**Central Wisconsin Health Partnership**

**Comprehensive Community Services Regional Coordinating Committee**

**Quality Improvement Committee Meeting**

Marquette County Department of Human Services

Thursday, September 22nd, 2016

**Present:** Tancy Helmin, Consumer/Community Representation; Allison Else, Adams County; Amanda Negaard, Juneau County; Tanya Amos, Waushara County; Dan Naylor and Lori Martin, White Pine Consulting Service; Elizabeth Dehling, Southeast Regional Office

1. **State updates**
	1. As part of the reorganization of the State Department of Health Services, the Division of Mental Health and Substance Abuse Services (DMHSAS) is now the Division of Care and Treatment Services (DCTS). The CCS program is part of this Division.
	2. The Wisconsin Department of Health Services announced a new Medicaid Director and Administrator of the Division of Health Care Access and Accountability. According to the September 20th memo, “Michael Heifetz is will take over for Kevin Moore, who is leaving the position to pursue career opportunities in the private sector. Heifetz most recently served as State Budget Director at the Department of Administration”.
	3. The CCS Coordinator position formerly held by Cheryl Lofton has been filled by Danielle Graham-Heine. She has been assigned the 6 counties in our regional CCS. Danielle’s contact information: Danielle.grahamheine@wisconsin.gov, (608) 261-7652.
	4. Statewide meeting

*Links to materials from the statewide meeting can be found on the DHS website using the following link:* <https://www.dhs.wisconsin.gov/ccs/statewide-meetings.htm> (click on 2016 Fall Meeting)

* + - Tanya attended a session related to “Staffing Challenges with CCS” facilitated by Sharon Farrey from Green County. Green County utilizes college interns at both the bachelor and master’s levels to provide CCS services.
		- **Lori and Tanya attended a session on QA/QI Efforts presented by Jason Latva (CCS Coordinator -Door, Kewaunee, Shawano) and Susan Fernandez (Door County). Part of the session focused on a format for consistent and quality progress/case notes – TARP (Treatment plan goal; Activities that took place; Response/involvement of the consumer; Plan for next steps). The Committee reviewed a handout from the session, “Evaluating the Quality of a Progress Report” that includes a sample scoring grid for use when reviewing progress notes (the handout is available for download from the DHS website at the address listed earlier in this section). There is initial interest in obtaining more information and discussing possible use in the region. Tanya is already planning to implement in Waushara County and will be training her staff on Monday.**
		- Dan attended the “CCS, Substance Use, and Opiate Treatment Programs” session. The presenter talked shared several examples of AOD screening tools. Dan passed around one example. Lori will research to find one or more of the tools to share with the group for their review.
1. **NE Regional CCS Meetings and Workgroup**
	* + - 1. Northeast Regional CCS Workgroup – a workgroup that came out of the larger NE regional CCS meetings, tasked to review DHS 36, MA requirements, and results of the Office of Inspector General (OIG) audits to develop a checklist for use as an internal file review/audit tool. The group, coordinated by Robin Raj - DHS Area Administrator, is working with Kenya Bright to facilitate review of the document by DCTS, the Division of Health Care Access and Accountability (DHCAA), and the Division of Quality Assurance (DQA). Next step – develop model processes and sample forms for use in the region.
	1. Lori shared “CCS Questions Posed to DCTS Staff, August 2016”. The questions were posed by Robin Raj and reviewed/answered by Kenya Bright and Langeston Hughes. Topics included: using telehealth to provided CCS supervision, the requirement that doctors be MA enrolled, physician prescription, and consent to treat/admission agreement forms (see APPENDIX A for more information).
	2. The committee briefly reviewed the agenda for the September 27th NE regional CCS meeting taking place in Appleton
2. **2015 Regional CCS Survey** – committee reviewed a draft regional report. Lori will make suggested updates in preparation for review by the Regional Coordinating Committee at their meeting on October 5th.
3. **Consumer Assessment**
	1. Quality of life scale
		* In follow-up to the request made at a Service Facilitator meeting regarding additional information on the Quality of Life Scale, Lori shared the “Understanding Scores on the Satisfaction with Life Scale” by Ed Diener with the Service Facilitator at their recent meeting. A summary of points from this document may be included in a future supplemental guiding document to the CCS Assessment.
	2. Assessing trauma
		* At the last Service Facilitator meeting, the group reviewed the current “Trauma and significant life stressors” section of the regional CCS Assessment document; and then also reviewed the “Adverse Childhood Experience (ACE) Questionnaire: Finding your ACE Score”. The Service Facilitators expressed interest in the ACE questionnaire, but also noted several of the items on the current assessment they wanted to keep.
		* Committee discussion – before changing the current assessment / going with the ACE questionnaire, additional information and training would be needed. This would be a potential topic for future regional training.
	3. Review of MA requirements
		* Lori shared “Attachment 3: Mental Health and Substance Abuse Services Documentation Requirements” from the June 2014 ForwardHealth Provider Update. Discussed importance of meeting the MA requirements for assessments, treatment plans, and progress notes (in addition to DHS 36 requirements).
		* Discussed the importance of the role of the mental health professional – there is interest in a workshop on the topic of the role of the mental health professional and their relationship to the team, consumer, and service facilitator.
4. **Other**
	* + - 1. Consumer Satisfaction Surveys – same regional process as last year – counties responsible for administering and collecting the surveys. Completed surveys sent to White Pine who will enter the data into the appropriate spreadsheets and submit the data to the state (by December 31st). White Pine will also develop a regional data report for review by the Regional Coordinating Committee. Lori and a colleague have been asked to facilitate a training for St. Croix and LaCrosse Counties on the administration of consumer satisfaction surveys. Lori would be happy to share the material and/or do a similar workshop in our region.
	1. Discuss scheduling of future Service Director meetings
	2. Discussion regarding the reasons for discharge outlined DHS 36.17(5) as compared to the discharge reasons identified in the PPS reporting system. There are many differences. Lori suggests including both on our regional discharge summary form – DHS 36 reasons on the front, and PPS reasons on the back. There is a need to reconcile the PPS reasons with DHS 36 for consistency. Lori will bring this up as a question at the upcoming NE Regional CCS meeting.
5. **Final 2016 meeting** - November 10th (12:30 to 2:00)

