

**COMPREHENSIVE COMMUNITY SUPPORT SERVICES
CERTIFICATION REQUIREMENTS
SPECIFIC SERVICES SURVEY TOOL**

Draft

Service Definition: The purpose of Comprehensive Community Support Services (CCSS), to coordinate and provide services and resources to individuals/families necessary to promote recovery, rehabilitation and resiliency. CCSS identifies and addresses the barriers that impede the development of skills necessary for independent functioning in the community; as well as strengths, which may aid the individual or family in the recovery or resiliency process. CCSS activities address goals specifically in the following areas: independent living; learning; working; socializing and recreation. CCSS also include supporting an individual and family in crisis situations; and providing individual interventions to develop or enhance an individual's ability to make informed and independent choices.

In order to be eligible for reimbursement for CCSS provider must be FQHC, IHS hospital or clinic, PL 93-638 hospital or clinic, or licensed as CMHC by the BH Collaborative or other designated Department CCSS providers for children less than 18 years of age must be an FQHC, IHS hospital or clinic, PL93-638 hospital or licensed as a Core Service Agency (CSA) by CYFD..

Agency:	Date of Review:	Reviewer:
Client Name:	DOB: DOA:	Parent/Guardian: Primary CCSS Worker:

DXs:

CCSS TARGET POPULATION	Document	Yes	No	N/A	Interpretative Guidelines
<p>Any individual who meets <u>one</u> of the following medically necessary CCSS categories:</p> <p>() Children experiencing serious emotional/ neurobiological/behavioral disorders;</p> <p>() Adults with severe mental illness (SMI);</p> <p>() Individuals with chronic substance abuse; <u>or</u></p> <p>() Individuals with co-occurring disorder (mental illness/ substance abuse) and/or dually diagnosed with a primary diagnosis of mental illness.</p> <p>() CCSS is provided to the children, youth or adults with significant behavioral health disorders.</p> <p>() CCSS is provided in compliance with the medical assistance division (MAD) definition of medical necessity</p> <p>() Eligible clients who are 18 through 20 years of age may be served by an agency certified for CCSS by CYFD or DOH, as indicated.</p>					<p>Review Client file to determine if it documents compliance with meeting at least one of Target Population categories</p> <p><u>Medical necessity for Medicaid services</u></p> <p>Medically necessary services are clinical and rehabilitative physical or behavioral health services that:</p> <p>(i) are essential to prevent, diagnose or treat medical conditions or are essential to enable the individual to attain, maintain, or regain functional capacity;</p> <p>(ii) are delivered in the amount, duration, scope and setting that is clinically appropriate to the specific physical, mental and behavioral health care needs of the individual;</p> <p>(iii) are provided within professionally accepted standards of practice and national guidelines; and</p> <p>(iv) are required to meet the physical and</p>

