

**State Hospital CSP Training
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Facilitator & Recorder Training

Community Support Plan Process

State Hospital

www.ahci.org

Thought for the Day

- If you always do what you've always done, you'll always get what you already got.

CSP - a different approach to discharge

- Why this training today?
- What is different from traditional discharge planning?
 - consumer owns the meeting
 - designed to be creative
 - process of negotiation (safety and satisfaction)
 - collaborative process
 - independent facilitator and recorder
 - uniquely different experience for the consumer

Goals of the CSP Process

- Provide opportunity for consumers at state hospital/long term care to express their needs & wants for life in the community and participate fully in the development of the CSP.
- Provide an opportunity for all CSP participants to understand the strengths and challenges of the person for whom the plan is being developed.
- Provide an analysis of the assessments conducted in preparation for the plan process.
- Develop preliminary strategies for assisting the person in moving to the community.
- Develop a CSP that is congruent with the opinions of the individual and that is likely to succeed.

Goals of Today's Training

- Introduce the CSP planning process
- Identify the planning principles that will be the foundation of the process
- Identify the roles of the planning participants
- Review principles of recovery and their relationship to the CSP
- Identify the flow necessary to manage the process in the community

CSP Plan Process

- The priority for the process is individuals identified as becoming ready to move to the community.
- Most persons selected will have been in residence at state hospital for longer periods of time and may:
 - Have complex medical existing co-occurring condition
 - Need specialized support in community

More on the CSP Plan Process

- Before beginning CSP process, three assessments are completed
 - Peer Assessment
 - Clinical Assessment
 - Family Assessment* (consumer chooses family member, hospital secures consent)
- Transportation issues to CSP resolved by community and hospital
- ****Lesson Learned: Families tend to become more involved closer to discharge***

Assessments

- All three assessments consider the following life areas or domains:
 - Psychiatric health
 - Education and work*
 - Family Involvement
 - Social and relationships*
 - Supports
 - Physical health *
 - Living/housing
 - Cognitive abilities

****Lesson Learned: These 3 domains require additional focus***

Peer Assessment

- The emphasis is “what does the individual want and need for community living.”*
 - The language used in the assessment should be understandable to most persons.
 - The assessment has been conducted “peer to peer,” in private.
 - Participation in the assessment is entirely voluntary.
 - Facilitators need to focus upon pulling this information out during the FIRST meeting
- *Lesson learned - this assessment contains the purest expression of the hopes and desires of the consumer***

Family Assessment Tool

- The family assessment is completed by a family member of the consumer.
- The assessment may be done either “face to face” or by phone interview
- This assessment asks questions related to type of housing thought to be necessary; the amount of assistance/support the individual may need, the presence of physical impairments, for example.
- Participation in the assessment is entirely voluntary and most families willingly participate.
- Facilitators can “hook” families by strengthening the connection between assessment and CSP process

Clinical Assessment

- The clinical assessment is conducted by a Hospital Social Worker and the County or Provider Hospital Liaison. Collaboration is essential.
- The assessment is convened by the Social Worker.
- Other staff may be involved in the assessment.
- The clinical assessment must be current, i.e. completed with the last month.

Additional Information

- The facilitator will need to seek out additional information including, but not limited to:
 - Incident reports over the past 12 months
 - OT assessments or community living assessments
 - Most recent psychiatric evaluation
 - List of medications
 - Psych testing
 - Documentation of legal status for any criminal activity
 - “Privilege Level” or equivalent at hospital for last three months
 - Any other assessments done over past 24 months

The Four Stages of CSP Meetings

- Information Gathering
- Options
- Transition
- Final Plan

In General

- The CSP meeting “belongs” to the Consumer
 - S/he may invite participants in addition to those who are required to be present
 - All comments are to be directed to the Consumer unless there was a direct question to someone else
- The first CSP meeting cannot be scheduled until the assessments are completed.
- The first meeting sets a positive tone and reinforces the importance of each person’s role and participation
- The quality of the plan depends on active participation by everyone at the table

In General (continued)

- The Facilitator is key to ensuring that all the meetings follow the principles, guidelines and behaviors discussed in subsequent slides.
- The Facilitator:
 - Provides the opportunity for all to gain common understanding of the assessment material
 - Is key to developing the relationship between the CSP Team and the consumer
 - Ensures that respect is always shown for all participants, in all comments and actions during the meeting
 - Reviews the ground rules and enforces them at meetings

In General (continued)

- It is helpful when participants offer differing opinions and bring out new information
- It is essential that language be clear and free of jargon that may not be understood by everyone at the table
- It is imperative that only one person speak at a time as much out of respect for one another as to allow the Recorder to accurately record the comments

Ground Rules

- Watch your body language - it lets others know how you are feeling, especially, if you are bored or aggravated or especially pleased. Body language says more than words many times.
- Direct all comments to consumers – it is a conversation with that person
- Avoid “idea killers”
 - “We’ve already tried that”; say instead, “When we try this again, we’ll need to be sure that adequate or different supports are present.”
 - “Yes but” – this little comment is probably the greatest killer of ideas ever.

