GREEN LAKE COUNTY
DEPARTMENT OF HEALTH & HUMAN SERVICES

HEALTH & HUMAN SERVICES
571 County Road A

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Post Date: 6/11/2020
*Amended

The following documents are included in the packet for the Department of Health & Human Services Board held on Monday, June 8, 2020

- May 8, 2020 DHHS meeting agenda 5:00 p.m.
- March 9, 2020 Draft Minutes
- Administrative Report May 2020
- Aging Report May 2020
- *Behavioral Health Unit Report – May 2020
- Children & Family Services Report – May 2020
- Economic Support/Child Support Reports – May 2020
- Proclamation Economic Support Specialist and Case Managers Week
- *Economic Support – thanks for all staff is doing
- Fox River Industries May 2020
- *Fox River Industries Garden Project
- Health Report May 2020
- Environmental Health Report May 2020
- CCS DHS 36 Policy and Procedures – Revised
- Home/Office Visit Safety Recommendations

GREEN LAKE COUNTY
DEPARTMENT OF HEALTH & HUMAN SERVICES

Office: 920-294-4070 FAX: 920-294-4139 Email: *glcdhhs@co.green-lake.wi.us*

Health & Human Services Committee Meeting Notice

Date: June 8, 2020 Time 5:00 PM
Green Lake County Government Center
571 County Rd A, COUNTY BOARD Room #0902 Green Lake WI

**** AMENDED AGENDA***

Committee Members

Joe Gonyo, Chairman
Harley Reabe, Vice Chair
Brian Floeter
Joanne Guden
Nancy Hoffman
Christine Schapfel
Richard Trochinski
Joy Waterbury
Charlie Wielgosh

Karen Davis, Secretary

Kindly arrange to be present, if unable to do so, please notify our office. Sincerely, Karen Davis, Administrative Assistant

1. Call to Order
2. Certification of Open Meeting Law
3. Pledge of Allegiance
4. Elect Chair
5. Elect Vice Chair
6. Minutes 3/9/20
7. Committee Appointment(s)
8. DHHS Response to COVID-19
9. Veteran's Service Office Report
10. Advisory Committee Reports
    - ADVOCAP/Headstart Report (Gonyo)
11. Unit Reports
    - *Administrative Unit
    - Behavioral Health
    - Children & Family Services
    - Economic Support Unit/*Child Support
      - Governor Evers Economic Support Specialist and Case Managers Week
    - Fox River Industries
    - Health/Environmental Health
12. Personnel Updates
    - New Worker – Economic Support Unit
    - Children & Family Services Unit – Intensive In-Home Therapist position
13. *Policies
    - *Comprehensive Community Services (CCS) DHS 36 Policy and Procedures Revised
    - *Home/Office Visit Safety Recommendations
14. Budget
    - 2020
    - 2021 Budget Planning
15. Committee Discussion
    - Future DHHS Meeting Date (July 13, 2020 at 5:00 p.m.)
    - Future Agenda items for action & discussion
16. Adjourn

Due to the COVID-19 pandemic, this meeting will be conducted and available through in person attendance (6 ft. social distancing required) or audio/visual communication. Remote access can be obtained through the following link:

Join Zoom Meeting
https://zoom.us/j/92016081644?pwd=dDhzTC9GaWRRSkdPSlJIdUtrOU1MZz09

Meeting ID: 920 1608 1644
Password: 472587
One tap mobile
+13126266799,,92016081644# US (Chicago)
+19294362866,,92016081644# US (New York)

Dial by your location
+1 312 626 6799 US (Chicago)
+1 929 436 2866 US (New York)
+1 301 715 8592 US (Germantown)
+1 346 248 7799 US (Houston)
+1 669 900 6833 US (San Jose)
+1 253 215 8782 US (Tacoma)
Meeting ID: 920 1608 1644
Find your local number: https://zoom.us/u/acIBZ69YA1

Please note: Meeting area is accessible to the physically disabled. Anyone planning to attend who needs visual or audio assistance, should contact the County Clerk's Office, 294-4005, not later than 3 days before date of the meeting.

THE FOLLOWING ARE THE OPEN MINUTES OF THE HUMAN SERVICES BOARD HELD AT GREEN LAKE COUNTY GOVERNMENT CENTER, 571 COUNTY ROAD A, GREEN LAKE, WI 54941 ON MONDAY, MARCH 9, 2020 AT 5:00 P.M.

PRESENT: Joe Gonyo, Chairman
Harley Reabe, Vice Chairman
Richard Trochinski, Member
Joy Waterbury, Member
Joanne Guden, Member
Nancy Hoffman, Member
Brian Floeter, Member

EXCUSED: Charlie Wielgosh, Member
Christine Schapfel, Member

OTHERS PRESENT: Jason Jerome, Director
Karen Davis, Administrative Assistant
Dawn Klockow, Corporation Counsel
Jon Vandeyacht, Veteran's Service Officer

Certification of Open Meeting Law: The requirements of the Open Meeting Law have been met.

Call to Order: The meeting was called to order at 5:00 p.m. by Chairman Gonyo.

Pledge of Allegiance: The Pledge of Allegiance to the Flag was recited.

Action on Minutes: Motion/second (Guden/Waterbury) to approve the minutes of the 1/13/20 Health & Human Services Board meeting as presented. All ayes. Motion carried.

Committee Appointment(s): The Commission on Aging Advisory Committee is in need of 2 Committee members. The requirement is to be over age 60. One is needed from the Southern end of the County and one from Green Lake area.

2019 Annual Report: Jerome presented/explained the 2019 DHHS Annual Report to Committee members. Questions were answered.

Veteran's Services Report: Vandeyacht reported regarding Veteran's Services activities.

2019 Annual Report: Vandyacht presented/explained the 2019 Annual Veteran's Service Report.

Advisory Committee Reports: Advocap/Headstart Report: Gonyo reported that he will be attending the meeting on Thursday the 12th. Gonyo reported that Mike Bonertz spoke at the February County Board meeting.

Family Resource Council Draft Minutes 3/2/2020: The Draft Family Resource Council 3/2/2020 minutes were reviewed and placed on file.

Unit Reports: The Aging January report was reviewed and placed on file.

The Behavioral Health Unit January/February reports were reviewed and placed on file.

The Children & Family Services letter was reviewed and placed on file. This recognizes Green Lake County Children & Family Services Unit for their efforts regarding children in out-of-home care.

The Fox River Industries Unit January report was reviewed and placed on file.

The Health Unit/Environmental Health January reports and the Environmental Health February report were reviewed and placed on file.

Discussion followed.

Personnel Update(s): Jerome reported regarding adding this to the agenda each month to update Committee members regarding any Committee updates.

Jerome reported regarding that there was a vacant CIP Aide position recently filled by Melonie Leu.

Jerome reported that the part-time Alternate Care Coordinator in the Children & Families Worker was hired - Mandy Kurtz.

Committee Discussion: None.

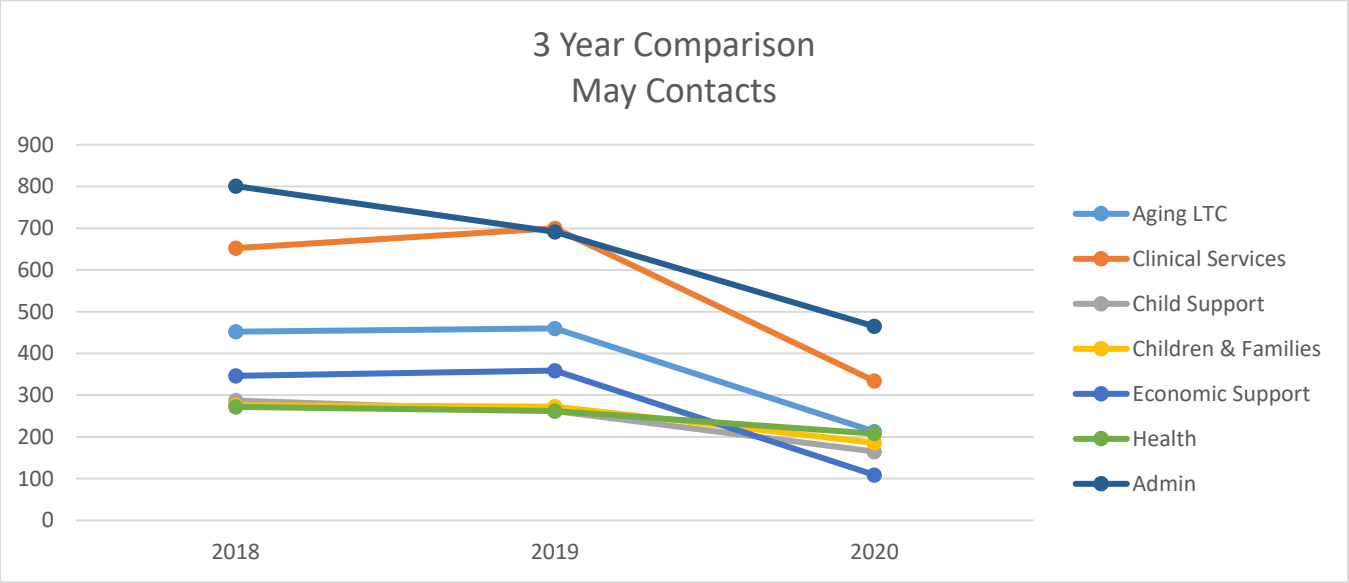
Future Meeting Date: The next Health & Human Services Board budget hearing meeting will be Monday, April 13, 2020 **at 5:00 p.m. at the Green Lake County Government Center.**

Future Agenda Items For Action and Discussion: None.

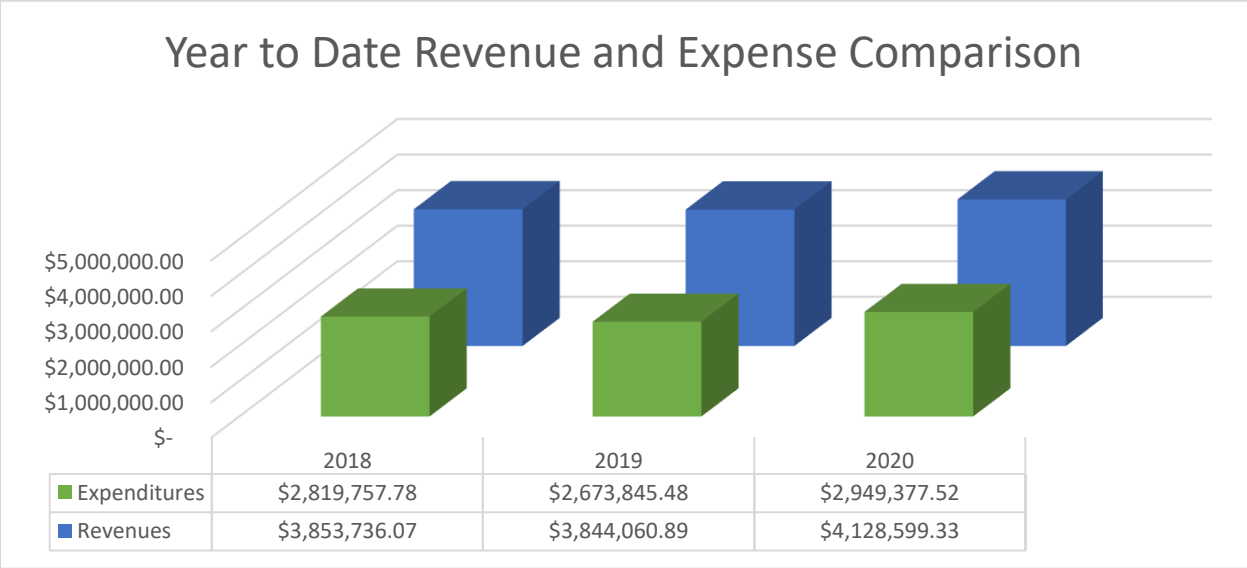
Adjournment: Gonyo adjourned the meeting at 5:20 p.m.

Admin –May 2020

As we continue with the Covid-19 Pandemic and the office being open "limited" our contacts have been greatly impacted. Contacts have decrease by 60% from May last year. The numbers are reflected in the graph below.



Despite the drop in contacts the Admin Unit has continued to modifying the work flow to accommodate all the changes happening with COVID-19 Pandemic. The changes have greatly impacted the Admin Units workload, increasing paperwork, mailings, rescheduling, and webinars to keep up with the changes for billing. Staff is keeping up very well and our revenues have reflected that. Below is a comparison graph of expenditures and revenues for the past three years.



	2018	2019	2020
Expenditures	$2,819,757.78	$2,673,845.48	$2,949,377.52
Revenues	$3,853,736.07	$3,844,060.89	$4,128,599.33

AGING REPORT - 2019

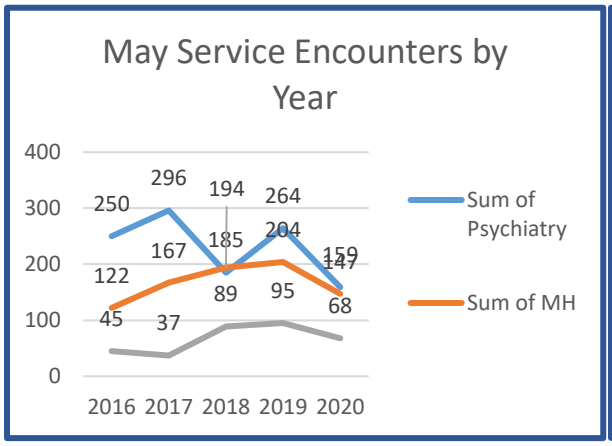
Mealsites - Berlin Senior Center, Dartford Bay Apartments, Grand River Apartments																		
	HOMEBOUND								CONGREGATE						2020			
	Berlin		Green Lake/Prince.		Markesan				Berlin		GL/Princeton		Markesan				MEAL PROGRAM	
	HDM #	DONATION AMOUNT	HDM #	DONATION AMOUNT	HDM #	DONATION AMOUNT	HDM TOTAL MEALS	HDM TOTAL DONATION	CONG # SERVED	DONATION AMOUNT	CONG # SERVED	DONATION AMOUNT	CONG # SERVED	DONATION AMOUNT	CG TOTAL MEALS	CG TOTAL DONATION	TOTAL MEALS	TOTAL DONATION
January	819	$2,158.08	584	$1,708.43	462	$1,455.00	1,865	$5,321.51	296	$1,046.00	127	$68.00	52	$20.00	475	$1,134.00	**2,340.00**	**$6,455.51**
February	651	$2,541.31	452	$1,886.50	401	$1,312.32	1,504	$5,740.13	285	$853.00	122	$63.00	50	$40.00	457	$956.00	**1,961.00**	**$6,696.13**
March	833	$2,678.23	543	$1,885.82	485	$1,793.32	1,861	$6,357.37	309	$1,165.00	173	$132.00	62	$44.00	544	$1,341.00	**2,405.00**	**$7,698.37**
April	813	$3,180.58	528	$1,734.32	433	$1,503.00	1,774	$6,417.90	474	$1,671.00	133	$22.00	51	$24.00	658	$1,717.00	**2,432.00**	**$8,134.90**
May																		
June																		
July																		
August																		
September																		
October																		
November																		
December																		
TOTALS	3116	$10,558.20	2107	$7,215.07	1781	$6,063.64	7,004	$23,836.91	1364	$4,735.00	555	$285.00	215	$128.00	2134	$5,148.00	9,138.00	$28,984.91

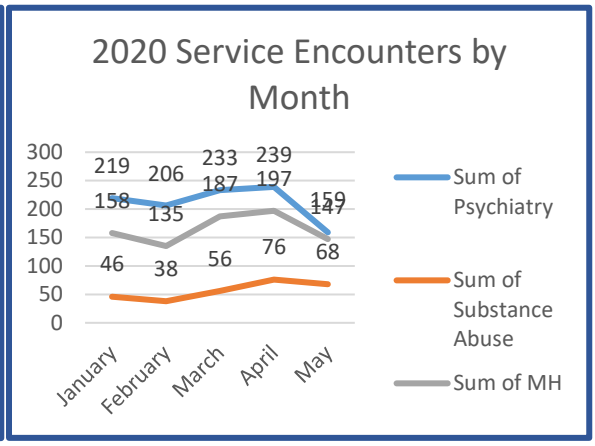
AGING REPORT - 2019

		ELDER ABUSE				Elderly Benefit Sprcialist Program				2020			DBS						
			REPORTED	REPORTED			I&A				QUARTERLY REPORTS								
	FOOD	OPEN	ELD ABUSE	VULNERABLE ADULT	ADRC	TRNG	CALLS FOR		OUTREACH		NEW	CLIENT $	OPEN						
	PANTRY	CASES	CASES	CASES	CONTACTS	HOURS	EBS	SPEAKING	HOURS	ADRC	CASES	SAVED	CASES						
January	176	48	9	0	356	5	137	0	9	0	17	$225,486.00							
February	166	49	4	0	291	7	138	0	6	0	15	$117,204.00							
March	194	50	2	0	294	3	112	1	1	0	13	$161,708.00							
											45	**$504,398.00**							
April	171	50	4	1	280	20	66	0	0	0									
May		53	3	3	214	18	67	0	0	0			68						
June																			
July																			
August																			
September																			
October																			
November																			
December																			
TOTAL	707	250	22	4	1435	53	520	1	16	0	90	**$1,008,796.00**							

Behavioral Health Unit—May 2020

<u>Outpatient Mental Health & Substance Abuse Programs</u>- *The majority of Behavioral Health clients are served via our outpatient clinic. The outpatient clinic serves clients' mental health and substance use disorder (AODA) needs.*

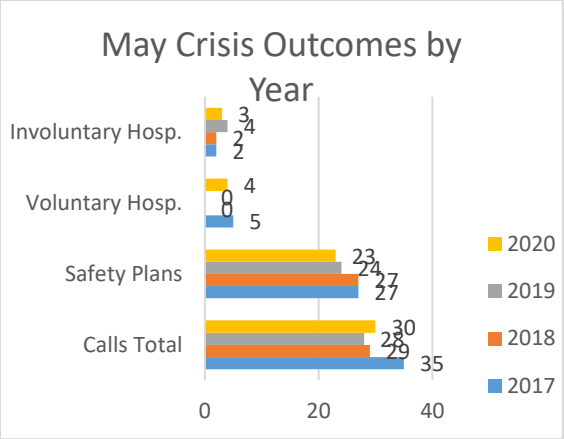


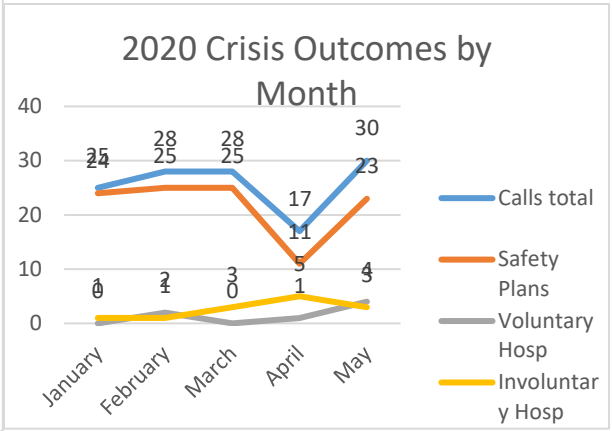


April 2020 Note: During May 2020, the clinic continued providing most services utilizing telehealth. In some circumstances, on-site visits proved necessary due to either acuity of a clients' situation or need for physical contact with provider (i.e. injections, med. observations, etc.). Providers continue to do an excellent job finding creative ways to engage clients in services over telehealth. For many clients, we notice positive outcomes with telehealth services and even a decrease in failed (no show/ cancel) appointments (possibly mitigated by the flexibility that telehealth allows to help community members access services who might otherwise have barriers such as transportation, childcare, etc.) A subsection of our population struggles with telehealth, and clinicians are beginning to integrate guidance on safety precautions to allow some based face-to-face contacts to resume for those identified individuals.

<u>Crisis Services-</u> *Crisis services are available 24/7 including weekends/ holidays for psychiatric and substance use disorder emergencies.* The charts below show crisis calls in May historically and trends within 2020. During the initial weeks of the COVID19 pandemic, crisis contacts increased. This month, calls returned to a rate consistent with what we saw prior to COVID19. In the current environment, safety planning is much more difficult. We see a slight increase in hospitalizations despite efforts to safety plan. Safety plans rely heavily on increased phone contacts staff—most days crisis workers conduct multiple follow ups (not represented in data below). Examples of COVID19-related crises that we encounter include:

- Substance use disorder emergencies— lack of support groups, altered supervision contacts, and decreased daily structure have seen many individuals relapse. Substance use history increases vulnerability to complications from respiratory illness such as COVID19.
- Anxiety over divided opinions: With the lifting of stay-at-home orders, many individuals struggle to navigate decisions about contact with family members, friends, & coworkers. who may observe differing degrees of social distancing from themselves.
- Health-related anxiety
- Isolation-related depression & exacerbation of trauma symptoms and family conflict





Wrap-Around Services- *Behavioral Health Unit provides three tiers of wrap-around services, allowing us to match individuals with a program that meets the level of need based on their unique situation.*

1. *Targeted Case Management (TCM)— Less intensive case management for clients.* ***This program expanded to include adult clients in summer 2018. It presently serves 6 individuals.***
2. *Comprehensive Community Support Program (CCS)—Recovery-focused support for clients who may benefit from an intensive level of services for a shorter period of time.* ***This program serves individuals across the lifespan and presently serves 46 individuals.***
3. *Community Support Program (CSP)- Intensive community-based support for individuals with chronic mental illness. This support is intended to be long-term and to support clients to maintain psychiatric stability in the community and to reduce hospitalizations.* ***This program presently serves 11 adults. Many of these individuals rely heavily on support from the program to assist with basic needs. These individuals continue to receive intensive monitoring, including delivery of some basic supplies, to assist them with managing needs as the safer-at-home order continues.***

Treatment Court- *Treatment Court is an evidence-based alternative-to-incarceration program that combines high levels of accountability and community-based supervision with intensive substance use treatment.* The program accepted its first participant in November 2017 and is designed to take 14-18 months to complete. **In May 2020, the program has 5 participants across its 5 phases. Participants attend court and other services utilizing telehealth. During May, regular drug testing of participants resumed.**

Children's Long Term Support Waiver (CLTS)—*Medicaid waiver program provides funding for families of children with long-term disabilities (developmental, physical, and/or severe emotional disturbance) to access services such as respite care and service coordination which are otherwise not covered by Medicaid insurance.* **In 2018, Wisconsin announced the dissolution of the waitlist which required Green Lake County to increase program capacity from 8 children to 16 and to continue to expand as new referrals come in. The program now serves 28 youth and continues to accept new referrals.**

Residential Clients- In May 2020, one youth remains inpatient at Winnebago Mental Health Institute since 10/15/19. This youth has a case management team actively involved to support discharge planning with intention to discharge in the near future. Two treatment court clients attended hospital-based detoxification programs. The Treatment Court team worked to help them obtain insurance that

covered much of the stay, and funded the uninsured portion. Both have now returned to less restrictive community-based care. One individual is placed at a community-based residential substance use treatment facility as part of a plan to transition to a less restrictive sober living home. The requirement to be in residential treatment prior to entering sober living is a temporary precaution that the sober living home is using as part of COVID19 measures.

