

# **Integrated Services Project (ISP) and Coordinated Services Team (CST) Initiative Project Director's Meeting**

**Tuesday, April 14<sup>th</sup>, 2009 Holiday Inn & Convention Center – Stevens Point**

**In attendance:** Patty Bula & Chuck Price, Adams; Shelby Fader, Barron; Anita Haukaas, Bayfield; Shannon Larson & Amanda Komisar, Buffalo; Tara Mrozinski & Stacey Frolik, Chippewa; Amanda Muma, Clark; Dawn Woodard, Columbia; Chris Lee, Dodge; Margaret Buhk, Door; Sarah Leskela, Douglas; Dorinda Kobs, Jocelyn Lingel, & Sylvia Piekarz, Dunn; Gina Caldwell, Carol Pulkrabek, & Kendra Cragin, Eau Claire; Lauren Martin, Fond du Lac; Pam Snyder, Iron; Barb Gang, Jefferson; J. Michael Roraff, Juneau; Kristine Buehler, LaCrosse; Jenny Bisonette & Susan Smith, Lac Courte Oreilles Band; Lisa Reindl, Nancy Randolph, Rachel Orth, & Alecia Koenig, Manitowoc; Joann Liska, Marinette; Ann Saarinen & Roger Klug, Marquette; Amy Zimmer, Ludene Balke-Smiths, Lauree Roberts, & Bryant Duchow, Menominee; Sarah Sullivan, Monroe; Bruce Retzlaff, Oconto; Chad Knutson, Polk; Susan Dolski, Portage; Jolie Hoogland & Dottie Moffat, Price; Patricia Gordon & Laura Gordon, Red Cliff Band; Dawn Campbell, St. Croix; Nancy Koene & Edie Ritsman, Sheboygan; Zac Todd, Trempealeau; James Lee & Celsy Wiemerslage, Vernon; Anne Focht, Washburn; Stephanie Gudmunson, Washington, and Eve Altizer, Waukesha. Others present were reps of regional offices: Fred Heffling (Western), Sue Matczynski & Chris Craggs (North East), Gail Chapman (Northern); and Ginger Fobart, WI Family Ties, Lori Martin & Dan Naylor of White Pines Consulting, and DHS staff Marie Danforth & Nancy Marz.

## **1. Round Robin Question: *What is one example of proven successful systems change? OR What is an example of a challenge to systems change you have overcome?***

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Below is a Summary of Responses:

### ***What is one example of proven successful systems change?***

- (8) CST working well with schools – school staff on board
- (4) Streamlined/simplified intake & referral processes
- (2) Rejuvenating the coordinating committee
- (2) Cross system CST training/service coordination training
- (2) Reorganization/children & adult departments working together
- (2) Human services support”active” partners/community buy-in
- Being able to bill for crisis services
- Coordinating Committee taking on community issues
- Law enforcement collaborating with crisis response planning
- Multi-systems workgroup
- Utilizing Children’s Long Term Support Waiver (CLTSW) for some children/families with severe needs
- Family satisfaction is high
- Family advocacy/identifying natural supports
- Creativity utilizing CCS (Comprehensive Community Services) planning to meet needs
- CST values and principles throughout agency (Child Protective Services/Child Welfare/Mental Health)
- Charter school using wraparound
- Community response program (alternative to CPS involvement) using wraparound
- Head Start using wraparound
- Improved agency communication
- Network/share efforts with other counties
- Using wraparound and wavier to support kids in out-of-home placement in their homes & communities
- Accepting out-of-agency referrals
- Tribe and county working together
- Family buy-in/ownership of their plan
- Applying for other grants to support wraparound
- Pocket guide for police officers

### ***What is an example of a challenge to systems change you have overcome?***

- (5) Blending CCS/CST/LTSW

- (5) Getting “active” partners to the table – partner buy-in/ownership
- (4) Sustainability
- (3) Staff/administrative turnover (especially with school admin)
- (2) Implementation/expansion of CST/buy-in
- (2) Working with court ordered (non-voluntary) vs. “voluntary” clients
- (2) Difficulty with school involvement
- (2) Reaching service coordination capacity
- Getting community services involved (mental health)
- Integrating CLTSW & CST
- Lack of service providers
- Lack of understanding of what CST is/isn't