Other Ground Rules

- Think positively and creatively.
- Try to swap places with the consumer for whom the CSP is being developed; behave like you would want others to behave at your meeting!
- Feel free to offer compliments and support to other people at the table.
- Be as prompt as possible for the CSP meetings.
- Have consistency in CSP team membership as individuals not just organizational representation
- Be prepared for meetings by completing assigned tasks

CSP Team Members

- The consumer who is to be discharged - first and foremost.
- Anyone the consumer invites*
- The family members of the consumer or representatives of the family
- The hospital social worker
- At least one community worker
- External advocate
- The facilitator and recorder

The Consumer's Role

- Offers as much information about him/herself as possible.
- Validates the summary information from the assessments.
- Talks about the “best time” in his or her life.
- Assists in the development of a strengths list.
- Decides which life areas should be considered at this meeting.
- At a later stage, asks questions about what has been done and tells about any place he/she visited.

The Family's Role

- Assists in the presentation of additional pertinent information about the consumer
- Assists in the development of the strengths list
- Presents a favorite memory*
- Offers ideas about supports they believe are necessary
- ***Lesson learned: Facilitator needs to keep this positive.***

Hospital Staff Roles

- The consumer's social worker and psychiatrist are important participants; typically their contributions are clinical in nature
- The staff will provide an update on the status of the consumer
- The social worker will be responsible for scheduling meetings
- The social worker will ensure all the hospital tasks are completed
- *Lesson learned: Eliminate the “folklore” or reinforcing a negative reputation that may be following the consumer.*

County Role

- With provider, bring knowledge of resources to table
- Help resolve any problems or issues
- Help with developing needed services and supports
- Monitor the completion of tasks by provider and county
- Distribute plan to key individuals
- Arrange for contingency funds as needed
- Develop confidentiality agreement with facilitators and recorders

Community Provider Role

- The Provider will bring knowledge of the resources in the community to the table
- Responsible, with hospital staff, for ensuring client/resident has an opportunity to visit the community
- Visits clients in hospital on a regular basis
- With county, try to develop services and supports that the individuals needs and wants

Peer (Mentor/Specialist) Role

- Provide information to resident about the process
- Help engage consumer in the process
- Work with consumer to develop a WRAP (Wellness Recovery Action Plan)
- Visit the consumer on a regular basis
- Accompany the consumer off grounds as possible

Advocate Role

- Meet client prior to first meeting
- Review client's peer assessment and what client wants
- Represent client's interests at CSP meeting
- Go over CSP and the meeting following the meeting

Facilitator's Role

- “Chairs” the meeting
- Promotes creativity in exploring options
- Negotiates the details of the plan to ensure the consumer's satisfaction is met and balanced by his/her safety and the community's safety
- Enforces the ground rules
 - Protects the reputation of the consumer especially when s/he cannot do this her/himself
- Holds participants accountable for completing tasks
- Help others with their roles
- Ensures the detailed completion of the Final Plan

Recorder's Role

- Keeps copious notes and completes the CSP plan for each phase and meeting
- Make sure sign in sheet is complete
- Assists all CSP members in maintaining focus on tasks associated with development of the plan
- Assists by asking clarifying questions
- Review tasks list at beginning and end of each meeting
- Ensures the thoroughness, accuracy and detail of the information, especially for the Final Plan

Stages of the CSP Process

Stage One – Information Gathering

- Goals - meet other CSP Team participants, identify strengths of consumer; formulate challenges to community success
- All participants introduce selves and identify role and organization
- “Round Robin” in which all participants name at least one strength of the consumer
- Facilitator summarizes assessment information
- Participants identify challenges faced by consumer
- Participants identify tasks (who - what - when)
- Recorder reads back task list at end of meeting
- Facilitator negotiates next meeting date