Additional Notes:

During May 2020, the State of Wisconsin issued a call for county requests for supplemental block grant funding for mental health and substance use disorders programs to cover costs related to COVID19. Green Lake County submitted requests for both block grants, and we are awaiting further information about our award. These supplemental funds allow coverage for:

- Staff time to coordinate COVID19 response and participate in regional/state-level meetings to keep up to date about telehealth, Medicaid rule changes, and staff precautionary measures as well as training on pandemic-specific mental health concerns.
- Surgical level face masks to be used by staff providing face-to-face services.
- Technology for staff to ensure service provision via video+ audio telehealth platforms is widely available.
- Additional contacts with contracted providers that may be needed as a result of COVID19

CHILDREN & FAMILY SERVICES UNIT –May, 2020

Out-of-Home Care – as of 05/31/2020

Foster Care – Level I & II (Range of costs from $244.00 to 2000.00). **One (1)** child(ren) are local placement(s).

Treatment Foster Care **– Two (2)** children/youth were in treatment foster care through Pillar & Vine.

Court-ordered Relative Care ($244.00 month per child)
Four (4) children were in court-ordered relative care in May, 2020.
One of these children (1) Child was placed in relative care that is not being reimbursed. Total in Court ordered Kinship Care at month's end = **Four (4)**

Subsidized Guardianship – At the end of May, 2020, **three (3)** remained in subsidized guardianship.

Kinship Care – Voluntary ($244.00 month per child)
Eleven (11) children were in Kinship Care at the end of May, 2020.

Total out of home at month's end = 1 + 2 +4 +3 + 11 = 21

The base rate for relative foster care (level 1) and Kinship Care increased in 2020 to $254.00/month. This rate was raised in 2020.

****** Base rate on children in foster care was $720.00 to $845.00/month in a one time payment only in April/May due to COVID payments from the state. These children additionally have supplemental and exceptional rates added to the foster parent reimbursement.

ACCESS REPORTS

Child Protective Services (CPS) reports this reflects the month of April – 18

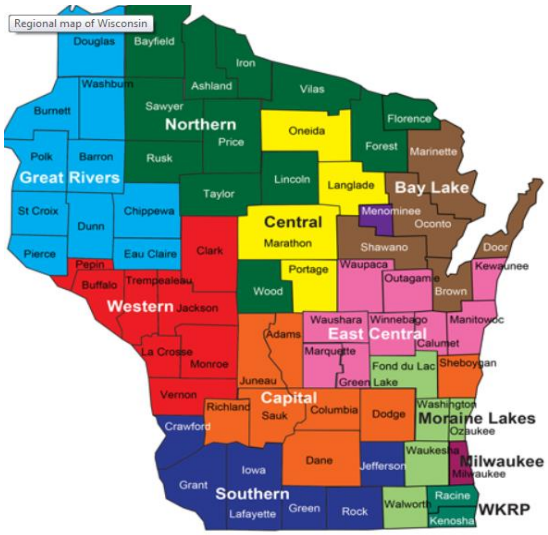
Screened in reports – 1
Screened out - 17
YTD (04/30/2020) – 80 with 26 being screened in.

Child Welfare – 1 - (April, 2020)

YTD (04/30/2020) – 1 screened in ****staff are focused on TCM/CCS referreals as a priority.

Youth Justice – May - 3

YTD (05/31/2020) _ – 24



Economic Support Unit Monthly Report

Mabel Plueddeman is the newest member of the Economic Support team. She is a recent graduate of UW- Oshkosh. She was raised and "rooted" here in Green Lake.

Economic Support continues to see a rise in applications for Health Care and Food Share benefits. In March 2020 Green Lake County had 48.3% more in Food Share applications than March 2019 and 69.6% more in April 2020 than April 2019. These numbers reflect the increase most of the other counties within our Consortia as well. Many in our community and surrounding areas have still not received anything in unemployment and are struggling. Some are returning to work, but not in full-time status.

Due to school closures as a result of the COVID-19 pandemic, families with a child or children who got free or reduced price school meals through the National School Lunch Program received temporary food benefits in place of the school meals. Each child who received free or reduced price schools meals received $176.70 for March and April and $148.20 for May and June.

Wisconsin Rental Assistance Program (W.R.A.P)

On March 27, Governor Evers directed Secretary-designee Palm to prohibit landlords from serving notice terminating tenancy. This temporary ban on evictions expired on May 26. While state and federal benefits helped soften the blow, they were not expected to cover all expenses a family must manage. This significant loss of income impacted their ability to keep up with rent and threaten housing insecurity.

ADVOCAP will be administering W.R.A.P for Green Lake County. Individuals interested in applying for this program should contact ADVOCAP to apply for Energy Assistance. My team will be assisting with these applications until such time as ADVOCAP is trained. We are expecting an increase in applications for this program for Green Lake County.

Shelby Jensen
Green Lake County DHHS
Economic & Child Support Unit Manager

Child Support Unit Monthly Report

Due to the COVID-19 Health emergency all paternity testing was suspended. Starting Monday, June 8th, Green Lake County Child Support will resume their paternity testing. This decision was made in accordance with the recommendations of our Health Officer.

Child Support staff continue to work diligently to get all case files scanned into LaserFiche, an electronic case filing system.

Shelby Jensen
Green Lake County DHHS
Economic & Child Support Unit Manager

STATE *of* WISCONSIN

OFFICE *of the* GOVERNOR

Proclamation

WHEREAS; Wisconsin's economic support specialists and case managers work tirelessly to administer our state's public assistance programs, ensuring the well-being of our people, and the preservation of our economic livelihood; and

WHEREAS; these specialists and case managers work diligently to deliver timely and accurate benefits and payments in a sensitive and professional manner, even as caseloads are steadily increasing throughout our state; and

WHEREAS; economic support specialists and case managers are experts in their field, and often volunteer on committees and work groups to refine their systems, facilitate communication between state and local agencies, and implement policy changes; and

WHEREAS; our economic support specialists and case managers provide continual relief for our state's most vulnerable populations and a social safety net for folks when they need one; and

WHEREAS; economic support specialists and case managers play a major role in promoting self-sufficiency and reducing the effects of poverty in their own communities; and

WHEREAS; this week, the state of Wisconsin joins economic support specialists and case managers, and all Wisconsinites who benefit from their services, in celebrating the essential functions they perform for our society;

NOW, THEREFORE, I, Tony Evers, Governor of the State of Wisconsin, do hereby proclaim April 27 – May 1, 2020, as

ECONOMIC SUPPORT SPECIALIST AND CASE MANAGERS WEEK

throughout the State of Wisconsin and I commend this observance to all our state's residents.

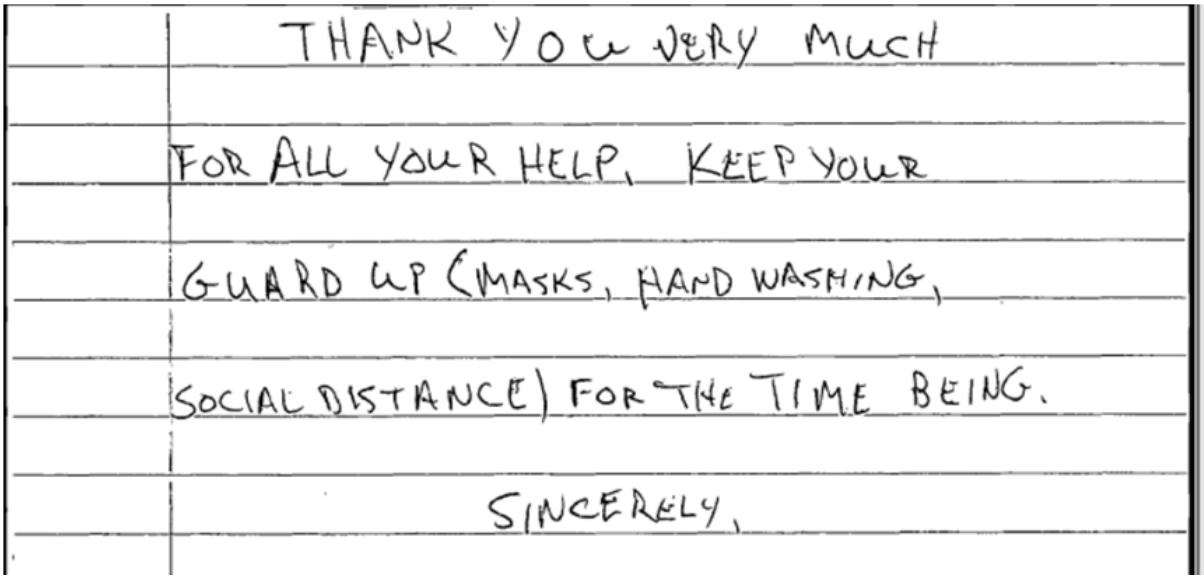
IN TESTIMONY WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Wisconsin to be affixed. Done at the Capitol in the City of Madison this 15th day of April 2020.

Tony Evers

TONY EVERS
GOVERNOR

By the Governor:

DOUGLAS LA FOLLETTE
Secretary of State


THANK YOU VERY MUCH

FOR ALL YOUR HELP, KEEP YOUR

GUARD UP (MASKS, HAND WASHING,

SOCIAL DISTANCE) FOR THE TIME BEING.

SINCERELY,

Case called the CCA to state thank you to all the workers who are helping him and expressed his gratitude for the assistance FS is giving him. I am passing along to you as you are his host county. He expressed the thanks towards the call center and the Green Lake County staff.

May 2020 Unit Update - Fox River Industries

Fox River Industries has continued to gradually add staff back from furlough to our program to assist with production sub-contract work. As of June 1st we have brought all staff back to work. Several staff members are assisting with health screening at the Justice Center building, and our Material Handler is currently being shared 4 days a week with the maintenance department. FRI has brought back 5 consumers to help out on the corn line, with several other casual workers to be added next week. Work continues to be steady with Alliance, Nelson-Miller (formerly Wilson-Hurd), and Fleet Farm corn orders remain very strong. FRI currently plans to bring back more consumers in a "phase 1 soft opening" starting on Monday June 22, if pandemic conditions and health department recommendations allow for this, as long as we can do so in a manner that mitigates infection risk to all consumers and staff members. FRI has created and implemented a COVID-19 policy, which includes wearing masks for all staff and consumers, health screens conducted at the main entrance for all staff and consumers, social distancing practiced throughout the building Additionally, portable plexi-glass self-standing partitions have been built and placed near various work stations and in the lunch room.

Fox River Industries Report

We have the start to our garden in loving memory of Betty.

My heart is filled and spilling over by all the people who have helped make this happen. We are living in such a world right now that our attention is forced to the negative but what has happened here is just small example of how a community should function. I cannot thank Jason Franke enough for what he has done in taking a dream, pulling together the generosity of partners he is established with, and going above and beyond to make this better than we could have imagined. Jason make sure every i was dotted and t crossed! And then went and surprised us with the flower bed and benches. I just can't get over it. I can't wait to fill it with plants, flowers, and people enjoying the space.

More pictures to come!!!

Dawn Brantley, Fox River Industries

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DEPARTMENT OF HEALTH & HUMAN SERVICES

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May 2020 Monthly, Report to the Health & Human Services Board

Our entire month has been full of activities related to COVID 19 response. I have increased hours for part-time staff Kari Schneider and Shari Krause to handle many of the calls and workload. We have also had Melanie Simpkins, RN return to help with this response on LTE position. Below is just one week of a typical week. Calls and requests for information from various community sectors has been overwhelming and a challenge.

Situation Report for week of May 25th-31st

May 27, 2020, Health Officer met with Princeton Chamber of Commerce members to discuss reopening of the Flea Market. The Chamber Board met after this meeting and decided to postpone the opening of the Flea Market for now for safety reasons.

May 27, 2020, Health Officer met with VFW rep from Berlin regarding their brat fries with Allison McCormick, EHS. Discussed safety measures that need to be implemented. The VFW met that evening and decided to hold off until mid-July so they could better prepare.

May 27, 2020, the Incident Command team met and discussed case counts, PPE, local events and much more. All feel local coordination is going well at this point. Group will have phone conference with staff from Governor's office and DHS staff at 1 pm on Friday with local mayors.

May 27th, 2020—Berlin School District sends outdoor graduation plan to Health Officer, Sheriff and EM Director. After approval from team along with their insurance company and school board, the district has decided to hold graduation on June 6th outdoors on the football field maintaining social distancing with graduates, families and school staff.

May 28, 2020—17th confirmed case in our county.

May 29th, 2020---18th and 19th cases of confirmed COVID in our county.

May 29, 2020—Health Officer met with superintendents from Green Lake, Markesan, Princeton and Berlin school districts on a Zoom meeting to discuss graduations, summer school, fall reopening and WIAA sports activities. Group found the discussion to be very helpful and will meet again in 3 weeks. Health Officer will coordinate this.

May 29, 2020—IC team and Mayors from Green Lake, Markesan, Princeton and Berlin had a phone conference with State Health Officer Stephanie Smiley and representatives from the Governor's office. A round robin style call allowed all to express local concerns to State. Issues included lack of communication, directing all issues to the local health department, remembering the issues of rural communities especially with schools and social distancing on busses and costs of these measures.

May 30, 2020—20th case of COVID 19 confirmed with person who drives Amish community members around the state. Contacts notified with assistance from Green Lake County Sheriff Mark Podoll and deputy Troy Schroeder who is our Amish Liaison Officer. During ill period this person drove 13 families to various places. Paper monitoring for these contacts has been instituted.

Respectfully Submitted,
Kathryn S. Munsey, RN
Green Lake County Health Officer

Environmental Health
Green Lake County
May 2020

Animal Bites/Exposures: Investigations – 5 (3 dog/human, 2 cat/human)
Reported Animal Bites/Scratches – 5
Animal Quarantines for Animal v. Human Exposures – 0
Animal Quarantines for Animal v. Animal Exposures – 3
Quarantine Violations and Enforcement Actions Taken – 0
Animals Exhibiting Positive Signs of Rabies During Quarantine –0
Animals Exhibiting Negative Signs of Rabies During Quarantine – 3
Enforcement Taken for Violations of Vaccination Requirements - 0
Animals Sacrificed for Exhibiting Symptoms of Rabies or Being Rabies Suspects- 2 (dog and cat, negative)

Well Water: No test kits distributed.

Lead: None.

Sewage: None.

Solid Waste: None.

Radon: 1 kit distributed

Housing: None.

Vector: None.

Asbestos: None.

Food/Water Illness: None.

Abandoned Bldgs: None.

Other: None.

Agent:

Routine inspections are temporary suspended due to the COVID-19 outbreak. 4 pre-inspections were conducted. Virtual school kitchen documentation inspections were also completed.

Distributed Red Cross clean-up kits to apartment tenants in Markesan on 5.01.2020.

Watched the UW-Madison Spring Symposium on 5.05.2020. The topic of the symposium was Working Together to Address Water Challenges.

Worked at the Waushara County Health Department COVID-19 testing clinics on 05.12.2020, 05.19.2020, and 05.30.2020.

Completed DSPS Pool training on 05.29.2020.

Conducted annual Berlin liquor license inspections on 05.28.2020.

The following emails went out to operators:

- Campground email
- Golf cart usage
- Campground restroom opening
- Campground email
- Green Lake County re-opening recommendations
- Rec. Ed. camp guidance
- Pool updates from DHS

1 day ETO used on 5.13.2020.

Green Lake County
Department of Health and Human Services
Comprehensive Community Services
DHS 36
Policy and Procedures

Appendix

All HFS has been changed to DHS for statutes !!!!

CCS *PLAN-DHS 36.07*
Organizational Plan and Structure - DHS 36.07(1)

CCS is a community-based psychosocial rehabilitation treatment service that focuses on a recovery model of treatment. Individuals to be served in CCS will include adults and children with mental health (MH) and substance use (AODA) problems who require more than outpatient services, but do not need the level of services that would be provided by a certified Community Support Program. The Green Lake County CCS will be organized within the Behavioral Health ~~Clinical Services~~ Unit of the Health and Human Services Department as a distinct mental health program along with the existing MH/AODA Outpatient Programs and the Community Support Program.

By developing CCS, Health and Human Services will expand its system transformation in which consumers receive services through a single coordinated system of care. CCS will be a wraparound program that is consumer driven, flexible, recovery oriented and strength-based.

The Ten Fundamental Components of Recovery include:

- Self-Direction
- Individualized and Person-Centered
- Empowerment
- Holistic
- Non-Linear
- Strengths-Based
- Peer Support
- Respect
- Responsibility
- Hope

The National Consensus Statement on Mental Health Recovery is available at SAMSHA's National Mental Health Information Center at www.mentalhealth.samhsa.gov or ~~1-80-789-2647~~

These values are congruent with the CCS Vision:
Embedded in CCS are mechanisms to ensure that CCS will deliver recovery-based services to children and adults ~~adults, older adults, and children~~ across the lifespan in such a way that it incorporates the vision and principles of the original Blue Ribbon Commission statement.

Meaningful participation

- Consumers and community have a significant representation on the local CCS ~~Advisory Board or~~ Coordination Committee.
- The CCS Coordination Committee provides meaningful input into program plan development.
- Consumers have a significant role in the development and implementation of their service plans.

Access

- All target populations are included in the CCS plan.
- Access to services is based on level of need as determined by the Department-~~approved~~ using a comprehensive assessment and functional screen process.

- Planful assertive outreach anticipates and identifies persons in need of services.

Recovery

- Recovery is evidenced by staff training and the appropriate and effective implementation of individualized services for each consumer.
- Agency forms and processes used for intake, assessment and planning are recovery-based.
- Recovery will also be evidenced by the supportive relationship staff have with consumers.

Meeting individualized needs

- Service plans foster natural and peer supports wherever possible.
- A flexible array of services is available.
- Service plans are reviewed for effectiveness and appropriateness and changed to reflect consumers' current needs and goals.
- Service plans are recovery-based, individualized, based on consumers' identified needs and life goals, and crafted in a recovery team with the consumer/family.
- Service plans are designed to assist the person to achieve the highest level of health wellness, stability, self-determination, and self-sufficiency.

Focus in Quality Improvement

- Continuous quality improvement is embraced as the responsibility of local program management; resources for quality improvement are integrated into program costs.
- Quality improvement processes support improving consumer outcomes and uses measurable quality indicators based on data/information the agency routinely collects.
- A quality improvement plan is in place at the time of full certification that is effective, measurable, and focused on the effectiveness of service delivery and satisfaction of consumers.

Generally, most consumers identified as needing psychosocial rehabilitation services are already involved with services in one or more areas of the county system of care. For this reason, CCS will operate as a "community-based mental health program". CCS team members will collaborate with consumers to develop a treatment team to best meet consumers' identified needs. Existing staff members of various Health and Human Services program units who work with a consumer may provide service facilitation or other services within CCS. That staff member's time will be allocated to CCS while he/she is performing CCS work. On the other hand, staff members from other units of the agency may coordinate closely with CCS, but maintain separate roles due to other program responsibilities. This integral connection of CCS to other Health and Human Services program units requires close coordination and clearly defined roles and responsibilities.

~~**CCS Structure**~~

~~The Family Resource Council has discussed how the CCS process could be structured in Green Lake County. The team leader (or designated person) would provide this service in addition to their other responsibilities. CCS teams are facilitated by an array of Master's level clinicians with varied skill sets around children, adolescents, adults, families, AODA, physical disabilities, mental health and developmental disabilities.~~

~~Possible criteria for selecting families for enrollment in CCS will be individuals who are currently enrolled in multiple Health and Human Services units where there is a need for integrated planning and support to ensure the delivery of psychosocial rehabilitative services to~~

~~those who have complex and enduring needs.~~

Staff Functions – DHS ~~HFS~~ 36.07 (l)(a)

CCS Service Director: The CCS Service Director meets the required qualifications and will fulfill the responsibilities ~~of the "administrator function" in CCS~~ to oversee the entire CCS program. The duties include the overall responsibility for CCS; including compliance with DHS ~~HFS~~ 36 and other applicable state and federal regulations and developing and implementing policies and procedures. The Service Director ~~Clinical Services Unit Manager~~ holds a Master's degree ~~in Marriage and Family Therapy and has program oversight for CCS~~ and is a Licensed Professional Counselor.

~~This position provides administrative supervision to the CCS Service Director and will meet regularly with her to discuss CCS admissions and policy and protocol. Furthermore, this position will report to the CCS Coordinating Committee on the progress of the program and share input from committee members on improvements for the CCS.~~

~~Service Director and~~ Mental Health Professional: The ~~Clinical Services~~ Behavioral Health Unit Manager ~~or designee~~ meets the required qualification of ~~the "service director function: and~~ the Mental Health Professional (MHP) function. The ~~Service Director~~ Behavioral Health Unit Manager holds a ~~MS~~ Master's degree and is licensed professional counselor and has program oversight for CCS. ~~She is also the agency's CSP Clinical Coordinator.~~ This position provides administrative supervision to the CCS Coordinator and will meet regularly to discuss CCS admissions, policy and protocol. ~~And document clinical and administrative supervision as to progress of the CCS.~~ The position also reviews and attest to the need for psychosocial rehabilitation services. The MHP participates in the assessment process and authorizes the services on the recovery plan**.**

Substance Abuse Professional: The Behavioral Health Unit Manager or designee meets the required qualification of the Substance Abuse Professional (SAP) function. When substance abuse issues exist, ~~one of the Clinical Services Dual Diagnosis Counselors~~ the SAP will either be consulted or participate in the assessment process, recovery team, service planning, and discharge planning.

If the Mental Health Professional has the qualifications of both a mental health professional and a Substance Abuse Professional, then the mental Health Professional may serve in both roles on the recovery team.

CCS Coordinator: The CCS Coordinator oversees the day to day program details of CCS. The position is responsible for quality assurance, training, and DHS 36 compliance. The CCS Coordinator works directly with recovery teams to insure the fundamental recovery based principles of CCS are present in each team. The CCS Coordinator will meet regularly with the Service Director and Mental Health Professional and Substance Abuse Professional for supervision and collaboration. The CCS Coordinator will also oversee the contracted providers utilized in the CCS service array and insure the same standards are present.

Service Facilitator ~~Function~~: The responsibilities of Service Facilitator ~~function~~ will be assigned to a qualified staff member of Health and Human Services ~~who has a case management-type or professional relationship to the consumer~~ is certified to provide CCS services. The CCS Coordinator and the Unit Manager of the staff member will agree on the designation of a staff member as a CCS Service Facilitator. When a staff member is fulfilling the CCS functions, the percentage of his/her time conducting

those responsibilities will be allocated as CCS staff time in the organizational structure. CCS service facilitation will be directed and supervised by the CCS Coordinator~~/Service Director~~ and Mental Health Professional, however, there will be collaboration between the CCS Coordinator and Unit Manager to delineate the multiple unit responsibilities.