## **2. Bureau of Prevention, Treatment and Recovery Update**

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### **• Impact of Budget**

- Marie Danforth commented on handout: “Governor Jim Doyle’s 2009 – 2011 Biennial Budget: Department of Health Services”
- Dan Naylor’s comments:
  - Cut in Mental Health Block Grant funds is not planned to affect CST/ISP funding
  - Encouraged the exploration of other grants that could support the efforts of collaboration – a couple of Office of Justice Assistance grants currently available (for more information, contact Nancy Marz or your regional office).
  - Importance of continuing to collect data – both statewide and county specific
  - Update on “CST Legislation” – legislation to solidify and expand funding for CST is expected to be re-introduced in the fall. Sites are encouraged to share their collaborative successes with their legislators & keep them informed of CST/ISP activities.
  - Gail Chapman encouraged counties not currently utilizing the Children’s LSW to reconsider – additional Children’s Waiver Slots may be part of the upcoming budget.

### **• Updates by Nancy Marz**

- Shared the Annual Crisis Conference “save the date” cards: September 24<sup>th</sup> & 25<sup>th</sup>
- Importance of hospitalization as an *appropriate* part of the continuum of care; better coordination between law enforcement and human services prior to admission to a hospital can reduce unnecessary/inappropriate admissions.
- Highlighted some upcoming conferences (passed around brochures) – UW Motivation Interviewing Conference; National Fetal Alcohol Spectrum Disorders Conference April 30 – May 2 in Madison; Boys & Girls at Risk Conference; Midwest Conference on Child Sexual Abuse in October; May 15<sup>th</sup> Mental Health Summit in Eagle River (for details/more information, please contact Nancy Marz: [nancy.marz@wisconsin.gov](mailto:nancy.marz@wisconsin.gov))
- Update on Family Satisfaction Surveys – Nancy has gotten some of the survey results back from Wisconsin Family Ties; she will begin sending site-specific and statewide feedback as it becomes available.

### **• Updates by Dan Naylor – Future Expansion of CST**

- 7 Sites ending funding June 30<sup>th</sup>, 2009: Adams, Crawford, Douglas, Pierce, Polk, Richland, and St. Croix Counties
- Sawyer & Wood began with CST funding late 2008; 6 additional sites to begin July 1 2009 include: Bad River & Lac du Flambeau Tribes, Clark, Green, Kewaunee, and Oconto Counties
- Financial assistance remains available for sites that need additional training & technical assistance. Please contact George [george.hulick@wisconsin.gov](mailto:george.hulick@wisconsin.gov) and/or complete request form on [www.wicollaborative.org](http://www.wicollaborative.org) website.

### **• Updates on Reporting and the CANS – Lori Martin, White Pine Consulting Service**

Lori gave update on behalf of Tim Connor – Mental Health Evaluation Specialist (attending a conference in Washington DC) - [Tim.connor@wisconsin.gov](mailto:Tim.connor@wisconsin.gov), (608) 261-6744

### *Paperwork Reduction Efforts*

- In past year – modified report due dates to better fit with the needs of sites – for example, the due dates of evaluation tools (8 Key Components and Goals & Expected Outcomes Checklist) now correspond with sites' Work Plan and Budget due dates
- Current efforts: to combine the information gathered on the 8 Key Components, Goals & Expected Outcomes Checklist, and System Update into one document.

### *CANS (Child and Adolescent Needs and Strengths) Assessment Tool Certification & Recertification*

- There are currently 164 trained CANS raters (57 trainers, 77 raters + 30 trained yesterday)
- Trainers trained by John Lyons in January 2008 recently completed their annual recertification process. In the coming months, notices will be sent to raters who are up for their annual recertification; this process entails completing (and passing) a CANS test vignette.

### Training of Reliable Raters

- Looking at developing a group of “super users” who can conduct periodic regional trainings – possibly in conjunction with regional project directors' meetings

### Data Submission to the State

- It is anticipated that by mid summer, the capability for online submission of CANS scores to the State will be completed. The preparations are nearly done – the State is in the process of finalizing the reports that sites will be able to pull related to the CANS data submitted.

### Using other versions of the CANS

- Because several counties/agencies have expressed interest in using the CANS Comprehensive, the Bureau and White Pine Consulting Service would consider working with 1-2 programs to pilot this version of the CANS and would work to develop the additional training materials necessary for learning how to use the CANS Comprehensive. We would draw on John Lyons and other states that have used this version to get the necessary expertise. The training would be supplemental to the current CANS training- CANS approach to assessing children would be the same, but training would be needed on the additional items on the CANS Comprehensive. Interested mental health programs/agencies should have established relationships with other child-serving agencies in their county so that the comprehensive assessment can be followed up with coordinated comprehensive services.