Stages of the CSP Process

Stage Two - Options

- Goal - locate or create service options which are congruent with consumer's stated needs and wants
- Majority of content of meeting(s) is information brought forth by CSP team members
- Process of questioning:
 - “What is the minimum it will take to keep -- out of the hospital?”
 - “Why is -- necessary? desirable?”
 - “If -- isn't currently available, what will it take to get --?”
- Complete task list (who - what - when)
- Set next meeting

Stages of the CSP Process

Stage Three – Transition

- Goal - Define activities necessary to assist consumer in his/her transition from hospital to community
- Address activities of both consumer and staff (hospital and community)
- Schedule visits to places that consumer will use in the community and allow time for consumer to actually participate in activities in those places
 - if housing - visit at meal time and eat with others*
 - if social - participate in a planned activity
 - include family in visits if consumer chooses
 - include community staff in visits, especially CM or CTT
- Develop resources and tasks that will ensure smooth transition
- ***Lesson learned: Don't visit places that are not feasible or possible.***

Transition Phase (continued)

- Assign task of developing comprehensive crisis plan (CM/CTT/consumer/advocate/peer/social worker)
 - Based on WRAP (when available)
 - Identify triggers
 - Include risk for suicide
 - Describe successful interventions to be used and when
 - Identify list of emergency contacts
 - family/guardian/rep payee
 - friends
 - mental health providers
 - medical providers
 - Include elements of Advance Directives (when available)
- Set discharge date (if possible)
- Review task list
- Set next meeting date

Stages of the CSP Process

Stage 4 – Final Plan

- Goal - provide detail to all supports offered to consumer once in the community
- Community staff
 - all medical, psychiatric, lab, specialists
 - name, address, phone, appointment date and time
 - contact info for housing, psycho-social, peers, education, vocation providers
 - Advance Directives, POA for Health/MH
- Hospital staff
 - current and accurate benefit info - SS #, benefits, names, contact info, rep payee
 - current, accurate med sheet
- Review task list
- Set/confirm discharge date (transportation who/when)

Final Finals

- Recorder completes filling out the Final Plan
 - may require calling responsible parties for details
- Facilitator reviews Final Plan for completion and accuracy
- Facilitator sends Final Plan to designated person for distribution and monitoring

Community Support Plan

Name: _____ Date: _____

County person is moving to: _____

Who is responsible and accountable for supervision and oversight of the Community Support Plan?

Name: _____ Title: _____

Agency: _____ Phone #: _____

ASSESSMENT STAGE:

1. CONSUMER ASSESSMENT SUMMARY

Strengths

Interests/Likes

Consumer's Dislikes

2. FAMILY ASSESSMENT SUMMARY

Strengths

Interests/Likes

Name: _____ Date: _____

Consumer's Dislikes

3. Clinical Assessment / Worksheet

Consumer Strengths

Consumer Interests /Likes

Consumer Dislikes

Consumer Psychiatric and Behavioral Conditions to consider

Consumer Physical Conditions to consider

Name: _____ Date: _____

INFORMATION GATHERING STAGE:

TOPIC AREA #1: RECOVERY SERVICES AND SUPPORTS IN THE COMMUNITY

Empty box for notes related to Topic Area #1.

TOPIC AREA #2: LIVING ARRANGEMENTS / HOUSING

Empty box for notes related to Topic Area #2.

TOPIC AREA #3: INSURANCE / BENEFITS / ENTITLEMENT

Empty box for notes related to Topic Area #3.

Name: _____ Date: _____

TOPIC AREA #4: PHYSICAL HEALTH CARE

Empty box for notes related to Physical Health Care.

TOPIC AREA #5: MENTAL HEALTH CARE

Empty box for notes related to Mental Health Care.

Follow-up items / person responsible / due date:

- 1. _
- 2. _
- 3. _
- 4. _
- 5. _
- 6. _
- 7. _
- 8. _
- 9. _
- 10. _

Date / time / location of next meeting: __

*This form was adapted from The Pennsylvania Office of Mental Health & Substance Abuse by the Mayview Regional Service Area Planning Project on 7/20/06

Name: _____ Date: _____

OPTIONS STAGE:

TOPIC AREA #1: RECOVERY SERVICES AND SUPPORTS IN THE COMMUNITY

TOPIC AREA #2: LIVING ARRANGEMENTS

TOPIC AREA #3: INSURANCE / BENEFITS / ENTITLEMENT

TOPIC AREA #4: PHYSICAL HEALTH CARE

Name: _____ Date: _____

TOPIC AREA #5: MENTAL HEALTH CARE

Follow-up items / person responsible / due date:

- 11. _
- 12. _
- 13. _
- 14. _
- 15. _
- 16. _
- 17. _
- 18. _
- 19. _
- 20. _

Date / time / location of next meeting: ___

Name: _____ Date: _____

TRANSITION STAGE:

TOPIC AREA #1: RECOVERY SERVICES AND SUPPORTS IN THE COMMUNITY

Empty box for notes under Topic Area #1.