The responsibilities of the Service Facilitator ~~staff members performing the "service facilitation function"~~ include ensuring that the service plan and service delivery for each consumer is integrated, coordinated and monitored, and is designed to support the consumer in a manner that helps him/her to achieve the highest possible level of independent functioning. This position is also responsible for facilitating the assessment and service planning processes on a regular basis.

~~For the qualifications and staff functions of specific Health and Human Services staff members who will be assigned duties in Green Lake County CCS, refer to the Staff Listing Forms in Appendix A on pages 15–17. This listing shows staff members who may provide services. More staff will be added to CCS to fulfill service facilitation functions as more consumers are admitted.~~

~~See attached job descriptions and credentials of all personnel in the CCS staff listing that are designated as service facilitators. All meet the qualifications of HFS 36.10(4)(g).~~

Quality Improvement- DHS 36.07(1)(b)

Green Lake County CCS will implement a Quality Improvement Plan to evaluate how effectively the services are meeting consumers' needs and to direct how changes may be implemented when needs are not being met. Data for evaluation will be collected regarding consumer functioning, quality of life, and consumer satisfaction. This information will be used to review the overall quality of the services and identify areas needing improvement.

Green Lake County CCS will also evaluate the quality of services at regular intervals for each consumer's involvement in order to assess consumer satisfaction and progress toward individual outcomes. The confidentiality of persons providing opinions to CCS will be protected.

All data and suggestions regarding program improvement will be shared and discussed during the Coordinating Committee.

Coordination Committee-DHS 36.07(1)(C)

The Coordination Committee has been established that includes at least 1/3 consumer membership (including parents of child consumers) and no more than 1/3 county staff. The Coordination Committee's role will be to review quality improvement information; personnel policies and program practices; and protect consumer rights. This committee will review and make recommendations regarding the initial and any revised CCS plans as well as the CCS Quality Improvement Plan. ~~(See Coordinating Committee agreement- Attachment XVII.)~~

CCS Coordination Committee Policy & Procedures

Policy

Per the requirements of DHS 36.09, Green Lake County Department of Health &

Human Services will establish a Coordinating Committee to assist in planning, monitoring, and evaluating the effectiveness of its Comprehensive Community Services Program. The following procedures detail how this will be composed and how it will operate. Green Lake County will also participate in the Regional Coordination Committee Meeting that is facilitated by the Central Wisconsin Health Partnership (CWHP).

Procedures

1. The CCS Coordination Committee shall include representatives from the following categories (individual appointees may represent multiple categories)
   a. County staff having a stake in the provision of CCS services shall always be included. At minimum there will be representatives from the Department's Long-Term Support unit for adults, Children & Family Services Unit, and mental health and substance abuse staff.
   b. Consumers of behavioral health services will also always be represented. These will likely include consumers of behavioral health services generally, though we will always have some consumers currently served by the CCS programs.
   c. Family members of consumers.
   d. Community mental health and substance abuse advocates.
   e. Service providers from contract agencies used by the CCS.
   f. Other interested citizens.

2. At least one-third of the total membership of the Coordination Committee shall be consumers (which include family members) and no more than one-third of the total membership shall be county employees.

3. The coordination committee shall meet at least quarterly and shall maintain written minutes of its meetings, as well as a current membership list.

4. The coordinating committee shall do all of the following:
   a. Review and make recommendations regarding the initial and any revised CCS plan required under s. DHS 36.07.

   b. Review and make recommendations regarding CCS quality improvement plan at least semi-annually.
   c. Review and make recommendations regarding personnel policies.
   d. Review and make recommendations regarding other policies, practices, or information that the committee deems relevant to determining the quality of the CCS program and protection of consumer rights.
   e. Committee members will go through an orientation and training on recovery principles.

Recruiting and Contracting with Providers - DHS 36.07(1)(d)

Green Lake County CCS will seek out appropriate providers to meet the service needs of consumers in the program. CCS will establish contracts or memorandums of understanding (MOU) with internal agency departments (when needed) and outside service providers in order to define clear roles and responsibilities, and ensure collaboration and quality of service. Release of Information will be obtained as needed with collaborative partners. Every contract and MOU will include agreements to

incorporate CCS service plan goals, participate as necessary on teams, protect consumer rights and adopt the "Core Values." Contracts and MOU's will also include agreement to incorporate court requirements and other legal mandates into CCS service plans, when applicable and desired by the consumer. All contracted providers will complete CCS certification and provide necessary documentation, and administrative paperwork as needed by the CCS Coordinator.

Updating and Revising the CCS Plan - DHS 36.07(1)(e)

Amendments or revisions to the Comprehensive Community Services Plan will be made when there are substantive changes to the CCS program including when services are changed or added to the service array and when policies and procedures of the program are added or revised. The CCS Coordination Committee will review all amendments and revisions of the Comprehensive Community Services Plan. The feedback of the Coordination Committee will be documented and maintained with the updated plan.

CCS Response to Recommendations - DHS 36.07(2)

~~The CCS response to the Coordination Committee recommendations will be submitted to BQA with the Coordination Committee recommendations. (See attached Coordination Committee minutes -June 2005, Appendix XVII). The CCS Committee recommended a mission and vision statement be developed for CCS. This will be done by a sub-committee workgroup and brought back to the full Coordination Committee for input/approval.~~

Minutes detailing all recommendations made by the coordinating committee as well as a written response to those recommendations will be maintained by the CCS Coordinator.

County System of Services - DHS 36.07(3)

Currently the systems that deal with consumers who have mental health and substance use issues are primarily contained within Green Lake County Department of Health and Human Services.

The ~~Clinical Services~~ Behavioral Health Unit of Health and Human Services provides outpatient mental health and substance abuse treatment services, Community Support Program services, and Crisis Intervention Services for county residents. Health and Human Services contracts with ~~Mercy Medical Center Theda Care, St. Agnes Hospital and Fond du lac Health Care Center~~ area health care centers to provide the majority of emergency inpatient psychiatric and detox services. ~~There are no private mental health and/or substance abuse treatment providers in the county.~~ There is one local hospital within the county used for medical clearance prior to transferring consumers to a psychiatric or AODA facilities.

Consumers with mental health or substance use issues may receive services in other program units of Health and Human Services. Families with children who have mental health or substance use issues may be involved in the child welfare system (Children and Families Services Unit). Adults may be involved with Aging/Long Term Care Unit. Adults may receive long- term support services or Adult Protective Services or other agency services (Developmental Disability Services, Economic Support

Services, Public Health or ADRC).

When multi-system involvement exists, there is a significant need for a formalized coordination of services to ensure consumers' needs are being addressed. Green Lake County CCS will develop and implement collaborative coordination of care within the Health and Human Services agency and agreements with community organizations to outline roles and responsibilities when working with consumers who are involved in multiple services.

Outreach & Discharge Planning DHS 36.07(3)(a)

Green Lake County CCS will conduct outreach activities in order to make non-CCS programs and facilities aware of the nature of Comprehensive Community Services and how to refer individuals. Specific referral sources that will be targeted for outreach will include but will not be limited to schools, hospitals, inpatient psychiatric or substance abuse treatment facilities, nursing homes, residential care centers, day treatment providers, and correctional facilities. Green Lake County CCS will screen referrals and determine the eligibility and need for psychosocial rehabilitation services. Individuals determined to be eligible will be admitted to CCS.

Green Lake County CCS will participate in discharge planning activities with these facilities to assist the consumer in making a successful transition. Individuals determined not eligible for CCS will be referred to other appropriate programs. ~~See attached Outreach Policy. (page 39).~~

Emergency Protective Placements DHS 36.07(3)(b)

As part of ongoing service planning and review for CCS consumers, the CCS team routinely considers options such as petitioning for protective services if a consumer may be in need of such care or custody.

Being a part of the same Department of Health & Human Services, the CCS readily and easily consults with protective service staff, whether from the children's or adult system, in determining whether protective services are an appropriate option, and, if so, on the procedures for bringing those services into play. Because of such routine consultation and cross-training, CCS staff are quite familiar with these options and comfortable accessing such assistance.

When protective services are required, workers within these other units will take the lead in any necessary investigations (e.g. if abuse of a child or elderly adult is suspected, etc.). They will also be the ones to petition the courts and see the case through the court system. But CCS staff will be directly involved along the way.

Specifically, CCS staff will provide needed information and evaluations of the consumers at the front end. They will work directly with the consumer to help them understand and navigate through the process. They will assist in finding suitable placement resources when ~~that will be~~ necessary. They will continue to meet with and provide other needed services to the consumer even during such placements. And they will coordinate with the lead units in doing the required annual reviews of such placements and services.

Teaming with Other Care Coordination Services DHS 36.07(3)(c)

When CCS is provided in conjunction with other care coordination services, ~~Green Lake~~

~~County CCS~~ service facilitators will work collaboratively with those service systems. When the care coordination service is provided within the Health and Human Services agency, as with adult protective services or child welfare services, CCS will join with existing teams or services to work as a fully integrated service system. CCS will work with other agency program units to define roles and responsibilities and outline how the systems will work together for the benefit of the consumer.

When a care coordination service is provided outside of the agency, as with school systems, Green Lake County CCS will pursue agreements, MOU's or release of information in order to ensure coordination of services with that system. Agreements will define roles and responsibilities and outline how the systems will work together for the benefit of the consumer.

Chapter 51 DHS 36.07(3)(d)

When an individual is living in the community under a civil commitment, Green Lake County CCS will provide outreach and screening to determine if he/she is eligible to receive Comprehensive Community Services. When Green Lake County CCS is providing services to a civil commitment consumer, the treatment requirements of the commitment will be incorporated into the CCS Service Plan. CCS will be responsible for providing appropriate treatment services to the consumer so that he/she can live in the least restrictive setting possible to ensure treatment and safety concerns within the community.

Community Agencies DHS 36.07(3)(e)

CCS will establish contracts or MOU's with internal agency programs and outside service providers in order to define clear roles and responsibilities, ensure collaboration, and quality of service. Every contract and MOU will include agreements to incorporate CCS Service Plan goals, participate as necessary on teams, protect consumer rights, and adopt the "Core Values." Likewise, contracts or MOU's will also include agreements to incorporate court requirements and other legal mandates into CCS Service Plans, when applicable.

Establishing New Services DHS 36.07(3)(f)

The CCS will establish contracts with providers when a needed service is not available in the existing array of services. Contracts will include the provider's agreement to incorporate CCS Service Plan goals, participate as necessary on teams, protect consumer rights, and adopt the "Core Values."

Crisis Services DHS 36.07(3)(g)

The Health and Human Services ~~Clinical Services~~ Behavioral Health Unit is the county's emergency Chapter 51 after-hour services program. County residents access this service by contacting the Green Lake Sheriff's Office when the agency is closed. The Green Lake Sheriff's Office calls the on-call worker who assesses the crisis situation and recommends or develops a crisis plan that may include linkage and referrals, natural supports strengthening, and safety planning as well as inpatient hospitalization if needed. The Health and Human Services Children and Families on-call system also responds to emergencies involving children who are in need of placement or currently involved in the child welfare system. Green Lake County CCS will arrange with ~~Clinical Services~~

Behavioral Health Unit on-call and the Children and Families on-call system to ensure identification and referral of CCS consumers who are in crisis. Individuals who contact the crisis system will be asked if they are working with CCS or any other program of Health and Human Services. When it is determined that the individual in crisis is a CCS consumer, ~~Clinical Services~~ Behavioral Health Unit staff or the Children and Families on-call system will follow the established crisis response plan and will ensure that CCS staff members are notified of the emergency contact so that appropriate follow-up can be conducted. Each consumer will have a developed safety plan at the time of assessment.

~~Section 2: PSR~~ Array of Services -DHS 36.07(4)

The service array for Green Lake County CCS is set up to address the needs of consumers who require and are currently receiving services. The array of psychosocial rehabilitation services for delivery and for which authorization for reimbursement will be sought is described below. (Appendix A) ~~on pages 25-29~~

The services and service providers will be determined by identifying anticipated service needs of potential consumers based upon the assessment domains and treatment needs identified during the assessment process. ~~Treatment interventions for minors and elderly consumers will be identified separately from other consumers.~~

The following was completely changed from the attached from the old policy.

~~AODA Treatment Services~~

~~This includes alcohol/drug assessment, outpatient treatment services, groups, which are gender/age specific and strength based.~~

~~Case Coordination~~

~~This includes all activities by CCS case managers involving advocacy for consumers,~~

~~making referrals for consumers and coordinating with other involved providers, agencies, or recovery team members.~~

~~Case Plan Development & Review~~

~~Based upon the Initial Assessment, this activity would include development of the case plan and any subsequent reviews.~~

~~Community Life Skills Training~~

~~This psychosocial rehabilitation service will assist individuals with a mental health or~~

~~alcohol/drug diagnosis to acquire community life skills such as: training in shopping,~~

~~laundry, how to access transportation, benefit education, money management, budgeting, apartment maintenance, health care access and independent living problem solving. This will be provided by staff of the Department of Health & Human Services or contract~~

~~agency either on a one-to-one basis or through group training.~~

~~Counseling~~

~~Counseling services that will be included in this service array include the following:~~

~~psychotherapy (individual, family, group), and juvenile sex offender/anger management assessment and counseling. Health and Human Services Clinical Services staff and~~

~~independently contracted providers who agree to participate in the CCS model will~~

~~deliver treatment services.~~

~~Two levels of service are provided within the Juvenile Sex Offender/anger management Counseling service. Group Counseling will consist solely of a specialized group~~

~~treatment counseling service. The Multi faceted Program is a more intensive treatment and will consist of several integrated components including individual, group and family programming, education, and ongoing safety assessment and planning.~~

~~Crisis Services~~

~~This is the provision of services to individuals within the CCS who are experiencing emergencies which require an immediate response by the Human Service System~~

~~(including those activities necessary to prepare for responding to conditions which are an immediate threat to a person's life or well being). The purpose is to ameliorate these conditions and link the individual with appropriate services.~~

~~Employment Related Skills Development~~

~~The provision of services in integrated community work settings, specialized facilities (e.g., sheltered workshops), or other setting for the purposes of enabling individuals to participate in work, develop work and related abilities, improve work performance,~~

~~and/or remove obstacles to gainful employment. Services may include but are not limited to: vocational assessment, job development, job coaching and on the job training within the community or agency.~~

~~Health Monitoring Training~~

This service provides medication administration, dispensing, and nursing assessment related to a consumer's mental health or substance use diagnosis. This service also includes administration and assistance in taking other medications if the need for supervision is related to the person's mental health or substance use diagnosis. A registered nurse acting on physician orders will provide the service.

Initial Assessment

This would encompass all activities associated with conducting and documenting the initial comprehensive assessment of a new consumer's needs.

Peer Support Services

Peer support services refer to support provided by people with mental illnesses or alcohol/drug diagnosis to other people with similar issues. These services can range from a support group to a peer-run program that provides one-on-one services. Peer support services provide an opportunity for people with mental illnesses or alcohol/drug issues to direct their own recovery and advocacy process, and to teach others the skills necessary to lead meaningful lives in the community. Throughout the country, people with mental illnesses and alcohol/drug issues are establishing peer support programs in order to expand opportunities for successful recovery, shared growth and wellness. The members of peer support programs assume personal accountability for their own treatment based on a framework of respect, mutual agreement of what is helpful and shared responsibility.

Psychological/Psychiatric Evaluation

This includes the initial meeting with the staff psychiatrist or psychologist to confirm diagnostic impressions, establish need for medication treatment, and initiate that treatment when appropriate.

Psychosocial Rehabilitative Residential Support Services (RRS)

Green Lake County CCS will initially target appropriate individuals currently receiving Rehabilitative Residential Support (RRS) services, thus this is included in the service array. These services will be comprised of adult group home, adult family home, child/adolescent group home, and child/adolescent treatment foster home services. The placement services will provide care, supervision, treatment and training as needed to support one or more aspects of living such as healthcare, personal care, supervision, behavioral and social supports, daily living skills training, and transportation when needed.

Psychotherapy Services

The provision of treatment oriented services will be delivered to individuals needing treatment for a personal, social, behavioral, mental, or alcohol and drug abuse disorder to maintain and improve effective functioning. Services typically provided in a office or a natural setting, may include, but are not limited to: assessment/diagnosis; case (treatment) planning, monitoring and review; and counseling/psychotherapy to individuals across the lifespan.

Service Facilitation

The functions of assessment and service planning go hand-in-hand and are therefore identified as a single service in the PSR Array. The Assessment and Service Planning service will ensure that a comprehensive strengths/needs assessment is completed with the participation of the consumer, informal supports, and involved service providers.

From the assessment, a service plan will be developed. The assigned service facilitator and the designated mental health professional will facilitate the assessment and service planning

~~process. A recovery team that includes the consumer, his/her selected supports, and other service providers will also be formed and will participate in assessment and service planning.~~

~~Service facilitation will be provided to ensure the consumer is linked with appropriate services and that those service providers collaborate to deliver a fully coordinated system of care for the consumer. Various assigned Health and Human Services staff members who meet the qualifications of a service facilitator will provide this service.~~

~~Symptom Management Training~~

~~The provision of services to CCS individuals for the primary purpose of decreasing the symptoms of mental illness; promoting mental or physical health and improved social and community functioning. Services, which are typically provided, include exercise, education and social activities.~~

1. Screening and Assessment

- completion of initial and annual functional screens
- completion of the initial comprehensive assessment and ongoing assessments as needed

2. Service Planning

- The development of a written plan of the psychosocial rehabilitation services that will be provided or arranged for the member.
- The service plan must be reviewed and updated based on the needs of the member or at least every six months.
- The service plan review must be facilitated by the service facilitator in collaboration with the member and the recovery team.

3. Service Facilitation

- Activities that ensure the member receives: assessment services, service planning, service delivery, and supportive activities in an appropriate and timely manner.
- Ensuring the service plan and service delivery for each member is coordinated, monitored, and designed to support the member in a manner that helps the member achieve the highest possible level of independent functioning.
- Assisting the member in self-advocacy and helping the member obtain other necessary services such as medical, dental, legal, financial and housing services.
- Coordinating a member's crisis services, but not actually providing crisis services.
- For minors it includes advocating, and assisting the minor's family in advocating, for the minor to obtain necessary services. Service facilitation that is designed to support the family must be directly related to the assessed needs of the minor.

4. Diagnostic Evaluations

- Specialized evaluations needed by the member including, but not limited to: neuropsychological, geropsychiatric, specialized trauma, and eating disorder evaluations.
- For minors, diagnostic evaluations can also include functional behavioral evaluations and adolescent alcohol/drug assessment intervention programs.
- The CCS program does not cover evaluations for autism, developmental disabilities, or learning disabilities.

5. Medication Management

- Prescriber Services
- Diagnosing and specifying target symptoms.
- Prescribing medication to alleviate the identified symptoms.

- Monitoring changes in the member's symptoms and tolerability of side effects.
- Reviewing data, including other medications, used to make medication decisions.
- Prescribers may also provide all services the non-prescribers can provide as noted below.
- Non-prescriber Services
- Supporting the member in taking his or her medications.
- Increasing the member's understanding of the benefits of medication and the symptoms it is treating
- Monitoring changes in the member's symptoms and tolerability of side effects.

6. Physical Health Monitoring

- Focus on how the member's mental health and/or substance abuse issues impact his or her ability to monitor and manage physical health and health risks.
- Include activities related to the monitoring and management of a member's physical health
- Include assisting and training the member and the member's family to identify symptoms of physical health conditions, monitor physical health medications and treatments, and to develop health monitoring and management skills.

7. Peer Support (Note: Services must be provided by Wisconsin Certified Peer Specialists)

- Assist the member and the member's family with mental health and/or substance abuse issues in the recovery process.
- Promote wellness, self-direction, and recovery by enhancing the skills and abilities of members to meet their chosen goals.
- Help members negotiate the mental health and/or substance abuse systems with dignity, and without trauma.

8. Individual Skill Development and Enhancement

- Training in communication, interpersonal skills, problem solving, decision-making, self-regulation, conflict resolution, and other specific needs identified in the member's service plan.
- Training in daily living skills related to personal care, household tasks, financial management, transportation, shopping, parenting, accessing and connecting to community resources and services, and other specific daily living needs identified in the member's service plan.
- Services provided to minors should
- Focus on improving integration into and interaction with the minor's family, school, community, and other social networks.
- Include assisting the minor's family in gaining skills to assist the minor with individual skill development and enhancement. Services that are designed to support the family must be directly related to the assessed needs of the minor.
- Skill training may be provided by various methods, including but not limited to modeling, monitoring, mentoring, supervision, assistance, and cuing.
- Skill training may be provided individually or in a group setting.

9. Employment-Related Skill Training

- Services address the member's illness or symptom-related problems in finding, securing, and keeping a job and may include but are not limited to:
- Employment and education assessments
- Assistance in accessing or participating in educational and employment-related services
- Education about appropriate job-related behaviors
- Assistance with job preparation activities such as personal hygiene, clothing, and transportation
- On-site employment evaluation and feedback sessions to identify and manage work-related symptoms

- Assistance with work-related crises
- Individual therapeutic support.

The CCS program does not cover time spent by the member working in a clubhouse. The CCS program covers time spent by clubhouse staff in providing psychosocial rehabilitation services, as defined in the service array, if those services are identified in the member's service plan.

10. Individual and/or Family Psychoeducation

- Providing education and information resources about the member's mental health and/or substance abuse issues.
- Skills training.
- Problem solving.
- Ongoing guidance about managing and coping with mental health and/or substance abuse issues.
- Social and emotional support for dealing with mental health and/or substance abuse issues.
- Psychoeducation may be provided individually or in a group setting to the member or the member's family and natural supports.
- Family psychoeducation must be provided for the direct benefit of the member.
- Family psychoeducation may include anticipatory guidance when the member is a minor.

If psychoeducation is provided without the other components of the Wellness Management and Recovery service array category (#11), it should be included under this service category.

11. Wellness Management and Recovery / Recovery Support Services

- Wellness management and recovery services (generally provided as mental health services), include:
- Empowering members to manage their mental health and/or substance abuse issues,
- Helping them develop their own goals
- Teaching them the knowledge and skills necessary to help them make informed treatment decisions
- Psychoeducation;
- Behavioral tailoring;
- Relapse prevention;
- Development of a recovery action plan;
- Recovery and/or resilience training;
- Treatment strategies;
- Social support building
- Coping skills.
- Services can be taught using motivational, educational, and cognitive-behavioral strategies.

If psychoeducation is provided without the other components of wellness management and recovery, it should be included under the Individual and/or Family Psychoeducation service array category (#10).

- Recovery support services (generally provided as substance abuse services), include:
- Emotional, informational, instrumental, and affiliated support.
- Assisting the member in increasing engagement in treatment
- Assisting the member in developing appropriate coping strategies
- Providing aftercare and assertive continuing care designed to provide less intensive services as the member progresses in recovery, including relapse prevention support and periodic follow-ups.

