W.I.S.E.
CSP Training

ADVANCED BEHAVIORAL HEALTH

Agenda

- What is CSP?
- What is the role of the Functional Assessment ?
- How do we teach skills?
- Documenting Services
- Resources
- Exercises
- Questions/Case Presentations

Community Support Program

HOW IS IT DEFINED?

Definition of CSP

- Community Support Program (CSP) consist of mental health and substance abuse rehabilitation services and supports necessary to assist the individual in achieving and maintaining the highest degree of independent functioning. The service utilizes a team approach to provide intensive, rehabilitative community support, crisis intervention, group and individual psycho-education, and skill building for activities of daily living.
- CSP includes a comprehensive array of rehabilitation services most of which are provided in non-office settings by a mobile team. Services are focused on skill building with a goal of maximizing independence. Community-based treatment enables the team to become intimately familiar with the participant's surroundings, strengths and challenges, and to assist the participant in learning skills applicable to his/her living environment. The team services and interventions are highly individualized and tailored to the needs and preferences of the individual.

Community Support Program

What does it cover:

- Reinforce Recovery
- Build Skills
- Practice Skills
- Integrating Skills into Daily Life
- Crisis response
- Education, support and consultation to family
- Psycho education
- Health and Wellness
- Development of self advocacy skills

What it does not cover:

- Day to day monitoring
- Telephone contact

Focus on the dysfunctional behaviors as well as skills abilities/needs that impact the clients level of functioning in daily living.

CMS Proposed Rules for Rehabilitation Services

- All Rehab Services are considered: Physical as well as Psychiatric:
  - Clear Emphasis on Restoration or Improvement of Function
  - Requires Person-Centered Planning in Psychiatric Rehab
  - Requires Progress; Maintenance of effort not sufficient
- For the Mental Health Waiver the order for CSP Services is written by the WISE Waiver Team and given to the agency providing the services.

Rehabilitation Focus

- Clearly rehabilitative, not **medical/clinical**
- Organized approach to development of new or redevelopment of old competencies
- Not clinically focused although clinical services may play an integral or supportive role in treatment (referenced separately)
- Symptom reduction is not the focus – symptom and disability self-management are.
- Must focus on restoration/improvement of functioning

Rehabilitation

- Focuses on issues caused or impacted by disability and directly related to psychiatric illness
- Not just beneficial – necessary
- CMS's proposed rules: "The rehabilitation plan must be based on a comprehensive assessment of an individual's rehabilitation needs including diagnoses and presence of a functional impairment in daily living."

Functional Assessments

WHY DO WE NEED THESE?

Functional Assessments:

The initial one will be done by the waiver team and given to the receiving agencies, with the info being evaluated by the CSP team as they work with the client in the client's home.

- Provide the justification and evidence for decision-making re: Assistance and Skills Training
- Should be a major driver for Treatment/ Rehabilitation/Recovery plans and interventions
- Assists in defining "Order for Services" Interventions" with expected duration, frequency & intensity
- Helps to define "Rules" to be followed (who, what, when, how, etc.)
- Determines "Levels of Assistance" needed

Functional Assessments

- Measures a person's ability to Function in a way that is fair, objective and relevant to an individual's lifestyle.
- Over time, measures "Change in Ability to Function" which is important to the individuals, their loved ones, their social support systems and healthcare planners
- Strengths-based, needs-based and an ongoing process that is responsive to changes
- Focuses comprehensively on functioning
- Documents the impact of illness and/or condition on functioning AND that functioning can be improved and/or restored

Using the Functional Assessment

- Re-assess the person's skills if skills are not developing
  - Sally is not grasping the concept of budgeting
- Assist in noting where barriers are
  - We have learned that Sally is not able to do basic math
- Buy in from client to note change
  - Sally really wants to budget her money and has been able to understand what she needs to learn
- Use WISE Skills Assessment or the DMHAS Functional Assessment

If we are trying to …

- Establish goals that help clients build the capacity to reach recovery and independence, while always trying to show/demonstrate their progress and the types of assistance & support provided.
- Eventually reduce the duration and intensity of assistance/care to the least intrusive level that will sustain health.