TOPIC AREA #2: LIVING ARRANGEMENTS

Empty box for notes under Topic Area #2.

TOPIC AREA #3: INSURANCE / BENEFITS / ENTITLEMENT

Empty box for notes under Topic Area #3.

TOPIC AREA #4: PHYSICAL HEALTH CARE

Empty box for notes under Topic Area #4.

*This form was adapted from The Pennsylvania Office of Mental Health & Substance Abuse by the Mayview Regional Service Area Planning Project on 7/20/06

Name: _____ Date: _____

TOPIC AREA #5: MENTAL HEALTH CARE

Follow-up items / person responsible / due date:

- 21. _
- 22. _
- 23. _
- 24. _
- 25. _
- 26. _
- 27. _
- 28. _
- 29. _
- 30. _

Date / time / location of next meeting: ___

**Pennsylvania Office of Mental Health & Substance Abuse Services
Torrance State Hospital - Community Support Plan**

Identifying Information		
Individual's Name	Date of CSP	Age DOB
Marital Status	Race/Sex	Case Number
BSU Number	Admission Date	Discharge Date
Discharge Commitment Code	Expiration Date	
Relation to Consumer	Print Name	Plan Development Team Contact Information
Consumer		
Facilitator		
Family Member/Friend		
Consumer Advocate		
Chief Medical Officer/Psychiatric Supervisor		
TSH Treating Psychiatrist````		
TSH Medical Physician		
TSH Social Worker		
TSH Nurse		
TSH Occupational Therapist		
TSH Psychologist		
TSH Therapeutic Recreation Worker		
TSH Dietitian		
TSH VAS Worker		
County MH Administrator		
County Casemanager		
CHIPP Coordinator		
Head Trauma Specialist		
MR Representative		
Spiritual Advisor		

ADDITIONAL SPACES AVAILABLE ON NEXT PAGE

Name: _____

Relation to Consumer	Print Name	Plan Development Team Contact Information
Consumer Satisfaction Services		
Aging Agency Representative		
Individual Therapist		
OMHSAS		
Probation/Parole Officer		
Recorder		

County person is moving to: _____

Who is responsible and accountable for supervision and oversight of the Community Support Plan while the individual is in the State Hospital?

Name: _____ **Title:** _____

Agency: _____ **Phone #:** _____

Who is responsible and accountable for supervision and oversight of the Community Support Plan in the community?

Name: _____ **Title:** _____

Agency: _____ **Phone #:** _____

Name: _____ **Title:** _____

Agency: _____ **Phone #:** _____

Name: _____ **Title:** _____

Agency: _____ **Phone #:** _____

Name: _____ **Title:** _____

Name: _____

Agency:

Phone #:

STRENGTHS:

❖ _____

❖ _____

❖ _____

❖ _____

❖ _____

❖ _____

LIVING			
Type of Residence <input type="checkbox"/> Permanent <input type="checkbox"/> Transitional	<input type="checkbox"/> Own home/Apt <input type="checkbox"/> CRR <input type="checkbox"/> Young Adult Sup. Residence <input type="checkbox"/> Other _____	<input type="checkbox"/> Shared home/Apt <input type="checkbox"/> All Inclusive Residence <input type="checkbox"/>	<input type="checkbox"/> Single room <input type="checkbox"/> PCBH
Total number of persons in shared living situation: _____			
Address: _____			
Agency: (If applicable)	Name of Agency	Phone #	
Agency Contact (or person supporting individual in residential setting):			
Insurance/ Benefits/ Entitlement:	SSI? <input type="checkbox"/> SSDI? <input type="checkbox"/> Amount _____ # _____ Medicaid: _____ Medicare: _____ Medicare D Plan _____ Policy # _____ Private Insurance: _____ Plan Name: _____ Medications Paid By: _____ Food Stamps: _____ Other Benefits: _____ Waiver: _____		
Current Available Identification:	Driver's License: <input type="checkbox"/> Yes <input type="checkbox"/> No Social Security Card: <input type="checkbox"/> Yes <input type="checkbox"/> No Birth Certificate: <input type="checkbox"/> Yes <input type="checkbox"/> No P.A. State ID: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Applications Filed & Follow-up Needed	Application	Follow-up action	Responsible Person
1) 2) 3) 4)			
Income	Amount \$ _____ every _____ Source:		
Representative/ Guardian/Payee	Name		
	Address		
	Phone	Relationship	