12. Psychotherapy

- The diagnosis and treatment of mental, emotional, or behavioral disorders, conditions, or addictions through the application of methods derived from established psychological or systemic principles for the purpose of assisting people in modifying their behaviors, cognitions, emotions, and other personal characteristics, which may include the purpose of

understanding unconscious processes or intrapersonal, interpersonal, or psychosocial dynamics.

- Psychotherapy may be provided in an individual or group setting.

13. Substance Abuse Treatment

- Day treatment (DHS 75.12, Wis. Admin. Code)
- Outpatient substance abuse counseling (DHS 75.13, Wis. Admin. Code)
- Can be in an individual or group setting.
- The CCS program *does not* cover

Operating While Intoxicated assessments,
Urine analysis and drug screening,
Detoxification services,
Medically managed inpatient treatment services, or
Narcotic treatment services (opioid treatment programs)

~~Section 3:~~ CCS Program Policies and Procedures - DHS 36.07(5)
Consumer Service Record ~~Policies and Procedures~~ - DHS 36.07(5)(a)

~~Policy~~
Per DHS 36.18, the CCS program shall maintain in a central location a clinical record for each consumer that it serves. Each consumer service record shall include sufficient information to demonstrate that the CCS has an accurate understanding of the consumer, the consumer's needs, their desired outcomes, and their progress toward goals. Entries into the record shall be legible, dated and signed. This consumer service record shall be maintained pursuant to the confidentiality requirements under HIPAA, s. 51.30 Stats, DHS 92, and if applicable, 42 CFR Part 2. In addition, electronic records and electronic signatures shall meet the HIPAA requirements in 45 CFR 164, subpart C.

In order to assure compliance with the above policy, the CCS will follow the procedures outlined below:

~~Procedures~~
Each consumer record shall be organized in a consistent format ~~and include a legend to explain any symbol or abbreviation used.~~ All of the following information shall be included in the consumer's record:

1. Results of the initial comprehensive assessment completed under s. DHS 36.16, including the assessment summary ~~by the service director~~.
2. All service plans and updates, including attendance rosters form service planning sessions.
3. The "authorization of services" statement from the service director/mental health professional.
4. Any request by the consumer for a change in services or service provider and the response by the CCS to such a request.
5. Documentation of all service delivery, including at minimum the following:
    a. Service facilitation notes and progress notes.
    b. Records of referrals of the consumer to outside resources.
    c. Description of significant events that are related to the consumer's Recovery Plan and that contribute to an overall understanding of the consumer's ongoing level and quality of functioning.

d. Evidence of the consumer's progress, including the consumer's response to services, changes in their condition, and changes in the services provided.
e. Observation of changes in activity level or in physical, cognitive or emotional status and details of any related referrals.
f. Case conference and consultation notes.
g. Service provider notes in accordance with standard professional documentation practices.
h. Reports of treatment or other activities from outside resources that may be influential in the CCS's service planning.

6. A list of current prescription medications and regularly taken over the counter medications. Documentation of each prescribed medication shall include all of the following:
   a. Name of the medication and dosage.
   b. Route of administration.
   c. Frequency.
   d. Duration, including the date the medication is to be stopped.
   e. Intended purpose.
   f. Name of prescriber.
   ~~Since Green Lake County CCS's prescribe medication as a service, the signature of the prescriber will also be included for those medications prescribed internally.~~
   g. Activities related to the monitoring of medication, including monitoring for desired responses and possible adverse drug reactions, as well as an assessment of the consumer's ability to self-administer medication.
   h. If a CCS staff member administers medication, each medication administered shall be documented on the consumer's individual medication administration record (MAR). This documentation shall include the time the medication was administered, by whom it was administered, and any observation of adverse drug reactions with a description of the adverse drug reaction. If there is an adverse reaction, then the time of the observation and the date and time the prescriber of the medication was notified must also be recorded. If a medication was missed or refused by the consumer, the record shall explicitly state the time that it was scheduled and the reason it was missed or refused.
7. Signed consent forms for disclosure of information and for medication administration and treatment.
8. Legal documents addressing commitment, guardianship, and advance directives.
9. Discharge summary and any related information.
10. Any other information that is appropriate for the consumer service record.

~~Policies and Procedures Regarding~~ Patient Confidentiality- DHS 36.07(5)(b)

~~There are a number of State and Federal Statutes and Administrative Codes governing patient records, making them strictly confidential and laying out the conditions under which they can be accessed or released. Because it is not possible to summarize all the information contained in those laws here, links to the most pertinent of them (HFS 92 and HFS 51.30) will be included at the end of this section of the manual for staffs reference. In this section, we will highlight only certain aspects of these laws, while also providing several guiding ideas for staff to sue when trying to put these laws into practice.~~

If you are unable to find clear direction from these materials, or whenever there is any question regarding patient confidentiality, staff is advised to err on the side of caution by asking questions.
Since the official "custodian of the record is the Deputy Directory, he will typically be the person to approach with such questions, but in his absence the CSP Clinical Coordinator can give guidance.

General Legal Principles
1. For practical purposes, the best way to understand what "confidentiality" of the record means is to see that the clinical record essentially "belongs" to the client. In legal language, we would say that the client "holds the privilege". Thus, as
with any other property that is owned, it is the client who determines who has
access to their record (i.e. the client has the "privilege" of determining access)
while being free to access it him or herself at any time (i.e. they have "privileged" access).
2. The corollary to the above is the notion that we are the "custodian" of the record,
i. e. the record may "belong" to the client, but it is in our "custody" and hence we have a duty to protect it and care for it in the best interests of the client. We
protect it in essentially three ways:
a. By making sure that anything that goes in the record is accurate and
appropriate;
b. By making sure that the record adequately documents the services that have been provided, i.e. it must be a "useful" record of the services
provided;
c. and by making sure that any disclosure of protected information is done only with the "authorization" of the client (see below).
3i Authorization in the present context is a legal term which essentially means that all of the following are true regarding the disclosure of protected infonnation
(having clients sign our "Authorization for the Release of Infonnation" form -a copy of which follows this section of the manual -meets these requirements:
* the client know "to whom" the information is to be release;
* they know "what specifically" will be released;
* they know the "purpose" for which it will be released;
* they know the "time period" during which the consent is effective;
* they have "signed and dated" a form giving authorization for this;
* they understand that they may withdraw that release in writing at a later time if it has not already been acted upon;
* and the signed fonn always includes the following two statements: that if an agency is releasing information to us, they are advised that the client or his or her legally authorized representative has the right to inspect and receive copies of the material which they divulge, and agencies or individuals who receive
information from the Clinic are advised that they are prohibited from any re-disclosure or re-release of that information without client consent.

Documenting and Protecting Confidential Information
1. Keep in mind that it is not just the "written" treatment records which are considered confidential and privileged to the client -any spoken information
which could in any way identify the client is also protected. As such, staff must be very cautious when speaking about clients not to let other people overhear.
Situations where this can be an issue include: talking with or about clients at the reception counter, talking with family members or other interested parties in the waiting room, or talking with other staff about clients in the hallway or in an

office with the door open (such that people in other offices or in the hall could overhear). As a general rule, such discussions should never take place in public areas and should instead be taken into office areas with doors closed.

2. Although we all work for the same agency and thus will frequently have to discuss clients as part of our work, this does not give us the right to exchange information about clients arbitrarily. In particular, just because something is interesting or amusing does not give us the legal right to share that information with other staff. The only legitimate person for the exchange of information of a confidential nature is that there is a job-related need for the other staff person to know that information. Thus staff should use this need to know rule in guiding them concerning questions of confidentiality between staff.

3. When dictating or typing information on a client, always keep in mind that the client has the legal right of access to their treatment records and thus you should not be recording anything that you would not be willing to share with them or have them read.

4. Even though records are confidential and privileged to the client, it is always possible for those records to get released against the client's will *e.g. by court subpoena). Hence, when dictating and keeping the record, always keep these other potential audiences in mind as well (i.e. lawyers, the court, child protection workers, etc.) and do not document anything that you would not be willing to stand behind in a court of law.

5. When acquiring information about a client from a third party (especially when that third party wants you to keep the information "in confidence") be sure to inform them first that the information will be available to the client. Though such information can be placed in a chart without identifying the source of the information, the third party should still consider whether the information itself might give them away. They might wish to reconsider what they want to divulge.

6. Even when we have a signed authorization from a client giving permission to release their records, that does not allow us to release information regarding other individuals who may be identified within that chart and who may also be clients receiving our services (e.g. family members in family therapy). Because of this, staff should always do their best not to identify others by full name in the chart, and when that information does get recorded, should be certain to delete before releasing the record.

7. Just because a client has once given their written permission to release information does not mean that that release remains always in effect. Not only are releases only good for a specified time period, but clients can always withdraw their authorization at any time. Hence, always check to make sure that a current and valid release is present before divulging any information.

8. Maintaining the confidentiality of treatment records includes the idea that those records are stored securely at the Clinic. Hence, staff members are not allowed to take any client information off the premises at any time (e.g. by taking dictation or reports home with you, etc.). Records do sometimes need to be transported between offices, but provisions are in place to protect the security and confidentially of these records while being transported.

Guidelines for Reception staff in Responding To Inquiries about Clients

Clinical Services reception staff often receive calls form third parties requesting information about clients without knowing whether there is a valid release allowing that information to be divulged. This section provides guidance in how to respond to these request. As will be seen, whether any information is shared, or even any

acknowledgement is made that we serve the client, will depend on who is making the request and which unit of our agency works with the person. In particular, it is never permissible to give more than a non-committal response to inquiries regarding ADDA clients.

1.As a general rule, if the person making the request for information is completely unknown to us and has no known connection to the client, nor to an agency that we work with, then we should be giving them only a non-committal response. This is true even if they are only looking to find out which staff person is working with the client. A non-committal response is one that neither affirms nor denies that the person is a client nor even that we have knowledge of such a person. Examples of such non-committal responses follow:

"I am sorry, but due to confidentiality, I am not able to acknowledge whether this person is a client of the Clinic. Is there a staff member here you would like to get back to you?"

"I am very sorry, but due to confidentiality I cannot answer your question. Could I have a staff member call you back?"

"I am sorry, but we are not allowed to give out information due to confidentiality of the Clinic records."

2. Sometimes such requests for unauthorized disclosures of information also come through the mail. A form letter will be developed for use in these situations.

3. If the person requesting information is a known family member of close personal friend of the client who is closely involved in that client's treatment or services, then it is permissible to connect that person up with the client's mental health case manager. Even though this does acknowledge that we serve the person, in this scenario, it is clear that the friend or family member already knows this and hence that making this connection is not revealing anything confidential. If such a connection is not clear, err on the side of caution by giving a non-committal response. Also, if reception staff does make the connection, they would leave it up to the case manager to determine what, if any, information to actually disclose.

4. If the person contacting us is very clearly from another agency that we work closely with (e.g. the school system, the housing authority, the victim-witness coordinator) and they are only wanting to be connected to an individual's social worker or mental health case manager, this is allowable, even though it does imply that we are providing services to the client. It would, of course, be up to that social worker or case manager to then determine what, if any, "specific" information to share about the client. As always, if you are not sure, err on the side of caution by giving a non-committal response.

5. If the person contacting clinic reception staff is from some division or unit of our own agency, then it is permissible to acknowledge serving the client in the clinic by connecting them with the assigned clinic case manager. But this is again only true if they are being served on the mental health side of the clinic. It is never permissible to acknowledge serving and AODA client, even to other units within our own Health & Human Services agency.

6.When a lawyer contacts us asking if a person has any record in our department, or wanting to review the medical record of a client, it is not appropriate to give the lawyer that information. This is so even if they claim to already be working with someone in our agency on a particular case, or if they claim to be the attorney for that client. Without a properly signed release, lawyers should be treated like any ordinary citizen, i.e. given a non-committal response and told that they would need to get a release before we could divulge any information to them, even the simple fact of whether or not a person has been served by us. If the lawyer is, in fact, working with some staff person on a case and has a legitimate need for the information, they

should be able to contact the staff person directly to request whatever they need.

And if the person is indeed their client, they should be able to get a properly signed release from them. The exception to this general rule would be if the lawyer were representing the client in a commitment or a re-commitment hearing and has proof of that relationship.

ALLOW ABLE DISCLOSURES OF CONFIDENTIAL INFORMATION

Notwithstanding general confidentiality protections, there are circumstances under which confidential clinical information can be legally disclosed to others without the client's prior authorization. The most important of these circumstances for practical purposes are outlined below.

Please note that these exceptions apply, only to Clinical Services Mental Health clients. Other rules apply to clients to other programs, particularly AODA clients. Please also note that HFS 92 makes clear "Whenever information from treatment records is disclosed, that information shall be limited to include only the information necessary to fulfill the request." Thus, even in all of these circumstances, we must be careful to disclose only the minimum amount of information necessary for the purpose at hand.

Lastly, please note that any time there is doubt about the appropriateness of divulging confidential information, always consult first with your supervisor or the Deputy Director before divulging.

1.When other health care professionals outside our own agency are also working with our client, there are certain circumstances under which we would be allowed to disclose limited information as part of our coordination with those professionals. These include the following:

a. Clinical Services professional staff may disclose limited confidential information from the client's treatment record to an inpatient psychiatric facility when that information is "relevant to an issue in proceedings to hospitalize the patient for mental illness". In general practice, staff should still seek the written authorization of the patient before sharing clinical information with hospital staff. But when circumstances make it impossible or infeasible to do so, and when the information is necessary to carry out the purposes of the admission (i.e. to get proper treatment for the patient), then law does allow staff to share such information without the client's authorization. Citations are s.51.30(4)(b)9 and s905.04(4)(a).

b. Confidential information about the patient may be released without consent to a licensed physician treating the person outside of the clinic when (and only when) the "life or health of the individual is in danger" and treatment without that information "could be injurious to the patient's health". Such disclosure is limited to only that part of the record necessary to achieve this purpose. Citation is s.5130(-4)(b)8 and HFS 92.04(8).

c. Limited information may be disclosed to staff of a laboratory or pharmacy that is processing or responding to a doctor's order for medication distribution or testing. The information to be disclosed must be limited to only what is required by the laboratory or pharmacy to carry out the doctor's orders. Citations are s.146.82(2)(a)2 and CRF t 64.506(c)(2).

d. Limited confidential information can be shared with the medical staff of a jail or prison, if we have been actively treating that person and the jail or prison medical staff indicate a need for that information, either to continue treatment for the person or for the safety of that or other inmates or staff. The information disclosed would have to be limited to only what was necessary to deal with this treatment or safety concern. Citations are

s. 146.82(2)(a)21 and CFR 164.512(k)(5)(i)(A).

2. In circumstances where someone is in danger, then in fulfilling our duty to warn and protect we may disclose limited confidential information without prior authorization in order to warn or protect the involved individuals as follows:

a. When the client poses a serious future threat to the health or safety of others we may be required to break confidentiality to the extent necessary to assure other people's safety. Specifically, we can disclose what we need to about that client:

* If in "good faith" we believe the disclosure is necessary "to prevent or lessen a serious and imminent threat to the health or safety of a person or the public" and

* we are giving that information "to a person or persons reasonably able to prevent or lessen the threat," including the "target of the threat".

Citation is CFR 164.5120)(1).

b. If in the course of our duties we come to suspect that a child we are seeing is being abused or neglected or has been threatened with abuse or neglect which is likely to occur, we are required to report that specific information to the proper authorities despite confidentiality concerns (per s. 48.981(2). In fact, we could be held legally accountable if we did not report such information, while we are legally protected when making such reports in good faith. We are also allowed to share the basis for our suspicions with the proper authorities during any subsequent investigation (per 48.981(3)). Citations for this allowed disclosure are s.51.30(4)17, s.146.82(2)11, s.905.04(4)(e), and CRF 164.512(b)(l)(ii)

c. If we learn that a minor 15 years of age or less whom we are treating is having sexual intercourse, we are required to report that specific information to the proper authorities despite confidentiality concerns (as a specific instance of the general duty to report abuse or neglect of children).

If the minor is 16 years of age or older, and if the sexual activity is clearly consensual, then it would not fall under the definition of abuse and would not have to be reported. This is true regardless of the age of the other person with whom this minor is having sex, though obviously the older the other person, the more likely you might be to question the consensual nature of the sex. Citations are s.48.981 and s.948.09.

d. If in the course of our duties we find reasonable grounds for the opinion that an expectant mother's unborn child is being iniured by her severe and habitual lack of self control in using alcoholic beverages or controlled substances, we are required to report this fact to the child protective services authorities and to share the basis for our suspicions with the proper authorities during any subsequent investigation despite confidentiality concerns (per s.48.981(2)(d). Citations for this allowed disclosure are s.51.30(4) 17, s.905.04(4)(e)3, and CRF l 64.512(c)(l)(iii).

e. If in the course of our duties we come to suspect that a "vulnerable adult" ie. an adult with a developmental disability, infirmities of aging, mental illness, or other like incapacities who is "mental incapable" of providing for his or her own care or making his or her own report of mistreatment) is being neglected, abused or materially abused, we are allowed to report that circumstance to the proper authorities and to share the basis for our suspicions with the proper authorities during any subsequent investigation (per s.55043) if in the exercise of professional judgement we believe the disclosure is necessary to prevent serious harm to the individual or other potential victims (per CFR 164.512(c)(l)(iii). If the individual whom we believe is neglecting or abusing the vulnerable adult happens to be their personal representative or

guardian, then we do not have to notify that person of our report (per CFR 164.51 (c)(2)(ii). Citations for this allowed disclosure are: s.51.30(4)(b)17 and s.146.82(2)7.

f. If in the course of your duties we come to suspect that an elderly adult is being mistreated, abused, or materially abused, we are allowed to report that circumstance to the proper elder abuse authority (per s.46.90(4)(a)) and to share the basis for our suspicions with the proper authorities during any subsequent investigation (per s.46.90(5)) but only if:

* the individual verbally agrees to the disclosure, or
* in the exercise of professional judgment we believe the disclosure is necessary to prevent serious harm to the individual or other potential victims, or
* we are first approached by law enforcement who represent that the information is needed for immediate enforcement activity and the individual is unable to agree because of incapacity. Citations for this allowed disclosure are: s.51.30(4)(b)l 7, s.146.82(2)7 and CFR 164.512(c)(l)(iii).

3. When an individual is involved in proceedings for involuntary treatment or protective services (due to their seriously deteriorated condition and inability to make care decisions on their own), limited information may be disclosed without prior authorization in order to facilitate the necessary legal proceedings as follows:

ap When an already involuntary committed patient is being transferred form one facility to another (as when someone on outpatient status must be transferred back to an inpatient facility), then the following limited treatment records may be disclosed to the receiving facility; a record of all somatic treatments and a discharge summary which includes a statement of the patient's problem, the treatment goals, the type of treatment provided, and recommendations for future treatment. Under these circumstances, the treatment director or designee of the first facility must review the record to ensure that no other information is released. Citations are s.51.30(4)(b)9 and HFS 92.04(9).

b. As pare of proceedings for involuntary commitment or review, the counselor or guardian at /item for the individual being committed, or the counsel for the public, may each have access to all the record "without modification" to prepare for such proceedings. Citations are s. 5l.30(4)(b)l l and HFS 92.04(11).

c. Certain confidential information may also be revealed when we are directly involved "in proceedings ... to appoint a guardian ... , for court ordered protective services or protective placement or for review of guardianship. protective services. or protective placements." This would most typically occur when involved in evaluating or sharing results of prior evaluations in initial proceedings, or when having to participate in an annual review of such placements. Citation is s.905.04(4)(a).

d. Treatment records may also be released to physicians or psychologists assigned by the court to do evaluations for the purpose of commitment or re-commitment hearings or for protective service proceedings. Citations are s.5l.20(9)(a) and s.905.04(4)(b).

e. Disclosure may also be made to appropriate examiners and facilities ordered by a court of law to determine whether a person is a "sexually violent offender" or "not guilty by reason of mental disease or defect" as outlined in s.971 and s.980. Citation is s.51.30(4)(b)8m.

f. As an extension of this last circumstance, disclosure may also be made to those private entities contracted by the state to collect and forward necessary records to these examiners for the purpose of outpatient

assessment of the individual's competency under these statutes (per 8-29-0 I opinion of DHFS secretary, these entities are functioning in a manner similar to a paralegal for an attorney).

4. If an individual we are treating is involved with the Corrections System, then there are certain circumstances under which we may disclose protected information without the client's prior authorization to personnel of that system.

a. When treatment services are being provided pursuant to a formal probation or parole supervision plan, certain limited information can be shared with the probation and parole agent without prior authorization. Specifically, we can disclose a report of the evaluation done pursuant to the supervision plan, a discharge summary at the termination of treatment, and "other information as may be necessary to implement changes in the individual's treatment plan or in the level and kind of supervision" provided during the treatment period. Citations are s.51.30(4)(b)10 and HFS 92.04(10)(a).

b. A correctional facility having custody of a person who is transferred to a treatment facility for services and then transferred back to the correctional facility is allowed to have a basic summary of the person's problem, treatment goals, the type of treatment provided, and recommendations for future treatment, as well as a record of all somatic treatments provided. Citations are s.5130(4)(b)9 and HFS 92.04(10).

c. A correctional officer who has custody of or is responsible for the supervision of an individual who is being transferred to or discharged form a treatment facility may be informed about the basic psychiatric status of that individual. Citations are s.51.30(4)(b)l2 and HFS 92.04(12).

d. The department of corrections may obtain protected information concerning a person required to register as a sexual offender under s. 301.45. Citation is s.51.30(4)(b)24.

There are a few circumstances where limited confidential information may be shared with law enforcement officers. Some of them are outlined above under the section "Duty to Warn". The other applicable circumstances are outlined below.

However, please note that HFS 92 makes very clear that, as a general rule:

"Access to treatment records is not authorized for any local, state or federal investigatory agency ... investigating crimes unless the agency presents a statement signed by the patient giving informed consent or a court order. "

Moreover, "In any situation involving court orders which appear to vie authorization for broad or blanket access to records, the treatment director, the program director or the secretary of the department or designee shall seek appropriate legal counsel before disclosing any records." Citation is HFS 92.04(15)(c) and (d).

a. When reporting a crime that the person has committed on the premises of the facility. Citation is CFR 164.512(f)(5).

b. When reporting the death of an individual that may have been due to criminal conduct. Citation CFR 164.512(f)(4).

c When a law enforcement officer is specifically investigating the death of a child or adolescent that took place in a child-caring institution or CBRF. Citation is 146.82(2)(a) 15.

d. When the officer is investigating a death reported to the state by the treatment facility having the records because of suicide, mediation use, or physical restraint. Citation is s.146.82(2)(a)l5.

e. In order to enable an officer to take charge of and return an individual on unauthorized leave from a treatment facility when that person was there on an involuntary status. Citation is s.51.30(4)(b)l2m and 13.