					behavioral health needs of the individual and are not primarily for the convenience of the individual, the provider or the payer.
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PROVIDER REQUIREMENTS	Document	Yes	No	N/A	Interpretative Guidelines
<p>All CCSS agencies will be responsible for demonstrating compliance with the following requirements:</p> <p>() The CCSS eligible client has <u>one designated agency</u> that has the primary responsibility for the purpose of implementing the comprehensive service plan.</p> <p>() CCSS services are offered at convenient times and locations to meet the needs of the client and family. The agency actively works to eliminate language, financial and other barriers to service. <u>(include in client interview)</u></p> <p>() Detailed case notes document all CCSS service intervention activities and locations of services provided for each service span delivered and include the CCSS worker’s name, credential and date of the service delivery.</p> <p>() The CSW provides services both off-site and face to face including at the client’s home, schools or other community settings for 60% of the service delivery (aggregated data)</p> <p>() Community support activities and other relevant providers are clearly identified in the comprehensive service plan. The primary CSW coordinates the service plan without duplication by the other service providers.</p> <p>() The primary community support worker (CSW), under the documented supervision of the CCSS supervisor, is identified on the client’s comprehensive service plan.</p> <p>() The CSW partners with the client and family for the purpose of coordinating and facilitating recovery and resiliency directed team meetings.</p> <p>() The CCSS Clinical Supervisor signed, with name, credential, and date the initial service plan indicating that he or she has reviewed and approved the comprehensive service plan and <u>each revision</u> as it occurs.</p> <p>() Behavior management skills development service (BMS) interventions are distinct and different from CCSS and are not considered to be CCSS.</p> <p>Note: Clients participating in medication management as the primary focus of service are not subject to the client-staff ratio.</p>					<ul style="list-style-type: none"> •The designated agency is chosen by the client/family. Documentation of client choice may be in the admission/intake note. This issue could also be gleaned thru the client interviews. • CCSS offered at times outside 8-5 is evaluated by client and staff interviews. •Review Client file to determine if the agency involves natural supports to overcome other barriers such as language. An example of this could include the use of Nat. supports with interpretation assistance during the in vivo services. The agency must comply with HIPAA regulations by having signed releases by the client and a signed HIPAA form by the natural supports. • Review Agency Quality Plan to determine if Internal monitoring of agency-specific aggregate data compliance with the 60% in vivo and the 1:20 for child & youth /or 1:30 for adult consumer case load requirement is to be documented in the agency’s internal CQI program. See quality/compliance section. • Review Client file to determine if CCSS service delivery includes comprehensive skills building and natural supports development versus BMS redirection approaches. • Review Client file to determine if Documentation of CSW discussions and planning with the family, natural supports etc. is found in service notes and treatment plan updates. A note summarizing the se stakeholder meetings could also be present in the client file . • Review Client file to determine if each client’s service plan and service plan updates are signed by Clinical Supervisor

CULTURAL COMPETENCY REQUIREMENTS	Document	Yes	No	N/A	Interpretative Guidelines
<p>() Cultural competence is demonstrated by the CCSS provider agency's policies, procedures, training, outreach and advocacy efforts, and throughout the array of service delivery framework.</p> <p>() The CCSS agency ensured culturally sensitive services were identified and addressed the barriers that impeded the client and family's development of skills necessary for independent functioning in the community.</p> <p>() The CCSS agency identified and addressed cultural strengths, goals and measurable objectives, which may aid the client or family in its recovery or resiliency process.</p>					<ul style="list-style-type: none"> • Review the agency Policy and Procedures is identified on the training plan. • Does the agency respond to specific cultural requests of the client and/or collateral requests? Do you see an effort to link the client to their cultural roots? • Review of the client's assessment and service plan to determine if it demonstrates documented efforts to explore cultural strengths and/or goals objectives provided by client and family. Explore issue in client and staff interviews about how cultural strengths are included in their service plan.
CCSS ASSESSMENT REQUIREMENTS	Document	Yes	No	N/A	Interpretative Guidelines
<p>() An assessment of baseline functioning was performed within 10 working days of the client's admission into CCSS services.</p> <p>() The assessment evaluated and documented the client's specific functional effectiveness in multiple skill domains based on the desired outcomes of the client or family</p> <p>() Functional level determination identifies domains in which functional limitations precipitated by the behavioral health disorder are present.</p> <p>() The client's diagnoses and assessments, including identification of functional limitations, are the basis for the comprehensive client or family-driven, goal-directed, measurable service plan. (As of 3/9/2009- directed by the Collaborative to allow masters clinicians to perform assessments as long as an independently licensed clinician signs off on the assessment work. Final interpretation pending from MA)</p>					<ul style="list-style-type: none"> • Review Client file to determine if An official admission date to CCSS should be documented in a client record that establishes the framework for the 10-day functional assessment requirement. • Review Client file to determine if the client's assessment yields BH disorder and/or BH diagnoses • Review Client file to determine if the documented functional assessment identifies functional strengths and limitations to be utilized in the service plan. • Review Client file to determine if comprehensive functional assessment is documented by the clinician evaluating functional strengths and limitations. No specific tool mandated at this time. • Review Client file to determine if the assessment includes client specific functional effectiveness, strengths and limitations in multiple domains.