Meaningful Daily Activity (Work, Volunteer, Leisure)	List specific information if known <input type="checkbox"/> Competitive Employment
	<input type="checkbox"/> Volunteer
	<input type="checkbox"/> Hobbies
	<input type="checkbox"/> Activities
	<input type="checkbox"/> Play

Learning Indicate interest in pursuing	<input type="checkbox"/> GED <input type="checkbox"/> Continuing Ed - College <input type="checkbox"/> Enrichment (pottery, gardening, etc.) <input type="checkbox"/> Other
---	--

Spiritual Supports	Supports for spiritual component of recovery:
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RECOVERY SERVICES AND SUPPORTS

Integrated Physical & Behavioral Health Care	Psychiatrist/Medication		
	Appoint Date	Name	
	Time	Address/Location	
	Phone		
	Diagnosis: See attached		
	Medications & Dosage (List or attach)	Supply (# of days)	expires on <u>(date)</u>
Who will fill new supply:			

Outpatient Treatment:	Details – agency, frequency, etc. if known <input type="checkbox"/> Outpatient <input type="checkbox"/> Drug & Alcohol/Co-Occurring Services <input type="checkbox"/> CTT <input type="checkbox"/> OVR <input type="checkbox"/> Psychosocial Rehab Program <input type="checkbox"/> Other
------------------------------	--

PHYSICAL HEALTH CARE (Attach Medical History)

Primary Care Physician	Diagnosis				
	Name		Address/Location		
	Phone		Appointment Date & Time		
	Medications & Dosage (List or attach)		Supply (# of days)	Expires on (date)	
	Who will fill new supply?				
Specialists	Specialty				
	Appoint Date		Time		
	Name				
	Medications				
	Specialty				
	Appoint Date		Time		
	Name				
	Medications				
Blood Work/Labs	Levels Draw	Last Drawn	WNL	Abnormal	
	_____	_____	_____	_____	
	_____	_____	_____	_____	
	_____	_____	_____	_____	
Special Needs	Note coordination of care, accommodations needed, assistive devices, etc.				
<input type="checkbox"/> Aging <input type="checkbox"/> Blind <input type="checkbox"/> Criminal Justice <input type="checkbox"/> Deaf <input type="checkbox"/> Hard of Hearing <input type="checkbox"/> Mental Retardation / Develop Disability	<input type="checkbox"/> Physical Disability <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Non-English Language <input type="checkbox"/> Dietary Issues <input type="checkbox"/> Other				
CULTURAL CONSIDERATIONS:					

Rehabilitative Services & Supports	<input type="checkbox"/> Mobile PRS <input type="checkbox"/> Site-Based PRS <input type="checkbox"/> Clubhouse <input type="checkbox"/> Supported Employment	
Supports Informal (Friends, family)	Name	Relationship

CASE MANAGEMENT SERVICES

Service Type	Provider	Type & Frequency of Contact
<input type="checkbox"/> Intensive Case Management <input type="checkbox"/> Blended Case Management <input type="checkbox"/> Resource Coordination <input type="checkbox"/> Administrative Case Management <input type="checkbox"/> Community Treatment Team		

Formal	<input type="checkbox"/> Compeer <input type="checkbox"/> Warmline/Helpline <input type="checkbox"/> Drop-In Center <input type="checkbox"/> AA, NA <input type="checkbox"/> CFST <input type="checkbox"/> Peer Specialist <input type="checkbox"/> Support Group <input type="checkbox"/> Peer-to-Peer <input type="checkbox"/> Consumer Movement (PMHCA, NAMI, etc) <input type="checkbox"/> Recovery Specialist <input type="checkbox"/> Other

SUCCESS FACTORS (based on the individual's history, what has helped the person remain in successful community placement?):	Success Factors: <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
--	---

RISK FACTORS (based on individual's history, what has occurred to put the person at risk for rehospitalization?):			
<input type="checkbox"/> Suicide Attempts/Ideation	<input type="checkbox"/> Medication Issues	<input type="checkbox"/> Anger/Aggression	<input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Self-Directed Travel/movement	<input type="checkbox"/> Self-Injurious Behavior	<input type="checkbox"/> Trauma History	

Comment:

Name: _____

Supports:

ADVANCE DIRECTIVE OR CRISIS PLAN

Physical Health Information provided _____ Additional Info or Assistance Requested _____

Mental Health Information provided _____ Additional Info or Assistance Requested _____

Individual has a WRAP Yes No Date Completed: _____

I have been involved in the development of this plan and I know how to contact members of my support team.

