCSW, President/ CEO
Created/Written By:	Kathy Rohr, Coordinator of Community Services
Effective Date:	1/4/2018
Date(s) of Revision:	
References:	HFS 63, CSP Discharge Summary

STATEMENT OF PURPOSE

This procedure outlines aftercare and follow up guidelines after discharge from Family & Children's Center's Community Support Programs occurs.

AREAS OF RESPONSIBILITY

All staff involved with Community Support Programs with Family & Children's Center are responsible for knowing this information.

PROCEDURE

Prior to discharge, CSP program staff work with the client and contracting agency/payer to develop an aftercare plan, as possible and allowed by the client. This is generally done by the case manager. Aftercare plans are noted in the CSP discharge summary, and identify services needed or desired by the person and specify steps for obtaining these services. All efforts are made to plan the transition in advance, to make the transition planful and successful. CSP staff assist the client in exploring suitable resources and contacting service providers, as appropriate and allowed by the client.

The CSP program follows up on the aftercare plan as decided in collaboration with the client and contracting agency/payer. In cases where the person has transitioned to a nursing home, incarceration, or other 24/7 service, follow up may not be indicated.

All cited documents, statutes, and manuals in this procedure can be referenced through hyperlink available in the references section of this procedure.

GETTING HELP

For questions about this procedure, call the Clinical Coordinator of the Community Support Program you are interested in.

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Procedure Name:	PERSONNEL
Procedure Number:	901
Domain:	CSP
Approved By:	Tita Yutuc, LCSW, President/ CEO
Created/Written By:	Kathy Rohr, Coordinator of Community Services
Effective Date:	1/4/2018
Date(s) of Revision:	
References:	HFS 63, WRIC CSP Joint Supervision Log, CSP Vernon Supervision Log, Orientation Checklist

STATEMENT OF PURPOSE

This procedure outlines the personnel and supervision of Family & Children's Center's Community Support Programs.

AREAS OF RESPONSIBILITY

All staff involved with Community Support Programs with Family & Children's Center are responsible for knowing this information.

PROCEDURE

Community Support Programs provide services to adults with serious and persistent mental illness, to help them achieve their highest level of self-sufficiency and recovery through gains in personal empowerment, hopefulness and competency. Services are provided to assist clients to live in the community, avoiding hospitalization, institutionalization, and incarceration, to the fullest extent possible. In addition, services are provided to assist clients in attaining their personal goals.

CSP staff who provide psychosocial or psychiatric rehabilitation services are supervised by qualified professionals and receive training on an on-going basis.

CSP services are provided by a multi-disciplinary team. The team is supervised by the clinical coordinator, psychiatrist, and staff that meet the criteria of the clinical coordinator position. These qualifications are directed by HFS 63:

- "A clinical coordinator who shall have overall responsibility for and provide direct supervision of the CSP's client treatment services and supervision of CSP clinical staff. The clinical coordinator shall be a psychiatrist or psychologist or have a master's degree in social work, clinical psychology or psychiatric mental health nursing or have met equivalent requirements. The coordinator shall have either 3,000 hours of supervised clinical experience in a practice where the majority of clients are adults with chronic mental illness or 1,500 hours of supervised clinical experience in a CSP".

SUPERVISON:
The CSP clinical coordinator provides supervision in the following ways:

- Individual, face to face sessions with staff to review cases, assess performance and give feedback
- Individual, side by side sessions in which the supervisor accompanies an individual staff member to meet with individual clients and the supervisor assesses, teaches and gives feedback regarding staff performance
- Team meetings for client report/staffing or recovery planning to review and assess staff performance and provide staff direction regarding individual cases

The CSP psychiatrist provides supervision in team meetings, individually and side by side, by reviewing and signing assessments and plans, providing consultation on client cases and by providing specialized training. The psychiatrist provides clinical supervision to the nursing staff, including advanced practice nurse prescribers.

The CSP clinical coordinator maintains a written log to record staff supervision. Supervision requirements are directed by HFS 63 and are as follows:

- For every 20 clients or every 40 hours of direct service in the CSP, the clinical supervisor shall spend at least 4 hours a week providing supervision.

- During the absence of the clinical coordinator, another staff person meeting the qualifications of the position will provide supervision and direction to the team.

ORIENTATION:
Refer to the CSP Orientation Checklist for full information on orientation provided to all new staff. This checklist is available via hyperlink at the top of this procedure, under References. Training received is documented on the orientation checklist and the checklist is turned in to Human Resources to be maintained in the employee file, but is also copied for the CSP Personnel Binder. Each staff person completes this orientation within their orientation period (3 months for full time staff and 6 months for part time staff). Each staff person is assigned a staff mentor and must job shadow at least six client visits before working independently with clients. The clinical coordinator is responsible for training of new staff and may assign topics on the orientation checklist to the mentor or other staff. Portions of new employee training are completed in the Agency New Employee Orientation (including Mission/Vision/Values, Ethics/Boundaries, Privacy/Confidentiality, and Mandatory Reporting) and portions of new employee training are completed through the use of online learning through Relias (including Defensive Driving, Trauma Informed Care 101, and Blood Borne Pathogens). All CSP staff

complete or are signed up for trainings on CPI, CPR/ First Aid, and Mental Health First Aid within their orientation period.

Other areas new staff receive orientation training on include:

Psychosocial rehabilitation- What CSP is, what ACT is, the statutes that govern CSP, the purpose of CSP

Substance use conditions- Basics of AODA diagnoses, Motivational Interviewing techniques, staging with stages of change and how this impacts what interventions to use, harm reduction strategies

Vocational issues- Intro to IPS in La Crosse, Jackson and Monroe counties, Vocational resources available in Vernon County

Crisis intervention- Crisis plans, crisis planning, how after hours works, Chapter 51 and Chapter 55 laws, emergency detentions, when/how to request a welfare check

The use, management and side effects of psychotropic medications- Dr. Diamond's book or internet research

The characteristics and treatment of mental illness- Via reading, Relias, or discussion- the basics of diagnoses and treatments

Recognizing the early signs of decompensation and risk factors that increase vulnerability to relapse- via discussion.

Case management essentials- including local and online resources, visits to local resources and introductions to local resources as appropriate

Use of Procentive electronic health records, documentation requirements, and billing.

ONGOING TRAINING/EDUCATION:
Each CSP staff person is required to attain 20 hours of continuing education each year and this training must include:
CPI every other year
CPR/First Aid every other year

Diversity training- 1 hour, as approved by supervisor
Self-Care/wellness training- 1 hour, as approved by supervisor
Blood Borne Pathogens
Trauma Informed Care

CSP staff workloads support the achievement of client outcomes, are regularly reviewed and are based on an assessment of the following:
The qualifications, competencies, and experience of the worker, including the level of supervision needed, the work and time required to accomplish assigned tasks and job responsibilities, service volume, accounting for assessed level of needs of new and current clients and referrals. Family & Children's Center's CSP programs adhere to assertive community treatment standards, with lower caseloads for case managers, with the average full time caseload being 12.

All cited documents, statutes, and manuals in this procedure can be referenced through hyperlink available in the references section of this procedure.

GETTING HELP

For questions about this procedure, call the Clinical Coordinator of the Community Support Program you are interested in.

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