If your site is interested in piloting the CANS-Comprehensive, please contact Tim Connor: [tim.connor@wisconsin.gov](mailto:tim.connor@wisconsin.gov)

For more info on CANS or other versions: [www.wicollaborative.org](http://www.wicollaborative.org) (early childhood, ANSA)

### Dept. of Children and Family Services search for an assessment tool

The Dept. of Children and Family Services is in the midst of strategic planning efforts in which they are considering new assessment tools re children's needs. The tool chosen from their planning process would be recommended for use statewide by all county child welfare agencies. DCFS recently presented information about several evaluation tools (including the CANS) to county child welfare professionals from across the state and gathered feedback on each. DCFS is currently reviewing the strengths and weaknesses of the assessment tools in anticipation of narrowing down the choices.

### CANS MA preauthorization for in-home therapy

Previously, the Children's Behavioral Checklist (CBCL) and the Child & Adolescent Functional Assessment Scale (CAFAS) were the only children's assessment tools approved by the State Medicaid agency for preauthorization for Medicaid billing for the in-home therapy benefit, but now the CANS has also been approved. The State Medicaid agency is currently working on updating policies and procedures to accommodate the use of the CANS for the preauthorization process and will make a formal announcement when the updates are

completed. In the meantime, however, county programs can submit the CANS for preauthorization starting immediately.

### **3. Wisconsin Family Ties (WFT) Update**

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- Ginger Fobart shared the update
- Working to have family advocates reimbursed for their services through MA utilizing CCS & Crisis Stabilization
- Seclusion & restraint update – in March, a “Prohibited Practices in the Application of Emergency Safety Interventions...” Memo was signed by DHS Secretaries (full memo can be found on Department of Quality Assurance (DQA) website)
- Disability Rights Wisconsin, FACETS & Wisconsin Family Ties have a joint-report to be released during press conference in Madison on April 22<sup>nd</sup>
- Family Fun Day at Mount Olympus water park available at a price of \$11/person, which includes a picnic lunch. Last year 855 people attended! This year’s date is Tuesday, July 7<sup>th</sup>.
- 2009 Children Come First Conference: Nov 16<sup>th</sup> & 17<sup>th</sup> at the Kalahari in Wisconsin Dells

### **4. Preferences for Afternoon Breakout Sessions**

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- Group discussed possible breakout sessions, based on the morning’s round robin discussion, including:
  - Working together with CCS/CST/CLTSW
  - New site development issues
  - Going from “program” to practice
  - Coordinating Committee & partner buy-in
  - Streamlining the intake process

### **5. 2009 CST Site Visits**

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- Site visits are being planned for Red Cliff Tribe (current site), Manitowoc County (formal funding ended 2 years ago), and Trempealeau County (newly funded site)

### **6. Trauma Informed Care: Making Time for Compassion – Elizabeth Hudson**

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- The Trauma-Informed Care Conference in May is already full
- “Trauma” refers to adverse experiences that impact our lives
- The prevalence of trauma is much higher than most people realize – approximately 56% of the general population have experienced a traumatic event
- Some examples of strategies:
  - Release and relaxation of your pelvic muscles (see “Transformation: From Sympathetic to Parasympathetic” handout)
  - Trauma-specific interventions – safely expose you to an experience you found traumatic and over time you see you weren’t destroyed by the process (hopefully feelings of liberation)
- Essential qualities of Trauma-Informed Care
  - Understand that trauma impacts many people’s lives
  - Provide services that are trauma-sensitive
  - Respect and collaborate with consumers
- Guiding Values of Trauma-Informed Care
  - Understand the prevalence and impact of trauma
  - Promote safety
  - Earn trust
  - Embrace diversity
  - Provide holistic care
  - Respect human rights
  - Pursue the person’s strengths, choice, and autonomy
  - Share power
  - Communicate with compassion

- Laurie Roberts, Menominee County, shared her experience of working as a mental health therapist with a “trauma-informed lens”. Listen to the person’s story – watch for diagnostic clues (e.g. not wanting to talk, forgetting, blaming). Allow the person to “tell” their story in a way that’s comfortable to them (e.g. drawing).
- A trauma-informed system of care needs to be a safe environment; agencies/workplaces need to implement the core values.
- For more information on trauma-informed care, contact: [Elizabeth.Hudson@wisconsin.gov](mailto:Elizabeth.Hudson@wisconsin.gov)