Consumer Signature: _____

Date: _____

SUMMARY:

PLAN DEVELOPMENT TEAM FOLLOW-UP:

PROJECTED DISCHARGE DATE:

OBSTACLES TO DISCHARGE (e.g., legal issues, person does not want to leave the hospital, desired setting not yet available, etc.):

Facilitator Tasks

Facilitator Tasks Checklist

- ___ Once assigned to a Consumer, meet with the Social Worker to determine time, date and location of first meeting
- ___ Several days in advance of the meeting, meet with the Consumer to introduce yourself and to ask him/her if there are any questions or concerns about the meetings or the CSP process
- ___ Receive and review all Assessments: Peer, Family, Clinical; and all other relevant assessments available - prior to the meeting. Use the "Assessment Work Sheet" to summarize and compare the assessments' content. Begin conceptualizing the similarities and differences across all the assessments and background material and plan how to address these in the first (Information Gathering) meeting.
- ___ Notify the Recorder of the confirmed time, date and location of the first meeting and ensure that she has the Assessments for review and a copy of the CSP form
- ___ At the conclusion of each meeting, de-brief the meeting with the Recorder and determine if there are any obstacles to her completing the CSP form for this stage of the process
- ___ Receive and review the drafted CSP form and, if you approve, send the form to Kelly Burda and the County Representative
- ___ Information Gathering meeting – keep it positive
- ___ Options meeting – ensure that the team plans for meaningful activity (as defined by the Consumer) whether it is a hobby, rehab program, school, volunteer work, training, paid employment (even a few hours a week). People need things to do to feel productive and well.
- ___ REMIND team members of the importance of being creative in suggesting and exploring options
- ___ Transition meeting – be mindful of the need for some individuals to have a lengthy transition into the community. Arrange for a variety of activities in the community where the Consumer will actually be living, working, playing.
- ___ START on time
- ___ END on time

FACILITATING THE MEETINGS

Step - by - Step

INFORMATION GATHERING (THE FIRST MEETING)

1. Introduce yourself and the Recorder
2. Explain the purpose and goals of the CSP Process and of this first meeting in particular
3. Have everyone introduce him/herself TO THE CONSUMER and everyone else; state his /her role and relationship to the Consumer and identify what s/he has to contribute to this process (E.G. Advocate - ensuring Consumer Rights; Peer - assisting with understanding the process and offering support; County Rep – developing/locating resources, etc.)
4. Describe the Facilitator's and the Recorder's roles
5. State the Ground Rules and explain that, as Facilitator, you will politely intervene when you see an individual or the group break a Ground Rule.
 - a. Always speak directly to the Consumer (unless answering someone else's questions)
 - b. Think creatively and outside those services and facilities that are routinely used
 - c. Consider all possibilities
 - d. Avoid the following:
 - i. "we've already tried that"
 - ii. "yes, but..."
 - iii. "you don't understand"
 - iv. "we don't have the resources"
 - v. "that won't work"
 - vi. body posture that conveys boredom, anger, resentment
 - e. Cell phones, pagers, etc are turned off
 - f. Same person attends all meetings (not just organization or team representation)
 - g. Tasks need to be completed between meetings
 - h. Always show respect towards all CSP team participants
6. Briefly summarize the Assessment material by starting with an overall positive tone. Highlight the Consumer's strengths and general willingness to help develop a discharge plan that has great potential for the Consumer's successful transition and tenure in the community. Highlight examples of successes from the Consumer's history, describe his/her positive stability or functioning or relate an example demonstrating that s/he is motivated and determined to try something different so that s/he will be successful in the community and not need to return to Torrance.
7. Initiate "Round Robin" where each participant (who knows the Consumer) tells to the Consumer one strength s/he knows that the Consumer possesses.
 - a. If family is present, have her/him tell a positive story about the Consumer