**APPENDIX A:**

**CCS Questions Posed to DCTS Staff, August 2016**

Please note: the questions in this document were posed by Robin Raj, Human Services Area Coordinator, to Kenya Bright and Langeston Hughes with the DCTS. The answers were provided/reviewed by both Kenya and Langeston, and shared with the northeast regional CCS workgroup on August 29th, 2016.

1. **Can telehealth be used to provide the required CCS supervision?**

Here is the link to the telehealth memo. <https://www.dhs.wisconsin.gov/dqa/memos/15-011.pdf>. Within the memo there is language to support telehealth and supervision. Here’s the language from the memo:

*Use of Telehealth for Clinical Supervision and Clinical Collaboration Telehealth equipment may be used for the purpose of clinical supervision and clinical collaboration, but it is important to note that all the requirements in this memo would still apply to the use of telehealth equipment for supervision and collaboration (e.g., transmission quality, ensuring that the transmitted information is not stored, etc.). In addition, certified programs are cautioned regarding the use of telehealth equipment for clinical supervision for substance abuse counselors as state regulations require at least one in-person meeting per month.*

SPS 162.01 Required supervision. (1) Clinical supervisors shall exercise supervisory responsibility over substance abuse counselors−in−training, substance abuse counselors, clinical substance abuse counselors, clinical supervisors−in−training and intermediate clinical supervisors in regard to all activities including, but not limited to: counselor development, counselor skill assessment and performance evaluation, staff management and administration, and professional responsibility. A clinical supervisor shall provide a minimum of:

(a) Two hours of clinical supervision for every 40 hours of work performed by a substance abuse counselor−in−training.

(b) Two hours of clinical supervision for every 40 hours of counseling provided by a substance abuse counselor.

(c) One hour of clinical supervision for every 40 hours of counseling provided by a clinical substance abuse counselor.

(d) One in person meeting each calendar month with a substance abuse counselor−in−training, substance abuse counselor or clinical substance abuse counselor. This meeting may fulfill a part of the requirements of pars. (a) to (c).

Funding for Telehealth – Medicaid Reimbursement. The Division of Health Care Access and Accountability will reimburse for Medicaid-covered services provided

Note: Please remember to adhere to the rules of CCS that pertain to supervision.

1. **Does the Dr. who is the CCS prescribing Dr. have to be a Dr. who accepts MA / is an MA authorized Doctor?**

In order for MA to reimburse the CCS program, the prescribing provider must be MA enrolled. This policy is found in:

* Topic #14137: “Ordering and referring physicians or other professionals are required to be enrolled as a participating Medicaid provider”.
* Topic #15737: “Claims for services that are prescribed, referred, or ordered must include the NPI of the Medicaid-enrolled provider who prescribed, referred, or ordered the service. Claims that do not include the NPI of a Medicaid-enrolled provider will be denied”.
1. **Is it OK for the county to wait on doing the CCS assessment until they have the Dr. prescription?**

I would say NO that is not a good idea because you only have 30 days to complete ALL of the intake paperwork. Waiting on a prescription is not a good idea. The person has already been determined to be functionally eligible through the Functional Screen and showing eligibility for CCS….keep the process moving forward. Also you must remember that the admission process starts with the application and admission agreement. Also consider Chapter DHS 36.13 (2)

1. **Regarding the prescription, does it need to be on a prescription pad paper, a county form, or any special type of document?**

I have not seen anything in DHS 36 or the Forward Health Provider Update for CCS that specifies that there is a particular format. Physicians need to follow all rules that apply to them, including any regarding to prescriptions. I would imagine it should be on some official type of form that clearly states the person who is prescribing the services, their title, date, signature and maybe the diagnosis.

1. **Can the county combine the consent to treat and the admission agreement on one form for the individual to review and sign? Or do they need to be two separate forms?**

There is nothing that clearly states that you should not combine the forms but, I personally think it would be a good idea to leave these two documents as separate documents. However, consumers may find it confusing. Also, the admission agreement doesn’t need to be redone annually. One thing to think about in combining forms, state staff reviewing charts may be looking for two separated documents. If they review one document and they are not aware that it is a combination of two, it may appear that one form was not done. Chapter DHS 36.13 (1m) does not require but indicates (a) and (b) must be covered.