We need to….

Assess a person's capacity and/or ability to perform and/or learn the skills of day to day living.

LOA's Defined

5. MAXIMUM ASSISTANCE – Unable to meet minimal standards of behavior or functioning in order to participate in daily living activities or performance of basic tasks approximately 75% of time. Cues – Step by step physical gestures, pointing and demonstrations.
4. MODERATE ASSISTANCE – Needs constant cognitive assistance such as 1:1 cueing, prompting/coaching or demonstrations to sustain or complete simple, repetitive activities or tasks safely and accurately approximately 50% of time. Cues - Hints to help organize thoughts. Prompts/Coaching – Step by step verbal directions.
3. MINIMUM ASSISTANCE – Needs periodic cognitive assistance (cueing and/or prompting/coaching) to correct mistakes, check for safety and/or solve problems approximately 25% of time. Cues -Hints related to the task. Prompts/Coaching – Step by step written and/or verbal directions.

(continued on next slide)

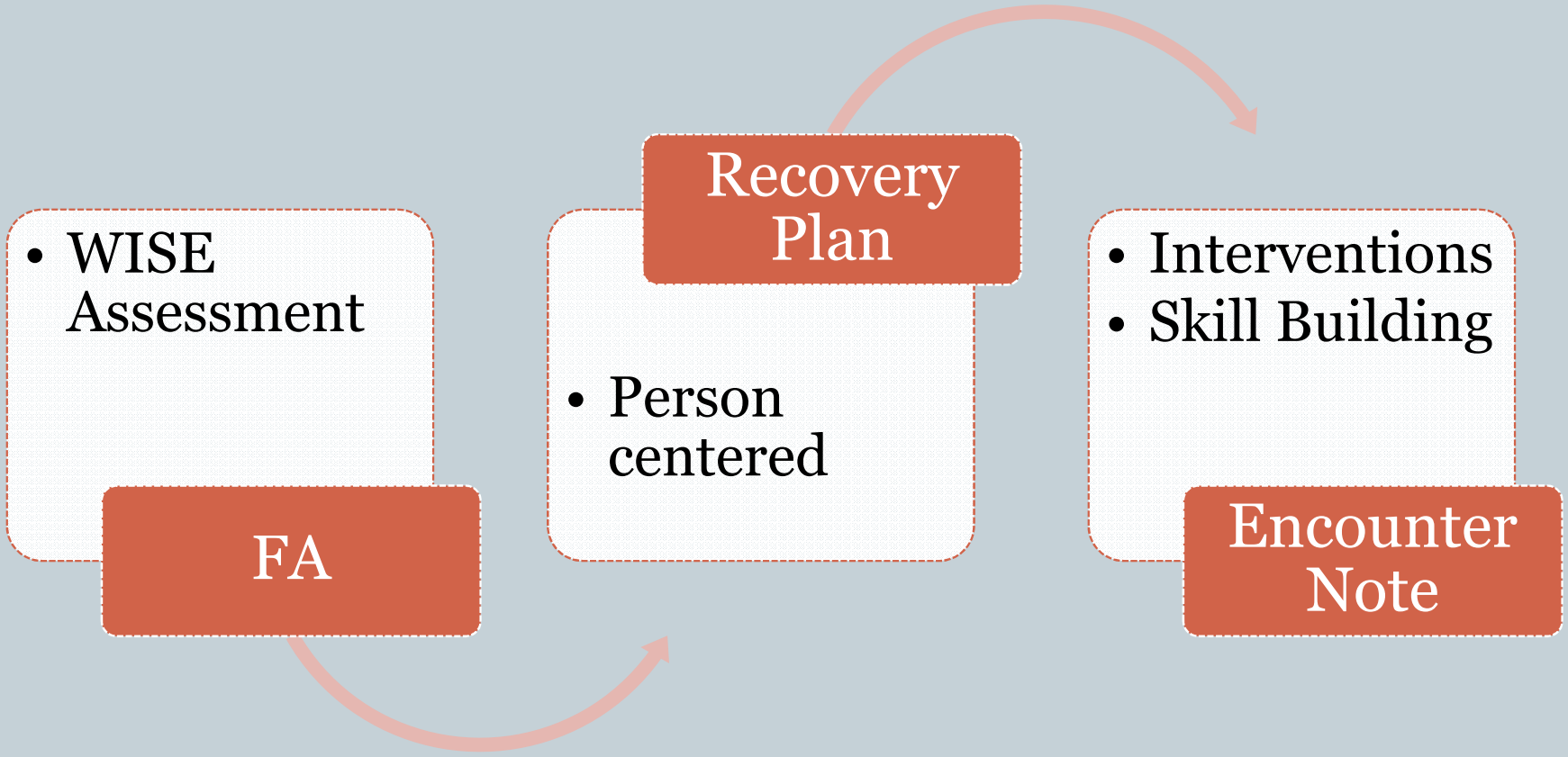
LOA's Defined

2. STANDBY ASSISTANCE – Supervision by one person is needed to enable the individual to perform new procedures for safe and effective performance. Cues – Visual demonstrations related to the task. Prompts/Coaching – Visual and physical directions that prompt the participant to perform the skills and/or tasks.
1. INDEPENDENT – No physical or cognitive assistance needed to perform activities or tasks.
0. UNABLE TO ASSESS – Individual refuses or has chosen to not actively participate in providing any evidence of skills and/or abilities or demonstrating any skills and/or abilities for this assessment

Rehab Domains

- Housing/Living Goals
- Relationship Goals
- Financial/Vocational Goals
- Spiritual/Religious Goals
- Health Goals
- Lifestyle Supports
- Health Management
- Nutrition
- Transportation
- Personal Hygiene
- Money Management
- Vocational
- Friends