- b. The Consumer can tell about a favorite time s/he remembers from living at home or in the community
8. Consistently offer encouragement and praise to all members of the group and especially the Consumer who is sharing private details of his/her life and dreams.
9. Solicit, first from the Consumer, and then from the group, challenges that s/he will probably face in the community
 - a. Help the participants talk in specifics, giving examples or defining and describing what is meant. This includes the Consumer
 - b. Keep it brief
 - c. Help the participants stay away from “catastrophizing” or “fragilizing”.
10. Validate everyone’s perspective but KEEP IT POSITIVE by reminding everyone that the main goal of the CSP process is to identify supports around these issues to minimize the negative impact they could have on the Consumer’s success.
11. Segue into the Options phase by explaining that the goal of the next stage is to begin to identify resources and supports specific to the strengths and challenges discussed earlier. At this point you may need to assign tasks of researching options to be discussed at the next meeting.
12. Introduce the notion of WRAP and Advance Directives. If the Consumer is interested solicit a Peer to assist with developing these tools.
13. Ask the Recorder to read back any tasks that were assigned, who got the assignment and the due date.
14. Set the next meeting time, date and location
15. Meet with the Recorder to de-brief and discuss any concerns about getting the notes typed up

THE OPTIONS AND TRANSITION MEETINGS

1. Quickly re-introduce team members by name only
2. Review the purpose of the current phase of the process
3. Ask the Consumer if s/he has any questions or comments or if anything has changed since the last meeting. Also inquire about any outings or visits that may have taken place since the last meeting.
4. Ask team members to report out on their assigned tasks. The Recorder may need to provide reminders to some.
5. Inquire if there have been any changes since the last meeting
6. Solicit any concerns (thorny issues) that have not been voiced and addressed. Reiterate that if these concerns don’t get laid out on the table now, the overall plan will fail.
7. Conduct a straightforward but respectful discussion regarding relevant to the meeting stage (Options or Transition)
8. Keep demanding specificity and minimize gross generalizations. Remain focused on strengths and needed supports for challenging conditions or behaviors. “On the part of the community, what will it take to keep – from returning to the hospital?”
 - a. Discuss how the Consumer and his/her supporters will know if things are going well; not well and if the supports are working as planned
 - b. Keep it objective and “measurable”

9. Have Recorder review tasks list
10. Set the next time, date, location for the next meeting
11. Debrief with the Recorder.

TRANSITION MEETING – specific considerations

1. Review (with the Consumer’s permission) some elements of his/her WRAP and/or Advance Directive
2. Assign team members to work with the Consumer on a Crisis Plan that would be implemented in the Community and consider elements of the WRAP and/or Advance Directive that should be included in the Crisis Plan
 - a. The ideal team would consist of: Consumer, Peer, CTT/CM, Social Worker, County Rep, , Advocate
3. Remind participants of the detail necessary to complete the Final Plan and ask them to review a copy so they are familiar with the content.

THE FINAL PLAN MEETING

1. By now all the CSP team members should have at least seen a copy of the Final Plan. Conduct this meeting strictly according to the form of the Final Plan
2. Expect that team members will have already provided or are prepared to provide all the details necessary to complete all sections of the Final Plan.
3. Work through each section of the Plan and, if necessary, allow a participant to briefly leave the meeting to find necessary information if it can be secured promptly
4. Ensure that the Recorder has accurate contact information for each team member who must get back to her with needed information. Give a deadline (e.g. the next day before noon) for getting this information to the Recorder
5. Ask the Recorder to review the tasks list
6. Determine a discharge date for the Consumer. Ensure that supports and housing will be available and that there is agreement regarding transportation, medications/prescriptions, benefits and cash that the Consumer will have available to him/her when leaving the hospital.
7. Remind all team members (especially the Consumer) that a draft of the Final Plan will be ready for their review. It will be available for review in no more than 5 working days.
 - a. They should give any feedback to the Facilitator who will pass it on to the Recorder
 - b. The Recorder will incorporate the feedback into the Plan
 - c. The Recorder will give the revised Final Plan to the Facilitator within five working days.
8. Review the Final Plan. Submit copies to Kelly Burda and the County Representative

Facilitator Worksheet

FACILITATOR WORKSHEET

What does each of the perspectives reveal about what this consumer needs or wants. Briefly summarize information from each of the assessments in the space provided. Analyze for similarities and differences. Present summary at Information Gathering meeting.