6. There are a number of other miscellaneous circumstances where disclosure without prior authorization is allowed by law:

a. For certain public health activities, such as reporting contagious diseases to proper authorities (with the exception of HIV, as HIV status is explicitly excluded from this), or when a physician must report an adverse event form medications to the Food and Drug Administration. Citation is CFR 164.512(b)(l).

b. The spouse, parent, adult child, sibling or other close personal friend of an individual may have certain limited information:

* If they are directly involved in providing care to or monitoring the treatment of the individual
* if that involvement is verified by the individual's treatment provider, and
* if the individual him or herself has either verbally approved that disclosure or has at least been given the opportunity to object but didn't.
* Except in an emergency, the request for information is to be presented in writing. In an emergency, the information may be released if the provider believes it to be in the best interests of the individual.
* In all cases the information to be disclosed is limited to a summary of the individual's diagnosis and prognosis, a listing of medications which they take, and a description of their basic treatment plan. Citations are s. 51.30(4)(b)20 and CFR 164.SlO(b).

c. A licensed physician is allowed to report to the state Division o(Motor Vehicles that a patient he or she is treating is unsafe to drive. IF such a report is made, the physician must document the name of the person or agency to which the disclosure was made, the date and time of the disclosure, and what exactly was disclosed. Citation is s. 146.82(3)(a).

d. Any health care professional treating an individual for an injury or illness that is a part of a workman's compensation claim is required to report any reasonably relevant information upon request to the employee, employer, worker's compensation insurer or department or it's representative. This information must be reported whether or not the subject of that information has signed an authorization for it's disclosure. Citations are s. 102.13(2)a and CFR 164.512(1).

e. Information can be shared between Clinical Services and the court when a proper subpoena for the records has been received. However, be aware that many subpoenas come merely from attorneys via the clerk of courts and are not actually signed by a judge, hence not being "proper" in this sense. New federal law allows disclosure of information upon presentation of a non-signed subpoena under certain circumstances. But because Wisconsin state law is more stringent on this issue, it takes precedence. Citations are s.51.30(4)(b)4 and HFS 92.04(4).

f. Limited confidential information can be released to the coroner or medical examiner when needed by them to make a death determination. It does not matter whether we contact the coroner or the coroner contacts us. Citations are s. 146.82(2)(a)l8 and CFR 164.512(g)(l).

It is the policy of Green Lake County Department of Health & Human Services (GLCDHHS) to comply with all Health Insurance Portability and Accountability ACT (HIPPA) rules as they pertain to CCS. Specifically, GLCDHHS operates under all State Statutes pertinent to the series provided. Prior to release of any information from Department records, it is necessary to determine which statutes, regulations or Department policies apply to the information for which release is sought.

GLCDHHS maintains confidential information, both written and verbal regarding individuals seeking services form the Department. The Department limits access by staff members to confidential information based on the employee having a legitimate job related reason or purpose to have access to any confidential material. Access to written or verbal does not imply approval to release to outside agencies or individuals. Breach of confidentiality can result in financial liability of the Department and the staff member(s) involved. , and can also result in disciplinary action up to and including termination of employment.

The Department also authorizes access to confidential information to contracted employees, contracted agencies and their employees, students, interns and others based on the individuals having a legitimate, job related reason or purpose to have access to any confidential material. Information sought must be relevant to the service the requesting staff person is providing. See s. 46.23(3)(e) WI.

Statutes. If two staff members cannot agree that the information exchange requested is relevant, the matter is then referred to the respective Unit Managers. If the two Unit Mangers cannot agree the matter is them referred to the Department Director.

Client information is covered under various State Statutes, Federal Statutes, and Agency policy regarding release outside of the Agency and use within the Department itself. Confidentiality laws specifically prohibit the release of any information, written or verbal, that may result in the identity of an individual receiving services form the Department being known. It is the responsibility of any staff member release information to another Agency that all State Statues, Federal Statues and Department policies have been followed.

INFORMATION EXCHANGE BETWEEN HEALTH & HUMAN SERVICES SUB-UNITS

It is clear that state statute allows us to exchange information internally between the various sub-units of our Health & Human Services agency without the informed consent of the client when such exchange is "necessary" for the performance of agency business. Specifically, statute 46.23(3)(c), "Exchange of Information," states that:

"any sub-unit of a county department of health & human services acting under this section may exchange confidential information about a client, without the informed consent of the client, with any other sub-unit of the same county department of health & human services or with any person providing services to the client under a purchase of services contract with the county department of health & human services, if necessary to enable an employee or service provider to perform his or her duties, or to enable the county department of health & human services to coordinate the delivery of services to the client."

However, because the actual application of this statute to daily practice can be complicated, the following guidelines have been developed for use by clinic staff when sharing confidential information within our Human Services agency. These guidelines have been reviewed and approved by our corporation counsel:

1. In general, any two sub-units of the agency can, at any time, freely exchange information regarding a client's demographics and enrollment. "Demographics refers to basic information such as client name, address, phone number, names of family members, etc. "Enrollment" includes information about what service(s) the client has been receiving or has been involved in within the agency. The one exception to this rule is with the AODA unit (see# 10 below for further clarification).

2. Any information other than demographics and enrollment (i.e. any details or specifics regarding the service provided or received) should still be considered "confidential" and hence should not be exchanged or shared between sub-units unless there is clearly a "need to know" that information. This is true whether that information is being shared verbally or through viewing of written or electronic records.

3. "Need to know" is defined simply as having a legitimate, job-related reason or purpose for obtaining certain information from another sub-unit. Generally, this means that someone is already working with that same client in their sub-unit, or that they have received a referral for services within their unit which they are currently processing, and information from some other sub-unit would have a bearing on what or how they provide those services. Note that within the Children & Family Services units, "client" typically refers not only to the child they are providing or arranging services for, but also to other family members who are involved in those services. Hence, the Children & Family Services Unit will sometimes look for information about adult clients of the clinic who are the parents of a child under some type of protective service, and this is a legitimate request.

4. Given this basic "need to know", clinic staff can legally share any relevant information that they may have about a client they are working with without the client's written

authorization. Most typically this will just involve sharing verbal information in order to coordinate services between the units, but it can involve actually copying and exchanging written information from the treatment record. However ...

5. HFS 92 makes clear that "Whenever information from treatment records is disclosed, that information shall be limited to include only the information necessary to fulfill the request. " Hence, when sharing treatment records, clinic case manager should still make some judgment about which parts of the client's record are pertinent for that other sub-unit's needs and should release only that specific information. Workers from some other Human Services Unit should never simply have free nor total access to a client's clinic record.

6. Notwithstanding the above, this provision of the policy is meant to be interpreted liberally to allow the appropriate exchange of information within the agency. It should not be used as a basis for arbitrarily "challenging" employees from other sub-units on whether they "really" need the requested information or not.

7. There will surely be occasions when clinic staff can not agree on whether certain requested information can or should be freely exchanged, or if unique circumstances exist that warrant keeping that information confidential. For example, a Children & Family Services unit may be looking for mental health information on a parent who does not want that information released and who has an adversarial relationship with the Children & Family Services unit. In situations such as this, staff should involve their Unit Mangers to help resolve the issue or should simply have the client sign an appropriate release of information form authorizing the release of that information.

8. If staff and supervisors are still not sure of the legality of exchanging the requested information, and if the client in these circumstances refuses to sign an appropriate release, supervisors should consult with the Deputy Director on how to proceed. The Deputy Director may, in tum, wish to consult with corporation counsel.

9. Despite the fact that sub-units can freely exchange information without the client's consent, it is still generally best to always inform the client when you intend to do this. Ask the client what other services they are receiving, inform them that you will be contacting those other involved service providers to discuss those services, explain to the client your reasons for doing this, and let them know what you will be sharing and/or releasing.

10. All staff need to understand that any information regarding the provision of AODA services is protected by much stricter federal laws which prohibit the free exchange of this information without a signed release. This even includes the sharing of basic "demographic" and "enrollment" information (i.e. the simple fact that AODA services are being provided) with other units of this agency (outside of Clinical Services). As such, none of the above applies to the AODA unit and any request for information from this unit (outside of the Clinical Services Unit) must be accompanied by a signed release from the client.

11. It is also very important for staff to understand that being allowed to exchange information internally does not mean that that information can be re-released outside of this agency without the client's consent. Indeed, as a part of our total agency, whenever other sub-units obtain confidential client information from within the client, the duty to protect that information from improper re-release now also extends to them. Thus, for example, Children & Family Services unit can normally share information with the school system for joint planning without a release, but that would not mean they could share information from, or copies of, mental health treatment records they may have obtained internally. Similarly, a mental health program that has a signed release to share mental health information with the corrections system would not thereby be allowed to share AODA information that they acquired internally from our Clinical Services unit (unless the signed release specifies AODA information). Any such re-release of confidential information would always require a specific and appropriately signed authorization from the client. And in these

circumstances, it is generally best that the outside party be told to get the release and send it (along with the request for information) directly to the sub-unit that originated the document in question.

Note that what counts here is where and how the information was obtained in the first place, not what the nature of the information is. Thus, if the client themselves informs the child welfare worker that they have received mental health treatment, or informs the mental health worker that they have received AODA treatment, and that child welfare or mental health worker now includes that within their report, that report can be shared with whomever they are otherwise legally authorized to exchange information. But if the child welfare worker got the information directly from the mental health treatment provider, or the mental health worker got the information directly from the Clinical Services unit, then passing it along would be a "re-release" and would require the specific consent of the client.

COURT APPEARANCES

On occasion, Clinical Services staff may get requests to appear in court to testify regarding their provision of services to clients or to offer their professional opinion on some other matter before the court. Staff must also proceed with caution here, as these situations often carry the risk of being asked to divulge information of a confidential nature without the consent of the client. Moreover, in these situations staff must always remember that they are not solo practitioners who could function as an independent professional in giving testimony. Instead staff would always still be an agent of the Department needing to insure that they are simultaneously representing the Department's interests. Given the above, and to help guide staff in responding to such requests, the following general policy statement have been developed, and these should be followed by all staff.

1. Whenever there is any possibility of a staff member becoming involved in a legal proceeding with reference to services provided to clients, it is necessary to inform and consult with their Unit Manager at the earliest possible opporutnity. The Unit Manager will, in tum, consult with the Deputy Director and Corporation Counsel in order to assure that the Department's interests are being served.

2. As a general rule, we do not want Clinical Services staff to get involved in individual adversarial court proceedings, wherein they would be asked by attorneys to testify for one side against the other. There are many reasons for this polity, including the great amount of staff time that such proceedings can involved, and the fact that it could result in Clinical Services getting a reputation for divulging personal matters in a public forum. Hence, when staff get these types of requests, they should simply make the Clinic's policy clear to the requester and then refer them out to private resources, who would be more appropriate for providing that service.

3. Though there will be exceptions, as a general rule, Clinical Service staff can get involved in court proceedings when functioning merely as a resource to the court or a "friend of the court". This occurs when the court has itself ordered us to appear (rather than individual clients or their attorneys) because they sent the person to us in the first lace for an evaluation in the expectation of getting back a report. As a "friend of the court" staff is merely giving a professional opinion on a legal question and hence has their allegiance to the court and to the due process of law rather than to any individual party.

4. As a general rule, Clinical Services staff can also get involved in court proceedings when the request for testimony comes from our own Corporation Counsel's office, since the office of the Corporation Counsel represents the County's interests and the County staff in the discharge of their responsibilities.

5. When it is impossible for Clinical Services staff to function as a "friend of the court", and when the request for testimony comes from our own internal Counsel, then staff are to appear in court only under subpoena. The Corporation Counsel for Green Lake County has advised that such a Clinic policy clarifies why Clinical Services staff is present. In addition, If there would then be on-going contact with the client following the court appearance, it makes clear to the client that the Clinical Services staff made the appearance under order.

6. However, be aware that many subpoenas come merely from attorneys via the clerk of courts and are not signed by a judge. These are not "valid" subpoenas and do not allow staff to appear and release information. A valid subpoena will always be signed by a judge and will merely require your appearance in court with the record.

7. Even when Clinical Services staff have been properly subpoenaed, questions of confidentiality still need to be addressed if the parties involved in the court matter have not given their written release to disclose information. In such cases, it is necessary for the staff person to raise the issue in court by advising the judge that there is no release and hence that laws of confidentiality do not allow the staff person to say anything. At that point, the judge will decide whether or not to override such laws. If the judge then orders the staff to testify, the staff has legal grounds to disclose confidential information.

8. Because staff member who appear in court are always serving as representatives of the Department rather than solely as independent professionals, they must also always be sure to coordinate closely with other department staff whose job responsibilities involve court-related work. For example, day-time crisis workers have the responsibility of coordinating with Corporation Counsel in developing the county's position with regard to commitments and other legal issues and staff must always work through and coordinate with them during commitment proceedings.

9. At times there may be some differences of opinion with regard to what the official Department position should be in court proceedings. In such situations, it is staffs role to indicate their professional viewpoint and opinion and to thereby give input into the determination of the official county position. But ultimately the Department Deputy Director and Corporation Counsel will have the final decision in such matters.

POLICY TO PROTECT BILLING INFORMATION

As a general rule, billing information is considered to be covered by the same provisions as those which cover treatment records. These provisions include Chapter 51.30, Wisconsin Administrative code HFS 92, and certain provision of the Uniform Fee System Administrative Code HFS 1. The general guideline is that the billing information is to be considered confidential in the same respect as confidential information, within treatment records. As such, clinical Services is prohibited in billing third party payers without the signed release of the client or the legally authorized representative of the client. Such release of information will be secured from the client during the financial interview establishing ability to pay. Also in compliance with confidentiality provisions, letters and billings should not disclose that the correspondence is form a facility which provides treatment services. In this regard, we will continue the practice of utilizing envelopes having only the address of Clinical Services when sending out bills.

POLICY REGARDING CHARGE FOR CLINICAL FINDINGS

Generally speaking, there are two types of requests for release of information from clinical charts - those coming from agencies or professionals and those coming directly from the client. Among the first type of requests, some agencies and professionals (e.g. the State of Wisconsin, various lawyers, some Federal agencies, etc.) will pay a clinical findings fee for our effort in making the information available. When such is the case, the clinical findings charge will be 25¢ per page. There are other agencies (e.g. other units of our own Department of Human

Services, Legal Services of Northeastern Wisconsin, etc.) who request information but do not customarily pay a clinical findings fee. We will not charge in these latter instances.
Links to HFS 92 and SS 51.30
By clicking on the following web addresses you will be taken directly to the state legislature's web site where you can directly read the relevant sections of the state regulations and statutes pertaining to confidentiality of treatment records.
For the relevant "regulations" regarding confidentiality (HFS 92) click on: www.legis.state.wi.us/rsb/code/hfs/hfs092.pdf
For the relevant state statute pertaining to mental health treatment records (SS 51.30) click on this address and go to page 21 : www .legis.state. wi.us/statutes/01 S tat005 l. pdf

The Timely Exchange of Information – HFS DHS 36.07(5)(c)

Information between the CCS and contracted agencies will be shared in a timely manner because service providers are identified for the recovery team by consumers early in the process and the necessary releases of information are obtained. Releases of information will be signed by the consumer once they have identified who they wish to have on their recovery team. This will allow the Service Director team members to share and obtain information from the contract agency with other members of the team and ensure timely service coordination. (see attached flow chart of the CCS process).

Consumer Rights – HFS DHS 36.07(5)(d)

CCS consumers will have a choice in the selection of recovery team members as described in Appendix A as well as other formal or informal support providers. They will sign the service plan (See attached Individualized Services Plan Appendix B) that delineates specific information about proposed services. Green Lake County's CCS will comply with all patient rights and grievance resolution procedures located in our approved HFS DHS 94 policy (See attached. Appendix C).

Culturally and Linguistically Appropriate Services- HFS DHS 36.07(5)(e)

CCS staff will receive training in cultural competence as part of their orientation. Within Green Lake County there is a Hispanic, Hmong and Amish presence. Training should focus on these cultures. In addition, training will include becoming familiar with the Department's Civil Rights Compliance Plan that ensures assistance for consumers who need assistance with the English language. Cards in various languages are available in the Department lobby for anyone not understanding English (See attached Language Access Policy and Civil Rights Compliance Plan. Appendix D). Furthermore, a list of interpreters for various languages is available to CCS consumers and staff. This includes not only interpreters for Hispanic and Hmong speaking consumers but also sign interpreters for those with a hearing impairment.

Furthermore, CCS staff will become familiar with resources within the community that provide literacy services for those who are interested in learning how to read and write. English as a second language is also offered as a service within the community that is available to CCS consumers.

Monitoring Compliance with CCS Regulations Policies & Procedures – HFS DHS 36.07(5)(e)

~~Policy~~

The services of Green Lake County's CCS programs are purposely designed with the goal of best supporting consumers struggling with ~~disabling behavioral health disorders and assisting them in gradually recovering from the disabling effects of those disorders.~~ Mental Health and Alcohol and Other Substance Use issues and assisting them in recovering.
All aspects of the program ~~from the criteria for determining consumer eligibility and the procedures for assessing and addressing consumer needs, all the way to the qualifications required of professionals staffing the CCS program and the means of documenting the services provided~~ are designed to achieve these goals while being most respectful of consumer autonomy and choice. ~~As such, fidelity to all the policies and procedures of the program is vitally important and will be monitored in various ways so as to assure that fidelity.~~

The following procedures outline the specific means by which Green Lake County's CCS programs will carry out these monitoring activities.

~~Procedures~~

1. Per the requirements of ~~HFS~~ DHS 36.10, staff working with the CCS programs will be required to meet specified credential criteria. At the time of hiring, CCS staff ~~assurances of meeting these credentials,~~ will have the professional certification, training, experience and abilities to carry out prescribed duties. ~~and of passing the Caregiver Background checks will be made by the County's Human Resources department in conjunction with CCS administrators.~~ They will comply with caregiver background checks and misconduct reporting requirements.

2. Per the requirements of ~~HFS~~ DHS 36.12, all staff working for the CCS program will receive the necessary orientation and ongoing training to assure knowledge of and fidelity to the principles guiding the CCS service philosophy.

3. Per the requirements of ~~HFS~~ DHS 35.11, all staff working within the CCS program will be supervised on an ongoing basis to assist in resolving problematic situations and making competent decisions about services provided.

4. Per the requirements of ~~HFS~~ DHS 36.08, administrators of the CCS program will be collecting and monitoring data on an ongoing basis relative to the effectiveness of the services being provided and the degree of satisfaction consumers have with those services. Feedback will be given to frontline staff so as to modify and improve service provision as needed.

5. Per the requirements of ~~HFS~~ DHS 36.09, service directors will meet quarterly with their coordinating committees to present information about the services provided and the success of those services and will look for and incorporate the feedback of that committee into the further operation of the program.

6. Per the requirements of ~~HFS~~ DHS 36.14 and 36.16, the Service Director in conjunction with the Mental Health Professional and CCS Coordinator, will review and approve all assessments and service plans for consumers, giving feedback to frontline staff routinely so as to create an atmosphere of constant learning. They will also monitor compliance with other documentation standards

via routine reviews of the clinical records for difficult consumers.
~~Per the internal policies of Green Lake County's Clinical Services teams as a whole, the ongoing Clinical Standards Committee review process will be used for monthly peer to peer review of case documentation practices, with peers giving feedback to each other and again creating an atmosphere of constant learning.~~
~~8. The Department also utilizes it's internal software (CMHC) to monitor that billable case notes are completed by all staff.~~

7. Through the bi-annual state re-certification review process we will have the means of reviewing the program as a whole to assure overall fidelity of the program to the requirements of ~~HFS~~ DHS 36 generally and will get and utilize any feedback from the Regional Surveyor during this process.

Communication to Consumer Regarding Services Offered, Costs, Grievance Procedures and Requirements for Informed Consent for Medication and Treatment – ~~HFS~~ DHS 36.07(5)(g)

Each Consumer will be fully informed of various services and providers both within and outside the Department. The County has a Resource Directory that lists all services, contact information and costs. Green Lake County is also part of a three County consortium (with Marquette and Waushara) to establish Aging Disability Resource Centers that CCS Staff and Consumers can access that will list a wide array of services to CCS target groups. Green Lake County's CCS Program will make available to all consumers the ~~HFS~~ DHS 94 grievance policy which lists all patient rights and grievance procedures. The prescribing physician and/or nurse will ensure that each CCS consumer is fully informed of the medication benefits and use. (Appendix E)

Consumer's Cultural Heritage and Primary Language- ~~HFS~~ DHS 36.07(5)(h)

Green Lake County's CCS complies with our County's Civil Rights Compliance Plan (~~see attached~~ Refer to Civil Rights Compliance Plan on site) to ensure that all consumers have access to programs regardless of heritage or language differences. Additionally, this Department has a Language Access Policy (~~see attached~~ Appendix D) that allows for interpreter service to be utilized when appropriate.

Providing Orientation and Training – ~~HFS~~ DHS 36.07(5)(i)

See ~~HFS~~ DHS 36.12 ~~on page 55~~ for a detailed policy on staff orientation and training.

~~OUTREACH SERVICES; APPLICATION AND SCREENING; RECOVERY TEAM DEVELOPMENT AND FACILITATION; ASSESSMENT; SERVICE PLANNING; SERVICE COORDINATION; REFERRALS AND COLLABORATION -HFS 36.07(5)(j-o)~~

~~See attachment XII. Staff qualifications and Credentials (Clinical Services General Policy)~~

Outreach Services – ~~HFS~~ DHS 36.07(5)(j)

The Green Lake County CCS will conduct outreach activities to potential CCS consumers. CCS will seek referrals from potential sources such as psychiatric hospitals, law enforcement and correctional agencies, other community agencies, departments within Green Lake County Health and Human Services, family members, significant others, members of the public, and potential consumers. Green Lake County CCS will provide updated information to the referral sources including pamphlets regarding services, referral forms, and information on admission criteria and

procedures. CCS will also provide case specific consultation as needed to community agencies and service providers.
~~The Green Lake County CCS Outreach Policy is included with this application in Attachment IV.~~

Application and Screening Process – ~~HFS~~ DHS 36.07(5)(k)

Any individual may apply for CCS ~~for him/herself~~. A person seeking CCS services ~~will be asked to complete an Application for Services.~~ will meet with the CCS Coordinator. ~~Upon receipt of an application the Clinical Services~~ The CCS Coordinator ~~CCS Supervisor or designated~~ along with the Mental Health Professional will determine the applicant's eligibility and need for psychosocial rehabilitation services.

The consumer will be provided with information outlining the nature of the program, ~~in which he/she will be participating,~~ including the hours of operation, how to obtain crisis services during hours when CCS does not operate, and staff member titles and responsibilities. The consumer will also be provided with information outlining consumer rights in CCS and the client rights and grievance resolution procedure.

~~The CCS~~ Wisconsin's Functional ~~screening~~ Eligibility Screen ~~tool~~ will be used to determine that an individual requires more than outpatient counseling but less than the services provided by a community support program; has a diagnosis of a mental disorder or a substance use disorder; and has a functional impairment that interferes with or limits one or more major life activities that results in needs for services that are described as ongoing, comprehensive, and either high-intensity or low-intensity.