## 7. Agenda for Next Project Directors’ Meeting

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- If you have suggestions for the next meeting, please contact Nancy Marz ([nancy.marz@wisconsin.gov](mailto:nancy.marz@wisconsin.gov)) or George Hulick ([george.hulick@wisconsin.gov](mailto:george.hulick@wisconsin.gov))

## 8. Small Group Breakout Sessions

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- **CCS & CST working together** – facilitated by Chris Craggs (note taker – Dawn Campbell)
  - *Notes attached – these could really be helpful if you are dealing with both programs.*
- **New sites – development issues** – facilitated by Dan Naylor
  - How to keep the Coordinating Committee active
  - What are the basic steps in getting CST off the ground
  - Do a basic review of values & purpose
  - How to develop a service coordination pool
  - Can schools bill for service coordination?
  - Who can bill for a team meeting?
  - Moving from mandated services to “voluntary” clients
- **Going from Program to Process** – facilitated by Chris Lee
  - “Dump & run” mindset
  - Importance of defining what CST is – defining roles
  - System and administrative support very important
  - Skills a facilitator can utilize in the team process
  - Skills for use at an administrative level – foster relationships
  - Suggestion – monthly “core group” meeting
  - “Contracting” with families as well as providers
- **Streamlining the Intake Process**
  - Current intake process:
    - Jefferson – single point of access, others “no”
  - Discussion about a Family Resources Unit:
    - Birth to 3
    - Wraparound
    - Developmentally Delayed
    - Severe Emotional Disabilities
    - PD/CD Waivers
    - Comprehensive Community Services for children
    - Family Support
  - Jefferson keeps status reports if voluntary then it is assessed if wraparound is needed.
  - Manitowoc doesn’t have access calls, just go to whom they feel is necessary
  - Menominee has a front desk who takes call, then passes to the children’s unit person, who may or may not have the information necessary refer appropriately
  - LCO CST intake only at this point. Families, schools, health department, and Indian Child Welfare make referrals.
  - Getting a superintendent to buy into the CST process and having it be an expectation.
  - Manitowoc – has 3 points of access – clinical, CPS, juvenile justice

- Common theme – it is hard to mainstream CCS/CLTS/CST because of paperwork differences and system changes.
- **Coordinating Committee Buy-In** – facilitated by Dottie Moffat
  - Issues from the group:
    - 7 year old committee – stuck; attendance decline from 20 to 4 participants in past 3 years
    - Committee members to take more responsibility (like subcommittees, move into community)
    - Lack of administrative support – how can line workers do it?
    - How to create good agenda – good meeting
    - Give purpose to the committee
    - Don't really have a coordinating committee
    - Frequency of meetings – monthly, quarterly, every 6 months, 2 months...
  - Ideas
    - Recruitment
    - Purpose on agenda
    - Stipends for parents
    - Letter from administration
    - Members from business community
    - State needs to hold counties responsible for grant requirements
    - Treats
  - Agenda possibilities & suggestions
    - Update on CST
    - Status enrollment report
    - Policy & procedure review
    - Budget
    - Coordinator report
    - Guest speaker
    - Training – training library

**Next Project Director Meeting Date:**

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- **Tuesday, October 6<sup>th</sup>, 10:00 to 4:00** at the Holiday Inn, Stevens Point

PLEASE NOTE...we are NOT MEETING Tuesday October 13<sup>th</sup>

## Notes from Break Out Group: CCS and CST- Working Together

Chris Craggs shared a couple of visual diagrams to show how the various programs (Coordinated Services Team Initiative (CST), Comprehensive Community Services (CCS), Children's Long Term Support (CLTS), and Targeted Case Management (TCM)) can interface. CST is the way of doing business and the others are programs that have funding attached to them to acquire needed services. Chris also described the differences in the layers of the programs such as: CCS is the most diagnostically specific and therefore the most restrictive regarding admission serving only MH and AODA diagnoses. CLTS serves additional target groups (DD, autism, PD); TCM is still less specific, and there are 15 or so identified target groups. CST does not have diagnostic requirements and really applies to anyone with identified needs that can be met through the CST process.