Life Domain	Peer Assessment	Family Assessment	Clinical Assessment
Living: type and location; how much personal support and/or restriction			
Benefits/Access to financial resources;			
Clinical treatment: meds, psychiatrist, CM, CTT, trauma, drugs, alcohol			
Meaningful Activity: PSR, volunteer, pd work, hobby, education, classes, community involvement			
Leisure/Social: what to do for fun			
Spiritual: place of worship or other spiritual practice			
Medical: physical health, special needs			
Cultural: specific to family, age, race, ethnicity			
Safety: what will help consumer feel safe			
Legal: current problems or past that may have impact on community options			
Family: who, how involved, consumer choices re: family			
Power and Control: rep payee, guardian recommendations			
Other:			

Recorder Tasks Checklist

RECORDER TASKS CHECKLIST

- ___ Talk with Facilitator prior to each meeting. Confirm time, date and location.
- ___ Receive and review assessments to begin to organize thinking about note-taking during the meeting and fill in information on plan.
- ___ Remind all CSP team participants to sign in on the Sign-In Sheet with contact information. Review for legibility prior to end of meeting and ask for clarification when necessary.
- ___ Read aloud the tasks from the last meeting.
- ___ Interrupt the meeting if a speaker is not loud enough or clear enough to understand.
- ___ Ask for any necessary clarifications to your understanding of an issue and tasks – prior to the end of the meeting
- ___ Read aloud the task list that has been developed during the meeting. Ask for clarification when necessary.
- ___ Prepare a draft of the CSP form within 5 working days and submit it to the Facilitator for review.
- ___ Ensure that all information necessary for a thorough Final Plan is gathered and incorporated into the first draft. This may mean phoning and emailing to members of the CSP Team who are responsible to get you the information.
 - If you are unable to get a particular member to give you information in a timely fashion, let the Facilitator know this.
- ___ Incorporate feedback into the Final Plan and submit a draft to the Facilitator within 5 days. If necessary, revise and return it to the Facilitator within 3 days.

Social Worker Tasks

SOCIAL WORKER TASKS

- ___ Provide an orientation to the CSP process for the Consumer and his/her family. Emphasize the following points:
 - Assessment information gathered in the interviews will for the basis of the Community Support Plan
 - The meeting will include whomever the Consumer wants from Torrance and the community in addition to the required participants
 - The Consumer may veto to the presence of certain individuals
 - The Facilitator is there to help the CSP Team generate new and different ideas of what might help the Consumer to live successfully in the community
 - The Recorder is there to document all the important things that are said so that important points, opinion, suggestions that come up are not overlooked or forgotten
 - Discharge will not occur until needed community services and supports are in place. (if some options are not available, alternative resources may be used)

- ___ Identify, **with the consumer**, all individuals that will be invited to the CSP meeting. Individuals that constitute the CSP team should include, at a minimum: the consumer; consumer's family and friends; Torrance clinical, medical and rehab staff; advocate; peer mentor; community MH provider; county representative; community residential provider (once housing has been identified)

- ___ Arrange a meeting with TSH clinical staff and county representative and complete the Clinical Assessment

- ___ Schedule the first CSP meeting in collaboration with the Facilitator

- ___ Notify Kelly Burda and the County Representative of the time, date, location of the meeting

- ___ Arrange location for all subsequent meetings once CSP team has agreed upon date and time

- ___ Coordinate discharge once the Final Plan is completed and a discharge date has been identified. Coordinate with Consumer, family and friends, community providers and County representative
 - Give to Recorder for the Final Plan
 - ___ most current medication sheet
 - ___ updated information including
 - ___ amount of income
 - ___ source of income
 - ___ accurate Social Security number
 - ___ health insurance provider
 - ___ Pennsylvania ID card

Benefits Table

Benefit Type	Description	Amount
Social Security Retirement (Medicare)	These are retirement benefits drawn on the person's own work record or a spouse's work record. This type of benefit is extremely rare for persons at Mayview.	Varies, depending on work history.
Social Security Disability (Medicare)	Commonly referred to as SSDI, these are disability benefits drawn on the person's own work record or on the account of a retired, disabled, or deceased parent, but only if the person is an unmarried, adult disabled child whose disability can be documented to have occurred prior to the age of 22 years. Most persons receiving SSDI benefits at Mayview are receiving benefits on a parent's account.	Varies, but the majority of SSDI beneficiaries at Mayview receive less than \$900 per month.
Supplemental Security Income Only—Living Independently (Medicaid)	Commonly referred to as SSI, these are federal cash assistance payments for aged, blind, and disabled persons who do not have a sufficient work record with Social Security to receive retirement or disability benefits.	\$623 per month The PA supplement added to this makes to total monthly income \$650.40.
Supplemental Security Income in combination with SSR or SSDI (Medicare/Medicaid)	This benefit is available only to persons whose income is below \$670.40.	Varies, depending on amount of Retirement or SSDI benefit
Supplemental Security Income—Living in the household of another (Medicaid)	This SSI benefit is reduced by one third from the standard SSI payment for persons living in the household of another and receiving support of some type towards room and board.	\$415.34 per month