If an applicant is determined to need psychosocial rehabilitation services and is eligible to be admitted to Green Lake County CCS, a comprehensive assessment will be conducted. See DHS 36.13, DHS 36.14, DHS 36. 15 and DHS 36.16 for further details.

Recovery Team Development – ~~HFS~~ DHS 36.07(5)(L)

During the initial assessment, a collaborative, multi-system team will be formed. The consumer will be asked to participate in identifying members of the recovery team. At a minimum, the recovery team will include the consumer, a service facilitator, and a mental health professional. Service providers, family members, natural supports and advocates will be included on the recovery team, with the consumer's consent. If the consumer is a minor or is incompetent or incapacitated, a parent or legal representative of the consumer, as applicable, will be included on the recovery team.

If the consumer has or is believed to have a co-occurring substance use condition, the recovery team will consult with an individual who has the qualifications of a substance abuse professional or will include a substance abuse professional on the recovery team.

Consumers will be equal participants on their teams. Every effort will be made to reduce barriers to successful engagement and participation, including providing practical supports to enable consumers to fully participate in CCS. Successful engagement and participation is more likely to occur when consumers are considered equal partners, treated with dignity and respect, and have a voice and ownership regarding their care.

The Service Facilitator will convene the team. Team members will have a clear understanding

of and respect for each other's roles, limitations, and strengths. The recovery team will participate in the assessment process and service planning. The role of each team member will be guided by the nature of team member's relationship to the consumer and the scope of the team member's practice.

Team members will provide information, evaluate input from various sources, and make collaborative recommendations regarding outcomes, psychosocial rehabilitation services, and supportive activities. This partnership will be built upon the cultural norms of the consumer. ~~The Green Lake County CCS Recovery Team Policy (Attachment VII) describes the process for convening the team.~~

Assessment Process – ~~HFS~~ DHS 36.07(5)(m)

~~An "assessment" is the process used to identify the strengths, needs and desired outcomes of a consumer and to evaluate progress toward desired outcomes.~~ Upon the determination of need for services, a comprehensive assessment will be conducted with the consumer (and his or her family when appropriate).

This will be accomplished through a collaborative team approach that will take into account the consumer's strengths, formal and informal supports, and will identify needs based on the consumer's full participation in the assessment process. The assigned service facilitator will conduct the assessment process collaboratively with the consumer, designated mental health professional, and recovery team. When co-occurring substance use issues exist, a substance abuse professional will be consulted or included on the team.

The assessment will be comprehensive, accurate, and based upon facts, recent information, and evaluation of co-existing mental health and substance abuse disorders, physical or mental impairments, and medical problems. The assessment will address the strengths, needs, recovery goals, priorities, preferences, values, and lifestyle of the consumer and will be updated as new information becomes available. The assessment will address age and developmental factors that influence appropriate outcomes including goals and methods for addressing them.

The ~~Clinical Coordinator~~ Mental Health Professional and CCS Coordinator will ~~complete~~ review the Assessment and Assessment Summary. The assessment process and the assessment summary will be completed within 30 days of receipt of an application for services. ~~The Green Lake County CCS Assessment Policy is included with this application in Attachment VIII.~~

Service Planning Process – ~~HFS~~ DHS 36.07(5)(n)

~~A "service plan" is the written plan of psychosocial services to be provided or arranged for a consumer that is based on an individualized assessment of the consumer.~~
The service planning process will be facilitated by the assigned service facilitator in collaboration with the consumer and recovery team. The service planning process will be explained to the consumer and, if appropriate, a legal representative or family member.

The Service Plan will address the needs and recovery goals identified in the assessment and will include the goal of empowering the consumer. The plan will define measurable outcomes and be completed within 30 days of the consumer's application for services.

The Service Plan will include:

- A description of the service facilitation activities that will be provided to the consumer or on the consumer's behalf;
- The psychosocial rehabilitation and treatment services to be provided to or arranged for the consumer including the schedules and frequency of services provided;
- The service providers and natural supports who are or will be responsible for providing the consumer's treatment, rehabilitation, or support services, and the payment source for each;
- Measurable goals and the type, frequency, intensity and duration of data collection that will be used to measure progress toward desired outcomes.

The consumer, a mental health or substance abuse professional, and the service facilitator will sign the completed Service Plan. The original Service Plan will be maintained in the Client Treatment Record. Documentation of the Service Plan will be available to all members of the recovery team. The service facilitator will be responsible for obtaining appropriate authorizations to release information to the recovery team members.

The Service Plan will be reviewed and updated as the needs of consumer change or at least every 6 months. The review will include an assessment of the progress toward goals and consumer satisfaction with services.
~~The Green Lake County CCS policies on Service Planning (Attachment IX) and Service Delivery (Attachment X) direct the service planning and delivery process.~~

Service Coordination, Referrals, and Collaboration – ~~HFS~~ DHS 36.07(5)(o)

When multi-system involvement exists, there is especially a need for a formalized coordination of services to ensure consumers' needs are being addressed. Green Lake County CCS will develop and implement collaborative arrangements and interagency agreements/release of information disclosure forms to outline roles and responsibilities when working with consumers who are involved in multiple services.

Green Lake County CCS will conduct outreach activities in order to make non-CCS programs and facilities aware of the nature of CCS and how to refer individuals. Individuals determined to be eligible will be admitted to CCS. Individuals determined not eligible for CCS will be referred to appropriate non-CCS programs.

Green Lake County CCS will work collaboratively with other systems including adult protective services, child welfare, school systems, crisis systems, and treatment/service providers with whom consumers are involved.

Consumer care/treatment plans of these systems will be incorporated into the CCS Service Plan. CCS will establish contracts with outside service providers so as to define clear roles and responsibilities, ensure collaboration, and quality of service.

~~The Green Lake County CCS policies on Outreach (Attachment IV), Application for Services and Screening (Attachment V), and Service Coordination (Attachment XI) direct how CCS will work in collaboration with other services and entities.~~

Advocacy for Consumers – ~~HFS~~ DHS 36.07(5)(p)

If requested by the Consumer or identified by the Recovery Team, an advocate will be provided to any CCS Consumer to assist in areas that will enhance his/her psychosocial

functioning. This may involve assisting in client rights advocacy, legal rights advocacy, etc. The Advocate will be a person the CCS Consumer chooses to represent him/her in any CCS process.

Support and Mentoring for the Consumer – ~~HFS~~ DHS 36.07(5)(q)

Green Lake County CCS will provide support and mentoring for consumers. Service facilitators will support consumers by providing education and training to help consumers develop self- advocacy skills, exercise civil rights, and acquire skills needed to exercise control and responsibility over other support services. Green Lake CCS will assure that consumers and legal guardians receive necessary information and assistance in advocating for their rights and service needs.

~~The Service Delivery Policy (Attachment X) describes how consumers will be supported in CCS.~~

Discharge Planning and Facilitation-~~HFS~~ DHS 36.07(5)(r)

See ~~HFS~~ DHS 36.17(5) ~~on page 57~~ for a description of CCS Discharge Policy and Procedures.

Monitoring and Documentation-~~HFS~~ DHS 36.07(5)(s)

See DHS 36.07(5)(f) and DHS 35.07(5)(b) ~~on page 19~~ for a description of how Green Lake County CCS will be monitoring and documenting CCS activities.

~~SECTION 4:~~ CCS QUALITY IMPROVEMENT PLAN-~~HFS~~ DHS 36.08

~~In compliance with HFS 36.08,~~ Green Lake County CCS programs have developed and will implement a quality improvement plan designed to assess consumer progress toward desired outcomes identified through the assessment process as well as consumer satisfaction with services generally. This quality improvement plan includes:

1. Procedures for protecting the confidentiality of persons providing opinions.
2. A description of the methods CCS will use to measure consumer opinion on the services offered by CCS, including assessment, service planning, service delivery, and service facilitation activities.
3. A description of the methods CCS will use to evaluate the effectiveness of changes in the CCS program based on results of the consumer satisfaction survey, recommendations for program improvement by the coordination committee, and other relevant information.

The specifics of the quality improvement plan derive from the fundamental mission of the CCS program, which is the improvement of consumer's lives and their movement toward recovery. ~~As such, the~~ That data ~~ranges from~~ includes, consumer-specific progress on identified goals, functional improvement across life domains, general satisfaction with life, specific satisfaction with CCS services, and team-wide success in helping the entire range of consumers served within the entire range of relevant life domains. ~~The specifics of this plan are outlined below.~~

~~Procedure~~

l. All newly referred CCS consumers will ~~administer~~ complete a quality of life survey eliciting their views about current satisfaction within basic domains of their life. The results of this survey will be used as one tool in guiding the initial comprehensive

assessment of that consumer's functioning and in guiding the initial identification of goals that they would like to pursue in their current service plan. At each 6-month service plan review, consumers will be asked to complete another quality of life and satisfaction survey so that change in satisfaction can be monitored over time. Comparison between surveys will serve as one measure of the value of CCS services to consumers. Since the intention of the survey is to give feedback to the consumer's recovery team, the results **will be** shared with the team. But the results will otherwise be kept confidential in the same way as other aspects of the consumer's clinical record.

2. In addition to their consumer-specific use in service planning, these life satisfaction surveys will also then have names and other identifying information removed (to protect confidentiality) and the data will be aggregated across the entire CCS program. This will allow ongoing measurement of the success of the CCS program as a whole is assisting the consumers of its services in improving the general quality of their life and their general life satisfaction.

3. As part of the established service planning process (i.e. of identifying need areas and related goals), staff will always identify measurable objectives for determining progress toward those goals. Then, throughout the treatment period, staff will observe and document in their service contact notes the ongoing progress consumers are making towards these goals and objectives.
During 6-month case reviews, staff will summarize the overall progress achieved for each consumer and will indicate for each goal on that consumer's current service plan those which have been substantially met during that 6-month time period. This will allow a shorter-term measure of consumer progress toward recovery.

~~4. Since all service plans are entered into an electronic database, supervisors will also runs reports annually to obtain a breakdown of the total number and percentage of goals met by CCS consumers as a whole. Breaking down these overall results across various life domains allows supervisors to judge what life domains are typically being addressed by consumers and their team, whether more or less success is being achieved in certain domains over others, whether noticeable gaps in services are evident in certain domains, etc. These results will give supervisors and administrators guidance for how services may be adapted during the coming year.~~

WAS #5 CCS staff ~~continue the current practices of~~ will also complete ~~an observer rating scale that we previously developed internally~~ a Progress in Recovery Scale that measures the longer-term progress consumers are making in their overall recovery ~~from psychiatric disability~~. It is completed by the service facilitator, after discussion directly with the consumer and other members of the consumer's recovery team, at the time of initial enrollment and then again at every 6 month service plan review. Use of the Progress in Recovery Scale gives a measure of the degree to which progress on individual treatment plan goals is translating into broader functional improvement across various life domains relevant to recovery.

~~This tool, know as the "Progress in Recovery Scale," rates the general level of functioning of consumers within a broad array of life domains relevant to recovery from psychiatric disability. It is completed by the primary case manager, after discussion directly with the consumer and other members of the consumer's recovery team, at the time of initial enrollment and then again at every 6 month service plan review. Use of this "Progress in Recovery Scale" gives a measure of the degree to which progress on individual treatment plan goals is translating into broader functional improvement across~~

~~various life domains relevant to recovery.~~

#5 (was #6)

5. ~~In addition to its consumer specific use in outcome measurement, aggregate pooling of the data from the~~

   Annually Service Facilitators assist in distribution of the Recovery Oriented System Indicators (ROSI) ~~and the state-specified functional assessment tool, the MHSID.~~ and the Mental Health Statistics Improvement Program (MHSIP). ~~"Progress in Recovery Scale" is done via a Microsoft Excel spreadsheet into which the data is routinely entered. The aggregate pooling data allows judgements about the overall effectiveness of the CCS program, its relative effectiveness relative to other Green Lake County treatment teams that also utilized this scale.~~ The results of these state tools are anonymously compiled by White Pines Consulting and used by the county to improve CCS Services.

   ~~Such program-wide judgments will enable altering of the program as needed (e.g. to emphasize services in certain domains, to evaluate why some programs may do better in some domains that other programs, etc.)~~

6. Was 8 – ~~Results from the aggregated surveys (life satisfaction and quality of life satisfaction), from the aggregated Progress in Recovery data, and from general electronic database reports~~ The data will all be shared with the CCS Coordination Committee during the committee's regular quarterly meetings. The committee will be asked to review and comment of these reports and it is expected that suggestions for program improvement will come from this committee based in part on these ongoing reviews.

7. Was 9 - CCS supervisors will annually set goals for their program based on results of the above outcomes measurement procedures and on the suggestions given by the Coordination Committee. They will also annually evaluate their team's performance over the past year relative to the goals set for the program the previous year. The supervisor's annual goals and reports will also be shared with the Coordination Committee. And the supervisor will review and update their general CCS plan based on the above procedures.

~~SECTION 5:~~ CCS COORDINATION COMMITTEE- ~~HFS~~ DHS 36.09

Consumers will be involved at all levels of Green Lake County CCS including program planning, design, and quality improvement. ~~The Green Lake County Family Resource Council appointed itself as the Coordination Committee on January 3, 2005 (See attached meeting minutes- Appendix XVII.).~~

~~Presently, the Family Resource Council has a total of twenty-four members consisting of two county employees, the Clinical Coordinator (representing mental health, substance abuse and child welfare issues) and the Children and Families Unit Manager, the Birth to~~

~~Three Coordinator, the Developmental Disabilities Coordinator, Economic Support Manager, one Health and Human Services Board member, UW Extension agent, Law Enforcement representative, the County Judge, school representative, faith representative, and nine consumers or consumer representatives. The Committee has over 1/3 consumer membership.~~

The Green Lake County Family Resource Council/CCS Coordinating Committee will be comprised of consumers, providers and community stakeholders. At least one third of the committee will be consumers, and no more than one third of the committee will be county employees or mental health and/or substance use providers.

The Coordination Committee meetings will be facilitated by an elected chair or vice-chair. The committee will meet at least quarterly. Written minutes of the meetings and a membership list will be maintained at Health and Human Services.

The Coordination Committee members will receive orientation and training related to the role of the committee, understanding mental health and substance use issues, learning the benefits of psychosocial rehabilitation, special concerns of child, adult and elderly populations, and an overview of the systems that serve CCS consumers. Orientation and training will be provided in the form of written information and in-service presentations at each meeting.

The Coordination Committee will serve in an advisory role to the Green Lake County CCS. The committee will review quality improvement information; personnel policies and program practices; and protect consumer rights. The committee will review and make recommendations regarding the initial and revised CCS Plans, and the CCS Quality Improvement Plan. (DHS 36.09 (3)(a)

~~Community representatives who are identified as stakeholders in the system of care will be invited to participate on the Coordination Committee or give input to the CCS program.~~

~~**COORDINATION COMMITTEE RECOMMENDATIONS -HFS 36.09(3)(a)**~~
~~**See HFS 36.07(1)(c) for description of CCS Coordination Committee on page 8. The recommendations of the Coordination Committee have not been completed. The Coordination Committee will review this application at its October 3, 2005 meeting. In the January, April and June 2005 meetings the committee members received orientation to Comprehensive Community Services and general training on the mental health system. The committee members were provided with an overview of the HFS 36 Initial Application, which includes the CCS Plan.**~~
~~**There is a Family Resource Council appointed sub-committee of CCS consumers who approve CCS program and policy updates.**~~

~~SECTION 6:~~ PERSONNEL POLICIES-~~HFS~~ DHS 36.10~~(2)~~

Discrimination Prohibited-~~HFS~~ DHS 36.10(2)(a)

Green Lake County's Civil Rights Compliance Plan (~~see attached~~ Refer to Civil Rights Compliance Plan on site) prohibits discrimination within its employment practices. Furthermore, the County has a Personnel Manual (adopted as a County Ordinance) that prohibits employment discrimination. Green Lake County is an Equal Opportunity Employer.

Credentials-~~HFS~~ DHS 36.10(2)(b)

Health and Human Services will verify that all individuals hired to provide services in Green Lake County CCS possess the required degrees, licenses, certifications, qualifications and training for each particular position to carry out prescribed duties.
~~The general Clinical Services policy (Attachment XII) and specific CCS policy (Attachment XIII) on staff qualifications and credentials addresses this requirement.~~

Caregiver Background Checks and Misconduct Reporting and Investigation-~~HFS~~ DHS 36.10(2)(c)

All staff and caregivers under the control of Health and Human Services will be trained to know and understand the rights of the consumers they serve and their responsibilities in reporting and documenting caregiver misconduct. This training occurs as part of each new employee's orientation. Training includes education on the Health and Human Services policy on Investigation and Reporting of Caregiver Misconduct. ~~(Appendix XV.)~~

Health and Human Services performs background information checks on applicants for employment. Health and Human Services requires agencies and providers with whom the agency contracts for CCS to perform background information checks on persons who have direct, regular contact with consumers. Background information checks are performed periodically (every 4 years) on existing employees and contracted providers. Health and Human Services will not hire or retain persons who because of specified past actions are prohibited from working with consumers. (Appendix K)

~~The Green Lake County CCS will comply with the existing Health and Human Services policies on Criminal Background Checks (Attachment XIV) and Investigating and Reporting Caregiver Misconduct (Attachment XV).~~

Staff Records- ~~HFS~~ DHS 36.l0(l)(d)

Staff records are maintained in a locked file cabinet within the Health & Human Services Department. Upper management has access to these files and staff, if requested, may inspect their personnel file. Information in these files include: staff employment application, employment references, credentials, caregiver background check, personnel evaluations and any discipline issued.

Staff Functions- ~~HFS~~ DHS 36.10(2)(e)

Green Lake County CCS will designate staff who meet the required qualifications of the functions in which they are assigned. The ~~Clinical Services Unit Manager~~ CCS Coordinator will conduct administrator functions. Service director functions will be conducted by the ~~Clinical Services Unit Manager,~~ Director, Mental Health Professional, CCS Coordinator, or qualified designee. Mental health professional functions will be conducted by the Behavioral Health Unit Manager, CCS Coordinator, or qualified designee. Service facilitation functions will be conducted by various ~~Clinical Services~~ Behavioral Health, or Children's and Family Unit staff who are assigned and hold one of the qualifications required for service facilitation.

~~The Green Lake County CCS Program Description and Required Program Components Policy. (Attachment XVI) and Staff Qualifications and Credentials Policy (Attachment Xlll) outline staff function assignments and responsibilities.~~
~~For the qualifications and staff functions of specific Health and Human Services staff members who will~~

be assigned duties in Green Lake County CCS, refer to the Staff Listing Forms in Appendix A on pages 22-24.

See attached job description/credentials and caregiver background check.
1. Mental health professionals and substance abuse professional functions will be performed by the following staff:

a. Jana Tetzlaff, LPC
b. Diane Anderson, LPC, SAC
c. Melissa Much, LCSW, SAC
d. Jon Mathew, PhD
e.Felipe Ambas, MD

2. Administrative Functions/Service Director
a. Jana Tetzlaff, LPC

3. CCS Coordinator/Service Director Functions
a. Gretchen Malkowsky, MSW, CAPSW

4. Service Facilitation Functions
a. Stuart Adler, MS, MFT-IT
b. Trixie Murphy, MS, LCSW-IT
c. Jana Tetzlaff, LPC
d. Gretchen Malkowsky, MSW, CAPSW
e. Nichol Grathen, LCSW-IT, SAC-IT
f. Diane Anderson, LPC, SAC
g. Cindy Stobbe, Mental Health Technician
h. Jason Jerome, LPC-IT
i. .Melissa Much, LCSW, SAC

Supervision and Clinical Collaboration - HFS DHS 36.10(2)(f)

See HFS DHS 36.11.

Minimum Qualifications- HFS DHS 36.10(2)(g)

Each staff member will have the emotional stability, interpersonal skills, training, experience, and the ability needed to perform the assigned functions of the position as outlined in the position description.

Each staff member who provides psychosocial rehabilitation services will meet the minimum qualifications outlined in HFS DHS 36. 10(2)(g)1-22.

Records of staff members who provide services within Green Lake County CCS will be maintained in the Health and Human Services personnel file and will include:

- References for job applicants obtained from at least 2 people, including previous employers, educators or postsecondary educational institutions attended if available, and documented either by letter or verification of verbal contact with the reference, dates of contact, person making the contact, individuals contacted and nature and content of the contact.
- Credentials including copies of degrees, licenses, and certifications.
- Confirmation of an applicant's current professional license or certification, if that license or certification is necessary for the staff member's prescribed duties or position.
- The results of the caregiver background check including a completed background information

~~disclosure form for every background check conducted, and the results of any subsequent investigation related to the information obtained from the background check.~~

- ~~Documentation of completed training.~~

~~Credentials of each CCS staff member will also be maintained in a Credential Binder, which will be available for review by consumers and parents or legal representatives of consumers if parental or legal representative consent to treatment is required. The requirements for minimum qualifications of CCS staff members is outlined in the general Clinical Services policy (Attachment XII) and specifically detailed in the CCS policy (Attachment XIII) on staff qualifications and credentials.~~

DHS 36.10(2)(g) Minimum qualifications. Each staff member shall have the interpersonal skills training and experience needed to perform the staff member's assigned functions and each staff member who provides psychosocial rehabilitation services shall meet the following minimum qualifications:

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

2. Physicians shall be persons licensed under ch. 448, Stats., to practice medicine and surgery who have knowledge and experience related to mental disorders of adults or children; or, who are certified in addiction medicine by the American society of addiction medicine, certified in addiction psychiatry by the American board of psychiatry and neurology or otherwise knowledgeable in the practice of addiction medicine.

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

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

5. Licensed independent clinical social workers shall meet the qualifications established in ch. 457, Stats., and be licensed by the examining board of social workers, marriage and family therapists and professional counselors with 3000 hours of supervised clinical experience where the majority of clients are children or adults with mental disorders or substance-use disorders.

6. Professional counselors and marriage and family therapists shall meet the qualifications required established in ch. 457, Stats., and be licensed by the examining board of social workers, marriage and family therapists and professional counselors with 3000 hours of supervised clinical experience where the majority of clients are children or adults with mental disorders or substance-use disorders.

7. Adult psychiatric and mental health nurse practitioners, family psychiatric and mental health nurse practitioners or clinical specialists in adult psychiatric and mental health nursing shall be board certified by the American Nurses Credentialing Center, hold a current license as a registered nurse under ch. 441, Stats., have completed 3000 hours of supervised clinical experience; hold

a master's degree from a national league for nursing accredited graduate school of nursing; have the ability to apply theoretical principles of advanced practice psychiatric mental health nursing practice consistent with American Nurses Association scope and standards for advanced psychiatric nursing practice in mental health nursing from a graduate school of nursing accredited by the national league for nursing.

8. a. Advanced practice nurse prescribers shall be adult psychiatric and mental health nurse practitioners, family psychiatric and mental health nurse practitioners or clinical specialists in adult psychiatric and mental health nursing who are board certified by the American Nurses Credentialing Center; hold a current license as a registered nurse under ch. 441, Stats.; have completed1500 hours of supervised clinical experience in a mental health environment; have completed 650 hours of supervised prescribing experience with clients with mental illness and the ability to apply relevant theoretical principles of advance psychiatric or mental health nursing practice; and hold a master's degree in mental health nursing from a graduate school of nursing from an approved college or university.

b. Advanced practice nurses are not qualified to provide psychotherapy unless they also have completed 3000 hours of supervised clinical psychotherapy experience.