- Leisure
- Care of Personal possessions
- Rights
- Medication Practices
- Side Effects
- Cognitive
- Quality of Treatment
- Quality of Life
- Symptoms
- Community Behaviors
- Personal Safety

Big Picture


• WISE Assessment
FA
Recovery Plan
• Person centered
• Interventions
• Skill Building
Encounter Note

Review of Treatment/Rehab Plan

- Mandatory Review of the plan at clinically appropriate intervals (at least every 180 days) with the WISE Staff and the Client
  - Determine effectiveness based on progress
  - Use monthly progress notes
  - Re-evaluate appropriateness and currency
  - Cannot do it without input of client
- Plan revisions
  - Revisit the client goal(s)
  - Re-examine needs
  - Change and update rehab goals (outcomes) and objectives
  - Look for new interventions and modalities
  - Adjust the time frames and target dates
- Plan should change – whether it is working or not!

Clinical vs. Rehab

Clinical	Rehab
Use tools and techniques to guide, facilitate and provide opportunity for change	Use tools and techniques to address functional impairment and restore level of function
Focus primarily on internalization to motivate behavioral changes	Focus on skill acquisition and mastery, adapting environment and accessing resources
Not always transparent and usually the balance of power is with the professional provider	Almost always transparent and is dependent on partnering to yield successful results
May involve skills: DBT, anger management, etc.	Almost always involves skills of one sort or another.

Skill Building

WHAT DOES THIS LOOK LIKE?

Skill Building Training

Helps Individuals with SMI or SED to:

"Perform physical, emotional, social, vocational, familial, problem-solving, and intellectual skills needed to live, learn, and work in the community *"with the least amount of help from agents of the helping professions".*

*Bill Anthony, 1979, BU Center for Psychiatric Rehabilitation.