The visual diagram is flawed, in that TCM cannot co-exist, in regards to billing, with CCS or CLTS. The function of "case management" or "service facilitation" is bundled into the two programs. Consequently, case management cannot be billed separately. The diagram should be looked upon as a tool to foster dialogue about working together, rather than a way to answer questions about the interaction of programs.

Discussed billing issues/options between programs and documentation that is necessary

The CST/Teaming process is not required in any of these other programs, but defines a "best practice approach" to providing services in nearly any program. It is important to have all involved parties on the team, regardless of the program; otherwise, it is not a comprehensive interdisciplinary team.

How can you include specialists as part of the planning process, etc.? Talked about the importance of having all involved parties on the team and also options of inviting some "specialists" such as Economic Support staff, therapists, etc. to a team meeting to share information and educate everyone. Those "specialists" would not have to participate in all meetings. If they are integral to services that the consumer/participant is receiving, however, these individuals should certainly be involved in every aspect of decision making (example given: a therapist that isn't invited to participate in meetings puts the therapist, the team, and ultimately the consumer/participant at a disadvantage).

There were some concerns about confidentiality and the use of computers; it could be covered in the release of information and that most systems were secure with sharing information via email, etc. provided practices used were consistent with applicable rules (agency policy, HIPAA, etc).

If kids are eligible for multiple programs, how do you choose where to enroll them? You have to look at what their needs are. If their needs can be met through one program, then enroll them in it; if some needs could be met with CLTS waiver services and other needs would only be met through CCS, then you might want multiple enrollment. CCS is a card service, however, and the waiver mandate applies to CLTS. When providing options to individuals, CCS eligible individuals should at least be offered CCS.

We discussed common services for kids that are paid for through CCS including therapy, parent training, mentoring, and some placement costs: the key is good documentation. Documentation needs to be related to diagnosis/symptoms of the client and show how the service being provided is directly related to that diagnosis. There is a different note style for CCS and billing and there was a lot of discussion on how it can be difficult to change to this style for staff and some providers as well. This is a training issue and several people indicated that they felt that they would benefit from staff or others being trained regarding this.

There was a discussion on placement costs and how often they were billed to through CCS for youth. As long as there are no lines crossed with IV E dollars, which can be tricky, then it is possible and it is believed counties have billed for some placement costs.

There was a question and discussion on evidence based practices and if all services provided through CCS need to be evidenced based practices. The general rule of thumb is that EBP should be used whenever possible but that the reality is that there are not enough of them to do it all the time. The State of Hawaii has a list that would be a good resource.

Question about the use of the Coord. Committee and the issues with possibly blending or overlapping the committees for CST and CCS. There were some concerns raised as they each have different requirements related to require membership and some counties that wanted to merge their two committees together couldn't because they would not have had enough consumer representation. Some suggestions were made as to having some members participate on both committees, ways to educate each committee on the activities of the other committee, etc. Green Lake has is structured such that its CCS committee is a subcommittee to the overall advisory committee that serves many purposes in the county.

There was a question about who the best contact person or resource is for questions about CCS funding/MA approved services. A DHS committee is trying to address these questions from a multidisciplinary perspective. Cheryl Lofton (608) 267-1427 is a good contact in BPTR, or consult your local CST rep or regional office to find a suitable contact.

Talked about blending of paperwork and what counties were using for Assessment, Plan, etc. Most counties use the same assessment and plan forms for everyone enrolled in CCS (youth and adults) some are using samples from the CCS website, CST website, etc. There isn't a specific form endorsed or recommended for use exclusively for CCS, or any other MA program or waiver. For CST/ISP, there are required forms, however, that can be adapted to contain required elements of all the programs.

It was noted that with all programs there is a similar pattern or casework flow that needs to happen:

1. Eligibility and Assessment
2. Plan of care (including goals, objectives/outcomes, measure of progress)
3. Follow up documentation as services are delivered (progress notes)
4. Review

It is the ongoing/follow up documentation that really tends to differ between programs. Clinically based programs require more "medical" charting than some other programs. If people get in the habit of documenting according to the CCS standards, then they will meet the needs of the other programs.

There were other general questions/discussion that clearly is related to implementation and how some counties or sites choose to structure their programs. In some counties the CST and the CCS programs are very separate and carried out by separate staff. These counties seem to struggle a bit more than others where the same staff work with the multiple programs and where programs are truly integrated following systems change efforts.