9. Certified social workers, certified advance practice social workers and certified independent social workers shall meet the qualifications established in ch. 457, Stats., and related administrative rules, and have received certification by the examining board of social workers, marriage and family therapists and professional counselors.

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

11. Physician assistants shall be certified and registered pursuant to ss. 448.05 and 448.07, Stats., and chs. Med 8 and 14.

12. Registered nurses shall be licensed under ch. 441, Stats.,

13. Occupational therapists shall be licensed and shall meet the requirements of s. 448.963 (2), Stats.

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

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

16. Alcohol and drug abuse counselors shall be certified by the department of safety and professional services.

Note: Persons previously referred to as "alcohol and drug abuse counselors" are referred to as "substance abuse professionals" in department of safety and professional service rules.

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

18. Certified occupational therapy assistants shall be licensed and meet the requirements of s. 448.963 (3), Stats.

19. Licensed practical nurses shall be licensed under ch. 441, Stats..

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

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

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

Records of staff members who provide services within Green Lake County CCS will be maintained in the Health and Human Services personnel file and will include:

- References for job applicants obtained from at least 2 people, including previous employers, educators or postsecondary educational institutions attended if available, and documented either by letter or verification of verbal contact with the reference, dates of contact, person making the contact, individuals contacted and nature and content of the contact.
- Credentials including copies of degrees, licenses, and certifications.
- Confirmation of an applicant's current professional license or certification, if that license or certification is necessary for the staff member's prescribed duties or position.
- The results of the caregiver background check including a completed background information disclosure form for every background check conducted, and the results of any subsequent investigation related to the information obtained from the background check.
- Documentation of completed training.

Credentials of each CCS staff member will also be maintained in a Credential Binder, which will be available for review by consumers and parents or legal representatives of consumers if parental or legal representative consent to treatment is required. The requirements for minimum qualifications of CCS staff members is outlined in the general Clinical Services policy

~~SECTION 7:~~ CCS SUPERVISION AND CLINICAL COLLABORATION - ~~HFS~~ DHS

36.11

~~Policy~~

~~In accordance with HFS 36.11,~~ Each staff member of Green Lake County's CCS programs shall be supervised and provided with the consultation needed to perform their assigned functions and to meet the credential requirements of this chapter and other state and federal laws and professional associations. This supervision may include clinical collaboration, but only for staff members qualified under s. ~~HFS~~ DHS 36.10(2)(g) 1. to 8. To assure compliance with this policy, the following procedures have been established.

~~Procedures~~

1. Each CCS staff member qualified under s. ~~HFS~~ DHS 36.10(2)(g) 9. to 21. (i.e. those who are **not** certified at the master's level as a MH professional) shall receive at least one hour of formal supervision per week for every 30 clock hours of face-to-face psychosocial rehabilitation services or service facilitation they provide. This is in addition to receiving day-to-day supervision and consultation, which shall always be available during CCS hours of operation.

2. Each staff member qualified under s. ~~HFS~~ DHS 36.l 0(2)(g) 1. to 8. (i.e. those who **are** certified as mental health professionals at the maters level) shall participate in at least one hour of either supervision or clinical collaboration per month or for every 120 clock hours of face-to-face psychosocial rehabilitation or service facilitation they provide.

3. Supervision and clinical collaboration shall be accomplished by one or more of the following means for each CCS staff person.
    a. Individual sessions with the staff member for case review, to assess performance, and to provide feedback.
    b. Individual side-by-side sessions in which the supervisor is present while the staff member provides assessments, service planning meetings, or psychosocial rehabilitation services in which the supervisor assesses, teaches, and gives advice regarding the staff member's performance.
    c. Group meetings to review and assess staff performance and provide the staff member advice or direction regarding situations or strategies.
    d. Other professionally recognized forms of supervision designed to provide sufficient guidance to assure the delivery of effective services to consumers by the staff member.

4. Clinical supervision and clinical collaboration shall be documented and dated with the signature of the person providing the supervision or clinical collaboration in one or more of the following:

    a. The master log.
    b. Supervisory records
    c. Staff record of each staff member who attends the session or review.
    d. Consumer records.

5. The service director may direct a staff person to participate in additional hours of supervision or clinical collaboration beyond the minimum identified in procedure statement in order to ensure that consumers of the program receive

appropriate psychosocial rehabilitation services.

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

~~SECTION 8:~~ CCS ORIENTATION AND TRAINING ~~POLICIES AND PROCEDURES~~ - ~~HFS~~ DHS 36.12

~~Policy~~

~~In accordance with HFS 36.12,~~ Green Lake County CCS programs have developed ~~and will implement~~ an orientation and training program for all new employees and an in-service training program for all ongoing employees. This program is designed to assure that staff have the requisite knowledge and skills to provide CCS services effectively, respectfully, and in accordance with all relevant laws, regulations, and internal policies. The following procedures outline the specifics of this orientation and training program.

~~Procedures~~

Orientation and training for new CCS employees includes all of the following:

a. At least 40 hours of documented orientation training within 3 months of beginning employment for each staff member who has less than 6 months experience providing psychosocial rehabilitation services to children or adults with mental disorders or substance-use disorders.
b. At least 20 hours of documented orientation training within 3 months of beginning employment with the CCS for each staff member who has 6 months or more experience providing psychosocial rehabilitation services to children or adults with mental disorders or substance-use disorders.
c. At least 40 hours of documented orientation training for each regularly scheduled volunteer before allowing the volunteer to work independently with consumers or family members.

Per ~~HFS~~ DHS 36.12 (l)(b), this orientation training includes, and staff members are required to be able to apply, all of the following:

a. Parts of ~~HFS~~ DHS 36 pertinent to the services they provide.
b. Internal policies and procedures pertinent to the services they provide.
c. Specific job responsibilities for each CCS staff member and any CCS volunteers.
d. Applicable parts of chs. 48, 51, & 55, stats, and any related administrative rules.
e. The basic provisions of civil rights laws including the Americans with disabilities act of 1990 and the civil rights act of 1964 as those laws apply to staff providing services to individuals with disabilities.
f. Current standards regarding documentation of services, including especially the provisions of HIPAA, s.51.30, stats, ch. ~~HFS~~ DHS92 and, if applicable, 42 CFR part 2 regarding confidentiality of treatment records.
g. The provisions of s.51.61 and ~~HFS~~ DHS 94 regarding patient rights.
h. Current knowledge about mental disorders, substance-use disorders, and co-occurring disabilities as well as related treatment methods.
i. Recovery concepts and principles to ensure that services and supports promote consumer hope, healing, empowerment and connection to others and to the community; and to assure that those services are provided in a manner that is respectful, culturally

appropriate, collaborative between consumer and service providers, based on consumer choice and goals, and protective of consumer rights.

j. Current principles and procedures for providing services to children and adults with mental disorders, substance-use disorders and co-occurring disorders. Areas addressed shall include recovery-oriented assessment and services, principles of relapse prevention, psychosocial rehabilitation services, age-appropriate assessments and service for individuals across the life-span, the relationship between trauma and mental and substance abuse disorders, and culturally and linguistically appropriate services.

k. Techniques and procedures for providing non-violent crisis management for consumers, including verbal de-escalation; methods for self-protection and protection of the consumer and others in emergency situations; and techniques and procedures for suicide assessment, prevention, and management.

l. Other training that is specific to the position for which each employee is hired so that they are fully aware of their job responsibilities and duties.

Per ~~HFS~~ DHS 36.12(l)(c), the CCS also ensures that each existing staff member receives at least 8 hours of in-service training a year that is designed to increase the knowledge and skills received by staff members in the orientation training provided at the time of initial employment. Staff shared with other community mental health or substance abuse or addiction programs are allowed to apply documented in-service hours received in those programs toward this requirement if that training meets the requirements under this chapter. Ongoing in-service training includes one or more of the following:

1. Time set aside for in-service training, including discussion and presentation of current principles and methods of providing psychosocial rehabilitation services.
2. Presentations by community resource staff from other agencies, including consumer operated services.
3. Conferences and workshops attended by staff members.

Per ~~HFS~~ DHS 36.12 (1)(d), updated, written copies of the orientation and ongoing training programs and documentation of the orientation and ongoing training received by staff members and volunteers shall be maintained as part of the central administrative records of CCS.

~~SECTION 9~~ CONSUMER APPLICATION - ~~HFS~~ DHS 36.13

~~See Attachment V. – Application for Services and Screening)~~

Any person seeking services under this chapter shall complete and application for services. Upon receipt of the application CCS shall determine the application need for psychosocial rehabilitation in accordance with DHS 36.14. In addition to referrals directly from consumers, other DHS units (ie: Children and Families, Behavioral Health) can bring possible consumers to the attention of the Service Director, Mental Health Professional or CCS Coordinator for staffing and review.

Admission Agreement - ~~HFS~~ DHS 36.13 (1M)

An admission agreement that includes all of the following shall be signed by applicant at the time of application to CCS (Appendix F)

1. The nature of CCS, including hours of operation, how to obtain crisis services after hours and staff members titles and responsibilities
2. The consumer rights under DHS 36.19

3. An acknowledgement of receipt and understanding of information in 1 and 2.

Services Pending Determination of the Need for Psychosocial Rehabilitation Services ~~HFS~~ DHS 36.13(2)

Pending determination of the need for psychosocial rehabilitation services, CCS can identify immediate needs of the consumer. The applicant may be provided services, supportive activities and identify recovery team members to meet those needs only after the following:

1. A mental Health Professional has authorized services as evidence by a signature DHS 36.15.
2. The assessment of initial needs and authorization for services have been documented.
3. An admission agreement is signed by the applicant.

The determination of need for psychosocial rehabilitation services shall be determined according to DHS 36.14. CCS shall ensure that no consumer is denied benefits or services or is subjected to discrimination on the basis of the following:

- Age
- Race or Ethnicity
- Religion
- Color
- Sexual Orientation
- Marital status
- Arrest of conviction records
- Ancestry
- National origin
- Disability
- Gender
- Sexual Orientation
- Physical Condition

~~SECTION 10:~~ DETERMINING NEED FOR PSYCHOSOCIAL REHABILITATION SERVICES- ~~HFS~~ DHS 36.14

~~See Attachment VI. Admission Criteria and Determination of Need for Psychosocial Rehabilitation Services Policy~~

Psychosocial rehabilitation services shall be available to individual who are determined to require more that outpatient counseling but less that the services provided by Community Support Program (CSP). A functional screen will be completed and the following criteria will be met;

1. Has a diagnosis of a mental disorder or a substance use disorder
2. Has a functional impairment that interferes with or limits one or more major life activities that results in a need for services.

Services can be ongoing, comprehensive and either high or low intensity. A qualifying functional impairment is depended upon whether the person meets one of the following descriptions:

- Group 1 - Persons in this group include children and adults in need of ongoing high intensity comprehensive services who have a diagnosis of a major mental disorder or substance use disorder and a substantial need for psychiatric or substance use/addiction treatment.
- Group 2 – Persons in this group include children and adults in need of ongoing low intensity comprehensive services who have a diagnosed mental or substance use

disorder. These individual generally function in a fairly independent and stable manner but may occasionally experience acute psychiatric crisis.

3. All efforts will be made to complete the functional screen at the time of application. If it cannot be completed at the time of application, CCS shall conduct an assessment of needs as outlined in DHS 36.16. It may be abbreviated if any of the conditions in DHS 36.16(5) applies.
   If the applicant is determined to not need psychosocial rehabilitative services, no additional services may be provided by CCS. Written notice will be sent to the applicant. Staff will refer applicant to another appropriate service.
   If the applicant is determined to need psychosocial rehabilitative services, a comprehensive assessment shall be conducted unless the following condition are present:
   - A comprehensive assessment was conducted prior to the functional screen.
   - The consumer qualified for an abbreviated assessment.

AUTHORIZATION OF SERVICES- ~~HFS~~ DHS 36.15

~~See Attachment VIII.~~

Before a service can be provided a mental health professional shall do all of the following:

- Review and confirm the applicants' need for psychosocial rehabilitation services and medical and supportive activities to address a desired recovery goal.
- Assure that a statement authorizing the proposed services is in the consumer's record.

If there is a substance use disorder present, a substance use professional shall also sign the authorization. (Appendix G)

ASSESSMENT PROCESS - ~~HFS~~ DHS 36.16

~~See Attachment I.~~

All of the following shall occur concerning the assessment:

1. The assessment process and the assessment summary shall be completed within 30 days of application for services. The facilitator will explain the process to the consumer or legal representative or family member.
2. The assessment process shall be facilitated by a service facilitator
3. A substance abuse professional shall establish the substance use diagnosis. They will also conduct their own substance use assessment including strengths and treatments needs.
4. The assessment process shall incorporate the consumer's unique perspective and own words about how they view their recovery, experience, challenges, strengths, resources and needs and be consistent with the following:
   - The assessment shall be comprehensive and accurate. It will include all domains listed as well as other domains identified by CCS staff and or the consumer and include the following:
   - Be based upon known facts and recent information/evaluations and include assessment for co-existing mental health disorders, substance use disorders, physical or mental impairments or other medical problems.
   - Be updated as new information becomes available.
   - Address the strengths, needs, recovery goals, priorities, preferences, values and lifestyle of the consumer.
   - Address age and developmental factors.
   - Identify cultural and environmental supports.
   - Identify the consumer's recovery goals and understanding of options for treatment

The Assessment Domains

1. Life Satisfaction
2. Basic Needs
3. Social Network and Family Involvement (Except where rights have been terminated, the family of minor shall always be included)
4. Community Living Skills
5. Housing Issues
6. Employment
7. Education
8. Finances and Benefits
9. Mental Health
10. Physical Health
11. Substance Use
12. Trauma and Significant Lie Stressors
13. Medications
14. Crisis Prevention and Management
15. Legal Status
16. Any other Domains

Abbreviated Assessment

The assessment process can be abbreviated if the consumer has signed an admission agreement and one of the following applies:

1. The consumer's health or symptoms limit the information that can be obtained immediately.
2. The consumer chooses not to provide information necessary to complete a comprehensive assessment at the time of application
3. The consumer is interested in receiving only specified services that require limited information

An abbreviated assessment shall meet as many of the assessment criteria as possible. Documentation of the reasons for the abbreviated assessment shall be in the consumer record. The abbreviated assessment shall be valid for up to 3 months from the date of application. Upon the expiration date, a comprehensive assessment shall be conducted to continue CCS. If a comprehensive assessment cannot be conducted when the abbreviated assessment expires, the applicant shall be given notice that they do not meet the need of services as stated in DHS 36.14.

Assessment Summary

1. The assessment shall be documented in an assessment summary prepared by a member of the recovery team and shall include the following:
2. The period of time within which the assessment was conducted. Each meeting date shall be included.
3. The information in which outcomes and service recommendation are based.
4. Desired outcomes and measurable goals as stated by the consumer
5. The names and relationships to the consumer of all individuals who participated in the assessment process
6. Significant differences of opinion which unresolved among team members
7. Signatures of persons present at the meeting

(Appendix H, Appendix I)

Recovery Team

Each consumer will identify members of their recovery team. The recovery team shall include all of the following:

- The consumer
- A service facilitator
- A mental health professional and/or substance abuse professional.
- Service providers, family members, other supports and advocates with the consumers consent and if appropriate

- If the consumer is a minor or is incompetent or incapacitated, a parent or legal representative will be present

The team will participate in the assessment and service planning process. The role of each team member will be guided by the nature of their relationship to the consumer and they scope of practice. Team members can provide information, evaluate input and make recommendations regarding outcomes, services and supportive activities.

SERVICE PLANNING AND DELIVERY PROCESS - ~~HFS~~ DHS 36.17

~~See Attachment IX. – Service Planning~~

Facilitation of Service Planning

A written recovery plan will be based on the assessment and completed within 30 days of the consumer's application for services. The service plan will include a description of all of the following:

1. The process will be explained to the consumer or if appropriate a legal representative or family member
2. The process will be facilitated by the service facilitator in collaboration with the consumer and team
3. The process shall address the needs and recovery goals identified in the assessment.

Service Planning Documentation

The recovery plan shall include the following:

1. All activities that will be provided to the consumer or on the consumer's behalf.
2. The service providers and natural supports who are or will be responsible for providing consumer's treatment, rehabilitation or support services and the payment source for each.
3. Measurable goals and type and frequency of data collection that will be used to measure progress toward desired outcomes.

An attendance roster will be signed by each person in attendance at each recovery planning meeting. The roster shall include the date of the meeting and the name, address and telephone number of each person attending the meeting. It will be maintained in the consumer's record. Documentation of the recovery plan shall be available to all members of the team. (Appendix B)

Service Plan Review

The recovery plan will be reviewed and updated as the needs of the consumer change at lease every 6 months. A plan that was based on an abbreviated assessment will be updated at the expiration of the assessment or before, if needs change. The review will include progress toward goals and the consumer's satisfaction with services.

Service Delivery

Psychosocial rehabilitation and treatment services shall be provided in the most natural and least restrictive manner. Services will be delivered with reasonable promptness and build upon the natural supports available in the community. Services will be provided with a frequency to support achievement of goals identified on the plan. Documentation of services shall be included in the consumer's record under DHS 36.18.

CCS DISCHARGE POLICIES AND PROCEDURES - ~~HFS~~ DHS 36.17(5)

~~Policy~~

In accordance with ~~HFS~~ DHS 36.17(5), discharge from Green Lake County CCS programs shall always be based on consumer-specific discharge criteria established in the consumer's service plan, unless any one of the following applies:

- The consumer no longer wants psychosocial rehabilitation services.
- The whereabouts of the consumer are unknown for at least 3 months

despite diligent efforts to locate the consumer.

- The consumer refuses services from the CCS for at least 3 months despite diligent outreach efforts to engage the consumer.
- The consumer enters a long-term care facility for medical reasons and is unlikely to return to community living.
- The consumer is deceased.
- Psychosocial rehabilitation services are no longer needed.

~~Procedures~~

1. For all consumers, discharge criteria will be established at the time that their original Plan of Care is developed and will be updated as needed during any subsequent Case Review process. Discharge criteria will specify what conditions will indicate to the consumer, to the CCS staff, and to the consumer's recovery team that the consumer no longer requires the services of the CCS.
2. When a consumer is being discharged from the CCS, whether based on their specific discharge criteria or on one of the above-mentioned general conditions, the case manager will develop a written discharge summary for the consumer. The discharge summary will be entered into ~~TCM~~ the record and will include all of the following:

   a. The reasons for discharge.
   b. The consumer's status and condition at discharge including the consumer's progress toward the outcomes specified in their service plan.
   c. Documentation of the circumstances, as determined by the consumer and recovery team that would suggest a renewed need for CCS services and procedures for re-applying for CCS services.

3. The discharge summary will always be signed by the case manager, the Service Director, and for consumers served for a substance use problem, by a substance abuse professional. Whenever the discharge was a planned one, it will also be signed by the consumer him or herself.
4. For a planned discharge, consumers will be given a copy of their discharge summary, which will include procedures on how to reapply for CCS services in the future. With the consumer's consent, their discharge summary shall also be shared with providers who will be providing subsequent services.
5. For an unplanned or involuntary discharge, the consumer will be notified that the discharge has taken place and will be given options for having that decision reviewed if they so wish. More specifically, if the consumer receives Medical Assistance, they will be informed of the fair hearing procedures prescribed in ~~HFS~~ DHS 104.01 (5). If the consumer does not receive Medical Assistance, they will be informed of the procedure for submitting an appeal of the discharge decision to ~~DHFS~~ DDHS. (Appendix J)

~~SECTION 14:~~ CONSUMER SERVICE RECORDS - ~~HFS~~ DHS 36.18

See ~~HFS~~ DHS 36.07(5)(a) on page ~~17~~ 12 regarding Policy on Consumer Records.

~~SECTION 15:~~ CONSUMER RIGHTS- ~~HFS~~ DHS 36.19

~~See HFS 36.07(5)(d) for description.~~

CCS shall comply with the patient rights and grievance resolution procedures in s. 51.61, and

ch.DHS 94. See DHS 36.07(5)(d) for description. Consumers will have choice in the selection of recovery team members, services and service providers. They have the right to specific, complete and accurate information about proposed services and for medical assistance consumers, a fair hearing process under DHS 104.01(5). For all other consumers, how to request a review of CCS determination by the department. The service facilitator shall ensure that the consumer understand the options of using the formal and informal grievance process in DHS 94.40 (4) and (5).

GREEN LAKE COUNTY

HOME/OFFICE VISIT SAFETY RECOMMENDATIONS

In response to the COVID-19 emergency, a Stay at Home order was issued in Wisconsin for persons to stay home and socially/physically distance except for essential services and activities.

Issue: The County needs to prepare to address required face-to-face contacts as well as to re-open the full array of county services within the health constraints of a pandemic.

Purpose: The purpose of this document is to provide guidance to plan for and continue all services in a manner that is safe for staff and the public during and after the stay at home order has been lifted. These recommendations will be reviewed weekly by the Director/Unit Managers or as often as needed.

Guiding Assumptions & Principles:

1. **The pandemic will continue for the next 12-18 months. We need to be prepared to continue with safety precautions for the public and the staff throughout this timeframe.**
2. **The timing of re-opening public spaces and services will be asynchronistic. Re-design of some spaces, services and procedures will take longer to implement than others. While services will need to be available, some portions of county buildings may not re-open fully to the public for the foreseeable future.**
3. **Methods of service delivery should be as safe as possible for both staff and public while maintaining increasing service delivery and quality.**

<u>BASELINE:</u>

- Workers should have very limited in-person contact with clients in their homes. Consult with Unit Manager/Director to determine ways that safety can be assured as opposed to entering the home. Unit Manager/Director approval should be initiated prior to contact.
  Face-to-face contact is required when:
  - Identified child/youth who is unsafe
  - Other children in the home who may be unsafe
  - Other household members, if necessary, to assess for safety
  - Youth who is charged with violent felonies
  - Vulnerable adults who are unsafe.

- When workers determine an in-person home visit must be conducted: s/he should complete the COVID -screening questions below. A telephone call must be made to ask the following questions: This call may be with a mandated reporter, law enforcement or hospital staff in the event that the individual/family has not initiated the contact.
    1. Does any household member have a lower respiratory illness (e.g. cough, shortness of breath) or temperature/fever over 100.4?
        a. Are there any other newly developed medical concerns such as vomiting or diarrhea, vomiting, diarrhea, fatigue, body aches,

sore throat, inability to smell or taste, chills or repeated shaking with chills?

2. Has anyone in the home been advised to self-isolate due to COVID 19 symptoms?
3. Has any household member come into close contact with a person diagnosed or under investigation for COVID-19?