Skills Training

- What is a skill?
  - Behavioral: requires action that can be seen or heard or in case of thinking skills can be described or written down
  - Purposeful : done for a reason
  - Transferable : can be performed or applied to many locations/situations
  - There is a "right" and a "wrong" way – but that doesn't eliminate options
  - Skills must be broken down into steps and taught in order
  - Benefits of learning need to be described and demonstrated

* **Adapted from Indiana curriculum Community Supports, copyright MTA, Inc and BCPR**

Structure of Skill Building Sessions

The practitioner should structure the skill building sessions to follow a predictable pattern. The following is an example:

- Informal socializing and identification of any major problems: 1-3 minutes
- Review previous session: 1-3 minutes
- Review homework: 3-5 minutes
- Follow-up on goals: 1-3 minutes
- Set agenda for current session: 1-2 minutes
- Teach new material or review previously taught material: 30-40 minutes (see next slide)
- Agree on new homework assignment: 3-5 minutes
- Summarize progress made in current session: 3-5 minutes

***Adapted from the SAMHSA IMR Toolkit**

The Process: What We Do

- Engage and educate
- Assess need, eligibility, interest, and commitment
- Provide support and shared decision-making to develop recovery goal(s) and work with the person to "risk recovery"
- Provide treatment , CM and other services as needed, that support goal(s) and help to reduce barriers
- Deliver skill building and other rehab services
- Provide support to maintain goal and change/progress

The Process: What the Consumer Does

- Determines their readiness to engage in recovery – change/hope/confidence
- Works on getting ready if not ready right now – building up to the idea/hope of recovery
- Chooses a goal for themselves – a environment based role
- Plans for how to reach goal – determine what kinds of help they need and what they need to learn
- Learns skills and develops supports
- Maintains their recovery goal

Skills Training

- What skills are we talking about:
  - Skills missing at this "point in time"
  - Inappropriately learned and/or applied skills
  - New skills needed to compensate or help the individual to accommodate for missing and non-retrievable skills
  - New skills that the individual is capable of managing but, may not have actually applied in life prior to onset of illness

Structure of Skill Building Sessions

*<u>*Session Length*</u>: Generally last between 45 and 60 minutes.

The most critical determinant of session length is the person's ability to be engaged and learn the material. Some people may have limited attention spans, comprehension problems, or severe symptoms that make it difficult to focus for more than 30 minutes. It may be desirable to take breaks during a teaching session or to simply have brief sessions. Another option is to conduct more frequent, brief sessions, such as meeting for 20 to 30 minutes two or three times a week.

Active skill building is intensive and requires diligence.

Appointments are critical – no show rates are meaningful.

***Adapted from the SAMHSA IMR Toolkit**

The Skill Builders Toolkit

1. The Individual Recovery Plan of every individual on your caseload – de-identified, of course.
2. Notebook of favorite curriculum(s), skill lists, role play ideas, homework assignments, etc.
3. Blank homework assignment sheets.
4. To Do Lists: to use as reminders to contact other providers about case management, MDs and other needs.
5. Paper, pen, pencils & markers- for writing out steps, lists, etc. so they are visible to both you and the individual.
6. Other items?.....visual aids (posters, flashcards, etc.), easel paper, sticky notes, etc.

Interventions

- Broken down skills that can be taught and relates to goal/objectives.

Person Centered Goal: "I want to get a job"

Objectives/Interventions

Sally will be able to demonstrate appropriate skills to obtain employment

- Assist Sally in creating a list of skills needed for employment.

Sally will develop healthy hygiene skills.

- Obtain and use hygiene products effectively.
- Develop a daily routine for good hygiene

Sally will develop a routine to manage her day including appointments.

- Teach Sam how to effectively schedule, prepare and get to appointments.
- Develop skills to use a daily calendar.

Sally will be able to complete a job application without assistance.

- Educate Sam on the basic materials skills needed to complete job application.

Assistive Techniques: Coaching, prompting cueing

Cueing and Prompting/Coaching are techniques that are used to teach skills, give information or instructions along with focusing and/or refocusing an individual's attention on a given task and/or skill.