CCSS STAFF-SERVICE DELIVERY REQUIREMENTS	Document	Yes	No	N/A	Interpretative Guidelines
<p>() The CCSS consumer has their own primary Community Support Worker and know who that individual is. <u>(include in client interview)</u></p> <p>() The client's CSW is under the documented supervision of the CCSS Clinical Supervisor.</p> <p>() CSW to Client Caseloads, on average across the agency, are not exceeding a ratio of 1:20 (one CSW to 20 clients receiving CCSS). The agency will develop and maintain an internal compliance review process to be performed quarterly</p> <p>() The CSW are making every effort to engage and partner with the client and family in achieving rehabilitative, recovery, and resiliency goals. Barriers to engaging the client or achievement of the service goals will be identified and utilized to amend the service plan interventions.</p> <p>() A primary CCSS worker coordinates and facilitates family/team meetings or treatment team meetings.</p> <p>() Necessary follow-up by the CSW to determine if the services accessed have adequately met the client's needs.</p> <p>Note: Clients participating in medication management as the primary focus of service are not subject to the client-staff ratio</p>					<ul style="list-style-type: none"> • Ask client/family during interview to name their CSW and to describe their relationship with the CSW. • Review Clinical Supervision file to determine if Clinical supervision documentation demonstrates regular supervision is present related to CSW case management issues • Agency documents its internal monitoring for compliance on average with caseload ratios. Child 1:20 or Adult caseloads requirement is 1:30 per the revised service definition. • P.notes and ser.plan updates document efforts to engage client/family in team meetings with natural supports and other interested parties goals. Service plan updates include barriers or achievement of the service goals. • Review Client file to determine if 90-day updates include a documented team meeting and its consistent effort to engage/invite natural supports and other agencies involved. Reasons for non-involvement of stakeholders must be documented and alternative strategies developed. • Review Client file to determine if Client record documentation by CSW demonstrates ongoing evaluation if services are meeting client's needs. • Review Client file to determine if A MDS meeting including service providers, natural supports identified by the client/family and representatives from other agencies involved occurred as the service plan is implemented. This meeting should be summarized in a progress note in the client file.

CCSS SERVICE PLAN REQUIREMENTS	Document	Yes	No	N/A	Interpretative Guidelines
<p>() Community support activities and all relevant providers are clearly identified in the comprehensive service plan.</p> <p>() The primary CSW are coordinating the service plan without duplication by the other service providers.</p> <p>() The CCSS comprehensive service plan is completed no later than 30 calendar days of the client's admission into CCSS services.</p> <p>() CCSS Service Plan: Includes the signature of the consumer, family as indicated, and all responsible staff assisting the consumer in obtaining his/her treatment goals/interventions.</p> <p>() CCSS service plan addresses goals as identified by the client or family specifically to meet recovery and resilience based outcomes in the areas of independent living, learning, working, socializing and recreation.</p> <p>() CCSS agency includes the development of crisis plan interventions, as defined in an individual crisis plan, as a component of overall CCSS comprehensive service plan.</p> <p>() Individualized CCSS interventions address objectives indicated in the assessment and comprehensive service plan (<u>Linkage Between</u>) The client's CCSS Service Plan interventions and/or objectives include the following:</p> <p>() community services and resources available to support the client's achievement of his functional CCSS service goals and objectives;</p> <p>() assistance in the development of interpersonal, community coping and functional skills (i.e., adaptation to home, school and work environments), utilizing evidence-based practices to support the skills development in the following domains:</p> <p>() socialization skills;</p> <p>() developmental issues as identified in the assessment;</p> <p>() daily living skills;</p> <p>() school and work readiness activities; and</p> <p>() education and management of co-occurring illness;</p> <p>() facilitating the development and eventual succession of natural supports in the workplace, housing/home, and social and school environments;</p> <p>() provision of client and family education as appropriate regarding:</p> <p>() self-management of symptom monitoring, illness management, and recovery and resiliency skills;</p> <p>() relapse prevention skills;</p>					<ul style="list-style-type: none"> • Review Client file to determine if all providers, agencies and natural supports should be clearly documented on the service plan. • CSW documents service plan coordination across other service providers as identified in the service plan. No evidence of service duplication by providers • Review Client file to determine if CCSS comprehensive service plan meets 30-day requirement from the date of official admission date and has all relevant signatures • The client/family should be able to tell reviewer what their service goals are during interviews specifically addressing skills building in domains present in service plan. • Client/family education and/or relapse prevention, as defined in service plan, is provided and documented by CSW as applicable • Review Client file to determine if Client functional assessment deficits are addressed through identified service plan interventions and client/family defined objectives. • Review Client file to determine if service plan defines and documents the community services/resources. • Review Client file to determine if the functional domains with deficits or limitations identified in the assessment are the focus of skill development <p>Are the objectives and interventions on the service plan designed to address barriers and enable the individual/family to achieve their recovery goals?</p>