Follow up: If the individual/family or reporter answers YES to any of the questions, ask: "Has there been follow-up with the person's medical provider for testing." If no, consult with Public Health. Good guidance is completion of the Health Check and Exposure Assessment Tool. See Attached.

- If it is determined that a home visit is necessary, the Unit Manager/Director will contact Public Health or Dispatch to inquire if the residence/persons have been flagged for COVID-19.
- Only Child Protective Services (CPS) workers, , Behavioral Health Unit (BHU) Crisis workers Community Support Program (CSP) and Adult Protective Services (APS) workers are permitted to enter flagged residences and those residences of people who have indicated positive screening questions.
- If a worker goes into a home where there is known or suspected COVID, the worker must check in with public health for guidance to review concerns with them prior to and subsequent to the visit.
    - The worker will consider appropriate location, transportation, and safety related interventions prior to visits.
- Non-emergency regular contacts should be done by technology if feasible and safe to do so.

EQUIPMENT/PPE GUIDELINES:

All staff making face-to-face contacts with families, providers, and other community partners are expected to use personal protective equipment (PPE) for their safety and the safety of others.

PPE are available for workers at DHHS Administration offices (Director). These bags include masks, latex gloves, foot coverings, trash bags, hand sanitizer, and disinfectant spray and paper towels. Also in that location you can find extra masks, and extra hand sanitizer (this is to re-fill small bottles). Cloth masks are available through the lower level Administration office.

Workers using PPE are required to be trained in proper use prior to obtaining it for fieldwork. This requires documentation that he/she has watched video instruction provided by Public Health.

1. Workers shall wear a mask at all times when making face-to-face contacts. Cloth, surgical, or N95 masks can be worn, although N95 masks should be used sparingly. Use hand sanitizer before placing the mask on your face. Avoid touching the surface of the mask.

    a. Masks should be put on prior to contact with others.

    b. Cloth masks should fit snugly but comfortably against the side of worker's face. It should be secured with ties or ear loops.

c. Workers should wash cloth masks after each use. Masks can be washed in a washing machine
d. Workers are not to reuse surgical or N95 masks.
e. Workers are to offer a mask to clients with whom they are having contact.
f. Workers should not remove their mask until he/she returns to their vehicle. The worker should use hand sanitizer after removing the mask. The worker should fold the mask so that the outer surface is held inward against itself to reduce contact with the outer surface during storage. The folded mask can be stored between uses (if necessary) in a clean sealable paper bag or breathable container.

2. The worker shall wear nitrile or latex gloves during the home visit. Use hand sanitizer before and after using the gloves is required.

3. The worker shall remove gloves following these steps:

    a. Grasp the outside of one glove at the wrist.

    b. Peel the glove away from his/her body, pulling it inside out.

    c. Hold the glove removed in his/her gloved hand.

    d. Peel off the second glove by putting his/her fingers inside the glove at the top of his/her wrist. Turn the second glove inside out while pulling it away from his/her body, leaving the first glove inside the second.

    e. Do not reuse the gloves!

4. Only bring in necessary supplies, equipment and materials.

5. Use disinfectant spray and paper towel to wipe down anything that may have touched during interactions with clients or in the community (bag, keys, iPad, pens, pencils, etc.)

6. Check and ensure that any vehicle used has adequate cleaning supplies prior to leaving the agency for any home visits or transportation of clients. Please re-supply any vehicle after use.

Considerations prior to initial and other in-person contacts:

Be efficient. Narrow the focus of the face-to-face contact and consider how to safely gather the information needed. What questions are needed to be asked and assessed? Given those questions, can contact occur outdoors with appropriate physical distancing? Can collateral information be gathered via phone or video conferencing to make safety decisions? Obtain information from the reporting source about collaterals that can provide accurate information.

Prioritze Information gathering. Gather relevant information to make decisions, then prioritize and start to gather the information needed to assess and plan. Thorough information can only be identified through the collection and assessment of information about the individual or family.

Collaborate with collateral sources to coordinate information gathering.

Worker's should only be entering homes if there are safety concerns relating to the condition of the home. All interviews should be completed outside the home. Follow these general guidelines:

1. Practice social distancing! Keep at least six feet of space between yourself and others.
2. Attempt to meet with family members outside the home whenever possible.
3. If you must enter the home to assess unsafe environmental conditions, when possible:
    A. Have anyone not directly involved or a primary member of the family wait in another room or outside of the home.
    B. Stand during your visit.
    C. Remain in a well-ventilated area.
    D. Do not touch anything in the home.
    E. Refrain from touching your face.
4. Change your clothes immediately upon returning home. Wash your hands with soap and water. Wash your clothes and cloth face mask in hot water.

LOBBY SERVICES:

- **HEALTH AND HUMAN SERVICES:**
    - Please schedule an appointment with the department for time- sensitive, critical or emergency services only.
    - Visitors with an appointment will be escorted by a county staff person to and from the appointment.
    - Appointments should be limited to only those individuals necessary to transact business.
- **COVID-19 PROTECTIVE MEASURES:** For the safety and well-being of Green Lake County staff and the public:
- **When the public or staff enter the Green Lake Government Center, the following measures must be followed:**
    - Each individual must participate in health screening protocols prior to entering the building and proceeding through security.
    - Unless mandated, children under the age of 16 will not be allowed to enter the building.

- Everyone must wear a mask when entering the building and moving about common areas (hallways, waiting rooms, conference rooms, public rest rooms, courts, common office areas, etc.) and while attending a meeting or gathering or court hearing. (exceptions will be made for members of the public who may have a health condition that may not allow for a mask)
- Anyone who refuses to participate in health screening protocols or wear a mask will not be allowed to enter the premises.
- Anyone who fails the health screening will not be allowed to enter the premises, and will be asked to return after being at least 24 hours symptom free.

Lobby Services are required for the purposes of applying for and obtaining Economic Support Services.

Lobby Services are also presently being used for the purposes of consumers that have appointments with the Psychiatric Nurse and/or Psychiatrist.

Protocols for conducting those visits are recommended in the scenario guide however are subject to modifications as directed by the Unit Manager/Director.

Use the following scenarios to guide your face-to-face practice both in the field and in the office:

Scenario	Environmental Controls	Personal Protective Equipment
1. Worker has to enter home where there are safety concerns where <u>everyone has a negative health screen</u>.	Only essential family members are in the same room as the worker. Everyone else is outside in the yard or in other rooms with the doors shut. Worker plans visit so that s/he is in the home for as little time as possible. Avoid touching high contact surfaces: doorknobs, railings, tabletops, etc. Workers and those in the household maintain separation of 6 feet as much as possible. Worker uses hand sanitizer before entering and when leaving (after taking off PPE); provides hand sanitizer or requests that all parties thoroughly hand wash to every person in the same room as him/her. In the event that any party refuses to use safety precautions, the home visit is to immediately end.	Worker goes into the home wearing a surgical facemask and anyone in the home who is in the same room as the worker wears a mask (surgical or cloth). Hand sanitizer use by all parties. Worker wipe down anything touched during interactions with clients or in the community (bag, keys, iPad, pens, pencils etc.)

2. Worker has to enter home where there are safety concerns and everyone has a <u>negative health screen and then after entering, realizes that there is a sick person in the home.</u> Workers should exit the residence and consult with their Unit Manager/Director Workers should proceed with environmental controls.	Only essential family members are in the same room as the worker. Everyone else is outside in the yard or in other rooms with the doors shut. Worker plans visit so that s/he is in the home for as little time as possible. Worker uses hand sanitizer before entering and when leaving (after taking off PPE); worker provides hand sanitizer or requests that all parties thoroughly hand wash to every person in the same room as him/her. Avoid touching high contact surfaces: doorknobs, railings, tabletops, etc. Workers and those in household maintain separation of 6 feet as much as possible. In the event that any party refuses to use safety precautions, the home visit is to immediately end.	Worker goes into the home wearing a surgical mask; anyone in the home who is in the same room as the worker wears a mask (surgical or cloth). Worker must leave the home immediately after realizing there is a sick person in the house. Worker~~s~~ goes to his/her car, uses hand sanitizer, and obtains full PPE (surgical facemask, face shield, gown and gloves) prior to re-entering the house. After the visit, worker and before entering their vehicle removes the PPE according to directions, placing the face shield in the clear PPE bag and the remaining PPE in the garbage bag. Worker must thoroughly clean vehicle if PPE or clients (s) meets automobile. Follow CDC Guidelines for Disinfecting vehicles. Worker wipes down anything touched during interactions with clients or in the community (bag, keys, iPad, pens, pencils etc.)

3. Worker has to enter a home where there are safety concerns and someone has a positive health screen or confirmed case of COVID-19.	Ask that the person with symptoms be out of the house and in the yard with a mask on; if that is not possible, then they be in a separate room with a mask on and the door shut. Only essential family members are in the same room as the worker. Everyone else is outside in the yard or in other rooms with the doors shut. Worker plans visit so that s/he is in the home for as little time as possible. Worker should be in the residence only long enough to observe the unsafe conditions. The remainder of the home visit and conducting interviews should occur outside of the residence. Worker uses hand sanitizer before entering and when leaving (after taking off PPE); Worker provides hand sanitizer to every person or requests that all parties thoroughly hand wash in the same room as him/her. Avoid touching high contact surfaces: doorknobs, railings, tabletops, etc. Workers and those in household maintain separation of 6 feet as much as possible. Workers should refrain from sitting on furniture or touching items or surfaces within the residence. In the event that any party refuses to use safety precautions, the home visit is to immediately end.	Worker goes into the home wearing full PPE (surgical facemask, face shield, gown and gloves) following all protocols prior to donning. After the visit and before entering their vehicle, worker removes the PPE according to directions, placing the face shield in the clear PPE bag and the remaining PPE in the garbage bag. Worker must thoroughly clean automobile if PPE or client(s) has touched the vehicle. Follow CDC Guidelines for Disinfecting vehicles Worker wipe down anything touched during interactions with clients or in the community (bag, keys, iPad, pens, pencils etc.)
4. Transportation for a child or adult is required. Worker needs to transport a child/or adult (no family is able to provide transport); all people in the home have a negative health screen.	Worker uses hand sanitizer before transporting and when finished (after taking off PPE); worker provides hand sanitizer to child/adult to use before entering the car. In the event that any party refuses to use safety precautions prior to transport, worker will not transport. Plan travel for the least amount of time possible. If possible, open windows in the car. Sanitize vehicle after transport.	Worker wears surgical facemask. Child/adult wears surgical or cloth mask. Children ages two and below will not be required to wear a mask. Worker wipes down anything touched during interactions with clients or in the community (bag, keys, iPad, pens, pencils etc.)

	Due to close conditions in the car, after the transport clothes should be washed in hot water.	
5. Transportation for a child or adult is required. Worker needs to transport a child/adult (no family is able to provide transport); at least one person in the home has a positive health screen or confirmed case of COVID – 19.	Worker uses hand sanitizer before transporting and when finished (after taking off PPE); worker provides hand sanitizer to child/adult to use before entering the car. Worker wears PPE and child/adult wears mask during the car ride. In the event that any party refuses to use safety precautions prior to transport, worker will not transport. Plan travel for the least amount of time possible. If possible, open windows in the car. Due to close conditions in the car, after the transport clothes should be washed in hot water. Sanitize the vehicle after transport.	Worker wears full PPE (surgical facemask, face shield, gown and gloves). Child/adult wears surgical or cloth mask. Children ages two and below will not be required to wear a mask. Once contact is concluded, worker removes the PPE according to directions, placing the face shield in the clear PPE bag and the remaining PPE in the garbage bag. Worker disinfects the vehicle. Follow CDC Guidelines for Disinfecting vehicles. Worker should wash their transport clothing in hot water. Use CDC Guidelines for Household Cleaning Small child car seat/booster should be sanitized after use. Worker will clean any county car seat/boosters. Parent/guardian/foster parent is responsible for cleaning their child's car seat/booster. Worker should obtain assurances that these have been sanitized prior to use in county vehicle. Worker wipe down anything touched during interactions with clients or in the community (bag, keys, iPad, pens, pencils etc.)

6. Worker needs to conduct an office visit with a client where all members of the client's household have a negative health screen.	Prior to visit worker will use disinfectant spray to wipe down all surfaces in the office that will be impacted by the visit (including tables, handles, chairs, light switch, doorknobs, lobby entry doors, etc.) In the event that any party refuses to use safety precautions prior to office visit, it will not occur. The only exception will be with a documented medical statement that the consumer cannot wear PPE. Workers and consumer will maintain 6 feet of separation as much as possible. After visit worker will use disinfectant spray to again wipe down all surfaces listed above and any other services that may have been impacted by the visit.	Worker will wear mask and gloves Consumer will be asked to wear a mask and gloves that will be provided by the worker Worker wipe down anything touched during interactions with clients or in the community (bag, keys, iPad, pens, pencils etc.) Cleaning supplies are located in the office meeting spaces.
7. Worker needs to conduct an office visit with a client where at least one member of the consumer's household has a positive health screen or one of the household members is positive for COVID-19.	Prior to visit worker will use disinfectant spray to wipe down all surfaces in the office that will be impacted by the visit (including tables, handles, chairs, light switch, doorknobs, lobby entry doors, etc.) In the event that any party refuses to use safety precautions prior to office visit, it will not occur. The only exception will be with a documented medical statement that the consumer cannot wear PPE Workers and consumer will maintain 6 feet of separation as much as possible. After visit worker will use disinfectant spray to again wipe down all surfaces listed above and any other services that may have been impacted by the visit.	Worker wears a mask, gloves, shoe covering and protective clothing covering. Consumer wears a mask, gloves, shoe covering and protective clothing covering. Worker will remove PPE and place in a trash bag with non- reusable items to be thrown away. Worker wipe down anything touched during interactions with clients or in the community (bag, keys, iPad, pens, pencils etc.) Cleaning supplies are located in the office meeting spaces.

HOSPITAL VISITS:

Workers must consult with hospital staff on the unit they need to go to (NICU, ER, Psych, etc.) before going to hospital to find out what the hospital's restrictions are. The hospital visitor guidelines are changing constantly so it is best that workers call before going.

a. Determine if face-to-face is necessary. Some face-to-face contacts may not be deemed necessary (such as baby in NICU that is healthy if parent interviews can take place elsewhere) – CONSULT with Unit Manager/Director
b. Request that hospital staff take pictures of the child to send to worker instead
c. Consider contacting collaterals such as formal and informal supports about the well-being of the person to help inform if a face-to-face needs to occur. Use hospital staff to gather child/adult functioning information via phone
d. Hospitals will likely accommodate CPS/Crisis staff coming on site if it involves an identified safety concern, safety planning, and/or temporary physical custody.
e. Hospitals are required to take the temperatures of all visitors at entrance to the hospital and will ask the required COVID screening questions, they will also require workers to wear PPE and may have to escort workers where they need to go

JAIL VISITS:

There should not be a need to conduct in-person jail interviews at this point. The jail is currently accommodating scheduled phone calls with inmates. These must be scheduled with the Jail Administrator.

TRANSITIONING CONSUMERS FROM TELEPHONE, TELEHEALTH/VIRTUAL TO IN PERSON VISITS:

Prior to an in-person contact, workers should assess for COVID-19 issues by using the Health Check and Exposure Assessment Tool by phone, text or email:

Workers in coordination with the local public health unit should provide additional guidance to determine how to proceed with the in-person contact, if the above questions indicate possible exposure. Safety and risk of the child and the worker should be considered in local guidance.

- Review individual service plans with consumers across all programs. This process should include an individual and person-centered plan with the focus of allowing a safe transition from phone or video/telehealth to in-person service delivery.
- Continue the use of telephone and or video/telehealth technology for consumers who have underlying health conditions or a reluctance to return to office setting environments following the pandemic should be considered.
- Temporary approvals for telephone and video/telehealth services may or may not continue permanently, which will affect agencies' ability to continue offering telephone or video/telehealth services.
- Utilize the office space/telehealth rooms designated in the county building (intake rooms, telehealth/virtual care offices) to allow consumers to have a safe, private, and video-equipped room for telehealth. This can serve to protect consumers and staff who might be at higher risk and need more time before they can safely resume face-to-face contacts.
- Provide written explanations to consumers regarding any telehealth services that are discontinued after COVID-19 temporary approvals are discontinued to help them understand and adjust.
- Alert consumers to the posted signage in all waiting rooms encouraging customers to practice safe distancing as they wait for appointments prior to their appointment.

Sit at least 6 feet apart from consumers during visits and sanitize sitting areas in between each consumer appointment.

Provide hand sanitizer to the consumer prior to the face-to-face appointment while in the waiting room areas.

Provide consumers with facemasks to wear during meetings and encourage consumers to safely store them for other use (cloth only).

ADDENDUM CPS/YJ

CPS/YJ CASE RESPONSE SHEET

- Priority 1 (Needs face to face contact):
    - Child at risk of placement or in placement (formal and/or informal)
        - Placement crisis - possible placement disruption
    - Non-verbal children on safety plans (average 0-6) - generally it's due to drug use, physical injury, and/or sex abuse
        - New assessments and ongoing safety plans (Parenting time is restricted in some way, for example, supervised visitation)
    - Any accepted Access Reports re: due to drug use, physical injury, and/or sex abuse that needs immediate assessment to determine initial risk/safety
    - Placement Danger Threat identified.
    - Children who have recently transitioned back into the home and there are ongoing concerns (ex. Trial reunifications where there are still safety concerns - not all trial reunifications will fall into this category)
    - UA's, oral tests or hair tests that are necessary in the above situations - new assessments & there is need to determine if protective plan/safety plan due to a present danger threat or impending danger threat or there is a safety plan in place and there is a current concern about parent's behavior
        - ** Parenting time for babies/non-verbal children who would not benefit from remote contact (this is still be worked out with the input of PH)
        - Youth taken into custody and alleged to have committed a violent felony
- Priority 2 (Needs regular/consistent contact - phone, skype, collateral contacts, etc.):
    - Child in placement but doing well/stable
    - Child is in a step-down safety plan - engage the network to help, utilize technology to step in
    - Parenting time with older children
    - Anything else that isn't in priority 1 where we were completing regular face to face contacts that we can safely do contacts differently
- Priority 3 (No face to face contact at current time Low risk or could be closed):
    - Child Welfare - unless (case by case) they would fall into the other categories
    - Kids in extended foster care
    - Low risk child protection cases, near closing (or have been waiting to be closed)

**UA's, oral tests and hair tests will be determined on case by case basis with the support of your Unit Manager; other than those listed in Priority one, most should be considered low priority

**We are unable to list all possibly situations; if a specific family situation does not fit, please speak to your Unit Manager

**Priority may change at any time

In some cases families may refuse to meet with worker for face-to-face due to the COVID-19 pandemic. Guidelines for documentation in these situations is below. If the family refuses to meet for other reasons, the worker should document as usual attempts to contact and engage the family.

Workers should document all their attempts in SACWIS and/or AVATAR.

Language that can be used –

- *IASW (last name) made attempts to set up F2F contact with parents/children on this case including: (list examples of phone calls to parents, their response, and accommodations that were made/offered by worker including meeting outside the family home or refusing to meet despite worker offering to wear protective gear, etc). The parents on this case refused to meet with IASW in person or allow IASW to interview their children, citing concerns about COVID-19 transmission. Given global and community restrictions that are currently in place due to COVID-19, F2F contact was therefore not able to take place on this case. After talking with a supervisor, it was determined that exigent circumstances do not exist in this case.*

- *IASW (last name) had phone/email/text communication with the parents/caregivers on this case and was informed that the family is under quarantine due to potential exposure or monitoring of COVID-19. Based on these circumstances, and in consultation with a supervisor, it was determined that it is not advisable for IASW to proceed with F2F contact with this family at this time per recommended guidelines by the CDC and Public Health administrators.*

- *After initial F2F contact was conducted with alleged victim, and parent/caregiver, no PDT's or IDT's were identified. Due to the ongoing concerns for contact with other persons in the community during the COVID-19 pandemic and with the State and County mandates for Safer At Home restrictions, after consultation with supervisor, further F2F contact with other household members was not conducted but contact with those household members were conducted by other means (i.e. telephone).*

FORENSIC INTERVIEWS:

- Safe Harbor, Madison, WI is available in limited circumstances due to the COVID-19 pandemic. Workers should continue to contact Safe Harbor to make referrals for the following types of cases:
    - Cases in which a primary caregiver of the child is the alleged maltreater
    - Cases where there are identified or possible safety threats to children
- Workers should continue to make referrals to Safe Harbor as usual; however, it is likely other types of interviews will not be scheduled at this time. These include sibling sexual abuse cases where parents are protective, secondary and non-caregiver cases, or cases in which there is a delayed disclosure. If there are no safety concerns for the child (ren), a Safe Harbor interview will not be scheduled at this time.

- If a Safe Harbor, interview is not scheduled and the worker is concerned about gathering all information within the 60-day IA timeframe, alternative arrangements should be made for a field interview after consultation with the worker's unit manager.
- PPE is available for families at Safe Harbor.
- Persons physically attending the Safe Harbor interview are limited to the assigned law enforcement official and the worker. All other parties appear by video.

FACE TO FACE CONTACT FOR CHILDREN IN OUT OF HOME CARE:

The waivers allowing video/phone contacts in lieu of face-to-face contacts are needed to continue remote service delivery. Present guidance is as follows:

Face-to-face contacts related to children and families of children in out-of-home care can be completed using technology (such as Skype, FaceTime, Zoom, etc.). This includes:

- **regularly scheduled monthly contacts between workers and children in out-of-home care,**
- **contact between workers and families of children in out-of-home care,**
- **family interaction between children in out-of-home care and their families,**
- **family interaction between siblings in out-of-home care,**
- **worker visits with families with no known active danger threats within the placement home, and**
- **bi-monthly contacts by child placing agencies workers serving treatment level foster care with children placed in a home licensed by the child-placing agency.**

Technology should be the preferred method of contact in the above situations, assuming Confirming Safe Environments have been completed and the child is considered to be in a safe setting. Risk management plans should continue to be monitored and updated as necessary.

Non-emergency regular contacts between families, children, and caseworkers, both in foster homes and group care, should be done by technology if feasible and safe to do so. The first priority for worker contacts should be to connect with the child through means that allow for the most interaction. Video-based visits are strongly encouraged, or telephone in the event that is unavailable. Efforts should be made to speak privately with the child during these contacts, where possible and appropriate. If technology is being used in lieu of in-person worker contacts this must be documented in the case note. Workers are encouraged to meet with the children on their caseloads more frequently when having contact via technology, and to check in specifically on how the conditions of a placement may have changed or adapted in light of COVID-19. Visits with parents also require that we minimize potential spread. Therefore, whenever possible, these visits should be by telephone, skype, video or other technology.

Family Interaction:

- The worker or designee will consider appropriate location, transportation, and safety related interventions for visits.

- The worker will review the plan with all caregivers and youth
- The worker will assess all physical environments of the child to assess the safety.

Other In-Person Contact Requirements

Youth Justice Intake Inquiries

- There is not a statutory requirement that youth justice intakes be done in person.
- Technology is encouraged to complete youth justice intake referrals.