Cueing and Prompting/Coaching can be done in four different ways or in a combination of two or more of these:

- Written information
- Spoken information
- Physical information
- Visual Demonstration

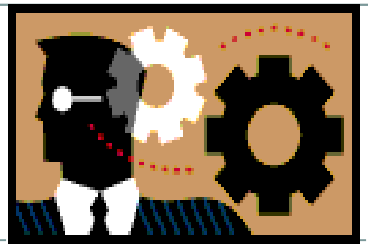
Written Information

Written cues are often *key words* or lists used to remind and to focus and/or refocus attention on a given skill/task.

Written prompting/coaching are *step by step instructions* used to promote memory, organization skills and retrieval or acquisition of skills. Written cues and prompting/coaching may take several forms including:

- Reminder words or notes
- Lists of tasks
- A daily schedule or chart
- A calendar to use for appointments
- Written step by step directions

Spoken Information



The difference between Verbal Cues and Verbal Prompting/Coaching are both *determined by the amount of information given and the specificity of the spoken information*.

Verbal Cue "Do you remember what to do first?" Or "Can you tell me how you would do .....?" (verbal hints)

Verbal Prompting/Coaching: "First, why don't you do/try this...Or "I'll describe/explain what you might do first and then we'll go from there." (These are examples of verbal directions)"

Physical information

The difference between Physical cues and Physical prompting/coaching ***is a matter of degree***.

- Physical Cue: You may point to a cue card, a list, a reminder note, an object etc. to assist an individual to follow and remember the steps of the skill/task. (hints)
- Physical Prompting/Coaching: The individual is preparing to do his/her laundry. You explain & demonstrate each step in the process of loading the Machine and selecting the settings in order for the individual to learn the skills independently. (directions)

Visual Demonstration

Some individuals learn primarily by visual demonstrations.

Role-playing and modeling. These are effective ways to demonstrate needed skills and/or tasks to be learned and to visually cue and/or prompt/coach the individual.

- Visual Cues: *(nodding, "OK" hand signals, etc.)* along with repeated practice and experience are an effective way for participants to learn and remember skills. (Visual "hints")
- Visual Prompt/Coaching: Role-plays are most effective when the skill and/or task is *demonstrated* first by the Recovery Assistant with an opportunity for the individual to ask questions and then perform the steps of the skill and/or task.(think of it as "Visual directions")

Documentation

HOW DO WE DOCUMENT THE SERVICES WE PROVIDE?

Documentation: Two Kinds of Rehabilitation Notes

Encounter (Billing) Notes

- Real-time notes of interventions related to the Rehabilitation Plan
- Completed by the person who performs the intervention. Client can participate/contribute.

Monthly Progress Notes

- Summary of progress toward Rehabilitation Plan Goals and Objectives
- Completed and signed by Licensed Clinical Staff (CSP clinical supervisor), in conjunction with other staff and client
- Serves as documentation of progress *and* of supervision.

Basics of an Encounter Note

- The provider must document each face-to-face encounter with the participant. This documentation should provide a measure (level of assistance) of how effective the intervention has been in supporting the participant in meeting their goals. It should contain a clear description of the staff's intervention (action), the participant's response to that intervention (action) and progress toward the goals and next steps.

Encounter Note

- What goal were you working on?
  - (from Recovery Plan)
- What was the intervention?
  - (reviewed, coached, prompted, assisted, encouraged, etc)
- How did the consumer respond?
  - (use feeling words and/or action words)
- What are the next steps?
  - (next visit, client will, client plans to…)

Two Notes for Sally

Objective: Sally will be able to use a planning guide to identify and select “healthy meals”.

Narrative

- Picked up Sally to go to the grocery store. We picked up food for several meals and discussed budget. Sally does not like fruit. Discussed importance of eating balanced meals including fruit. Sally was uncomfortable in store and wanted to leave. Told her I would be by again on Thursday.

Skill building note

- Coached Sally on selection of meals for the week using checklist we had developed on Monday. Sally was able to pick appropriate foods in 4 to 6 categories. Reviewed alternatives to fruit including extra vegetables. Sally began to get anxious in store. Encouraged and modeled deep breathing and visual imaging of doing yoga with cousin. Sally attempted to practice these skills. Scheduled to shop again on Thursday.

Two Notes for Sally

Objective: Sally identify side effects of medication which could result in her stopping medication.

Narrative	Skill building note
• Asked Sally to identify medication name, purpose and dosage instruction. Sally stated her medication makes her feel tired and hungry and she is gaining weight and cannot fit into clothes. Discussed why it is important to keep taking his meds.	• Sally said her medication makes her feel tired and hungry and she is gaining weight. Together we reviewed the "Solutions for Wellness" section about avoiding weight gain through food selection and exercise. Coached Sally on sugar free food selection. Modeled easy exercises Sally could do when watching TV. Sally practiced two of the exercises. We will use healthy selections food list when we go shopping on Thursday.

Sample Note: Correct

CSP/RP ENCOUNTER NOTE

Client Name: (First, Middle, Last): Sally **MPI/Client Number:**

DDaP/AVATAR Program Code:							
Location: Community	X	**Office**		**Type of Service: Ind**	X	**Group**	
Goal(s) Number:	2: " I want to be more healthy"		**Objective(s) Number:**	1: Sally will learn to make healthy choices in her everyday meals.			
Present at Session ☒ **Client Present** (If others, please identify name(s) and relationship(s) to client):							
Interventions Provided (Please continue on back if necessary)	I reviewed the healthy eating plan that Sally made last week. I asked her to name a few healthy meals she had last week. I encouraged her to clean her refrigerator and throw away the spoiled food. I also assisted Sally in making a reminder note to clean out her refrigerator once per week.						
Client Response to the Intervention/ Plan and Next Steps	Sally admitted she only made one really healthy meal. Sally stated that she felt guilty about this but reports she is motivated to try harder this week. Sally stated that she has been tired lately but she agreed to clean the refrigerator later tonight and make a grocery list. We made a plan to go grocery shopping on Friday at 3pm.						
***Level of Assistance** (please circle one)	5 Maximum	4 Moderate	3 Minimum	2 Standby	1 Independent	0 Unable	
Signature and Credentials of Staff	**Date of Signature**	**Date of Service**	**Start Time**	**Stop Time**	**Total Minutes**		
Kristie Scott, MSW	4.15.11	4.25.11	12:00pm	1:15pm	75		

Sample Note: Incorrect

CSP/RP ENCOUNTER NOTE

Client Name: (First, Middle, Last): Sally

MPI/Client Number:

DDaP/AVATAR Program Code:							
Location: Community		Office		**Type of Service:** Ind	X	Group	
Goal(s) Number:	2: " I want to be more healthy"		**Objective(s) Number:**	1: Sally will learn to make healthy choices in her everyday meals.			
Present at Session ☒ **Client Present** (If others, please identify name(s) and relationship(s) to client):							
Interventions Provided (Please continue on back if necessary)	I went to Sally's apartment and talked to her about her eating. She had rotten food in the frig so I told her to throw it out. I made her a reminder note and she thanked me.						
Client Response to the Intervention/ Plan and Next Steps	She needs to work on making better choices. Sally said she would clean frig later. She stated she made is ate out a lot and didn't cook much.						
***Level of Assistance** (please circle one) 5 Maximum 4 Moderate 3 Minimum 2 Standby 1 Independent 0 Unable							

Signature and Credentials of Staff	Date of Signature	Date of Service	Start Time	Stop Time	Total Minutes
Kristie Scott		4.25.11	12:00pm		75

Sample Note: Correct

CSP/RP ENCOUNTER NOTE

Client Name: (First, Middle, Last): Sally

MPI/Client Number:

DDaP/AVATAR Program Code:							
Location: Community	**X**	**Office**		**Type of Service: Ind**	**X**	**Group**	
Goal(s) Number:	**1: " I want to be able to budget my money"**		**Objective(s) Number:**	**1: Sally will learn budgeting basics.**			
Present at Session ☒ **Client Present** (If others, please identify name(s) and relationship(s) to client):							
Interventions Provided (Please continue on back if necessary)	**Assisted Sally in organizing her bills to getting paperwork to the bring to the bank. Prompted Sally on what steps to take to open an account at the bank.**						
Client Response to the Intervention/ Plan and Next Steps	**Sally was able to open account after reviewing steps and receiving some prompts. Sally felt proud she finally opened her own account. Sally will make another deposit on Friday after she receives her check.**						
***Level of Assistance (please circle one) 5 Maximum 4 Moderate 3 Minimum 2 Standby 1 Independent 0 Unable**							
Signature and Credentials of Staff	**Date of Signature**	**Date of Service**	**Start Time**	**Stop Time**	**Total Minutes**		
Kristie Scott, MSW	**4.25.11**	**4.25.11**	**12:00pm**	**1:15pm**	**75**		

Monthly Note (Progress Note)

- Report on each goal and objective written in Recovery Plan.
- Even if the goal or objective was not worked on, there should be a comment to state why there was not progress.
- These are the notes the WISE clinicians see to assess progress.

Make Sure You Show Progress

- Not so Good: “Sally continues to make progress.”
- Better: “Sally is now able to initiate deep breathing and visual imaging of yoga with cousin 50% of the time without prompting when she becomes anxious at the grocery store.”
- Better: “Sally is correctly using her meal planning guide to select healthy foods with very little assistance. She asks me to check her work and I seldom find errors.”

Resources

NO NEED TO RECREATE THE WHEEL

Resources

- Bazelon Institute
  http://bazelon.org.gravitatehosting.com/LinkClick.aspx?fileticket=SPUUDhrXplI%3d&tabid=242
- PSR Regulations: Michigan Club House
- Indiana Outreach Services
  http://www.in.gov/fssa/files/hospitalization_checklist_1.pdf
- APS Healthcare, Inc - Georgia
  http://www.ct.gov/dmhas/lib/dmhas/publications/CSPexcerpts.pdf
- Goals/Objective/Interventions (ABH)
  http://www.ct.gov/dmhas/lib/dmhas/publications/CSP-GoalsObjInt.pdf

Curricula

- Ansell - Casey Life Skills Guidebook
- LIFE Course Catalog
  http://www.ct.gov/dmhas/cwp/view.asp?a=2901&q=457094
- Illness Management and Recovery(IMR)
  http://stpre.samhsa.gov/product/SMA09-4463
- Illness Management and Recovery (Elli Whitney)
  http://treatmentteam.com/Pages/teamSolutions.aspx
- Solutions for Wellness(Elli Whitney)
  http://treatmentteam.com/Pages/solutionsForWellness.aspx
- Liberman Modules : Social and Independent Living Skills

Exercise

SKILL BUILDING AND DOCUMENTING

CSP Exercise

Goal #: 2	Date Goal Established: 6/2012				
Participant's Desired Goal (Note: In the person's own words): **"I want to improve my health"**					
Strengths: History of living in community		**Barriers:** Overwhelmed by daily tasks			
Objective: #1: Sally will prepare nutritious meals 4x/week with moderate assistance					
Specific Services/Activities/Supports/Tasks					
Provider/Service Type	**Intervention & Purpose** (Actions by person served/staff/ and natural supports)	**Frequency,** (e.g., 1X/wk)	**Intensity** (e.g., 30 min.)	**Duration** (e.g., for 3 mos.)	
CSP	CSP will assist Sally in exploring recipes and creating shopping lists	Up to 1x/week	Up to 15 minutes	Review within 180 days	
RA	RA will assist Sally in preparing meals through prompting and cueing as needed. Physical assistance can be provided when needed due to health constraints	Up to 5x/week	Up to 30 minutes	Review within 180 days	

CSP Exercise

- Review Recovery plan Goal # 2 and plan out two sessions with Sally using one new resources you learned.
- Role play with partner.
- Each person in group write an 2 encounter notes, one for each session.