<p>() knowledge of medication and potential side effects;</p> <p>() motivational and skill development in taking medication as prescribed;</p> <p>() ability to identify and minimize the negative effects of symptoms which potentially interfere with the client’s activities of daily living;</p> <p>() as indicated, supports to the client to maintain employment and school or community tenure;</p> <p>() facilitating the client’s abilities to obtain and maintain stable housing;</p> <p>() The CCSS service plan provides assistance in the development of <u>interpersonal, community coping and functional skills</u> (including adaptation to home, school and work environments) in:</p> <p>() Socialization skills</p> <p>() Developmental issues</p> <p>() Daily living skills</p> <p>() School and work readiness activities</p> <p>() Education in co-occurring illness</p> <p>CCSS Service Plan <u>specifies recovery and resiliency strategies</u> to include:</p> <p>() the community support(s) and any other rehabilitative and treatment interventions needed for the client to achieve his specified service goals and to meet recovery and resiliency outcomes;</p> <p>() the CCSS staff responsible for each recovery and resiliency intervention and the frequency of the planned interventions;</p> <p>() the client’s relevant diagnoses and other risk factors that place him at risk of further diagnoses;</p> <p>() measurable goals and objectives identified by the client and family as their comprehensive service plan priorities to meet desired recovery and resiliency outcomes;</p> <p>() a recovery/ resiliency management plan;</p> <p>() potential service plan barriers and applicable strategies; and</p> <p>() if requested, advanced directives related to client’s behavioral healthcare.</p>					<ul style="list-style-type: none"> • Review Client file to determine if the focus of the CSW progress notes are related to the specific skill domains documented in the service plan. • Defined, staff-specific Individualized activities are documented in the service plan related to empowering the client and family to take care of themselves and/or improve their ability to function in school and social situations. This focus can constitute recovery/resiliency strategies • Review Client file to determine if CSW notes include Client-defined outcomes linked to measurable goals/objectives are documented in the client record with emphasis on R/R • CSW provided Education is documented as provided in co-occurring illnesses to improve person’s understanding what they are experiencing and what strategies are effective in addressing co occurring disorders as defined in the service plan. • Review Client file to determine if documentation every 90-days of service plan meetings and updates re. Progress is made in CCSS objectives, goals and/or barriers encountered. When barriers are documented, modifications are documented per client’s defined needs. • Service plan updates document status of functional outcomes achievement at least every 90-days • Review Client file to determine if the service plan considers the domains in a holistic manner. Multiple domain deficits from the assessment should be addressed in the service plan. The focus for skill
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<p>() Encouraging the development and eventual succession of natural supports in workplace and school environments;</p> <p>() Assistance in learning symptom monitoring and illness self-management skills (e.g. symptom management, relapse prevention skills, knowledge of medication and side effects and motivational/skill development in taking medication as prescribed) in order to identify and minimize the negative effects of symptoms which interfere with the consumers to maintain employment and school tenure;</p> <p>() Assisting the consumer to obtain and maintain stable housing</p> <p>() Any necessary follow-up to determine if the services accessed have adequately met the consumer's needs;</p> <p>() Every 90 days after implementation of the comprehensive service plan, the CCSS team, in partnership with the client and family, meets to track and provide detailed documentation demonstrating progress made over time relating to the CCSS service goals, objectives and client/family designated recovery or resiliency outcomes.</p> <p>() The CCSS 90-day comprehensive service plan reviews are documented in the service plan updates with modifications made based upon barriers identified or redefined goals and objectives and future needs.</p> <p>() The follow up <u>service plan assessment</u> documents the current status of the client and family designated measurable recovery or resiliency functional outcomes.</p>				<p>development should be centered on these areas.</p> <ul style="list-style-type: none"> •Reviewer should see CSW notes as evidence of outreach and linkages or attempts to develop natural supports. •Review Client file to determine if CSW notes document discussions with the client/family regarding symptoms/behaviors/situations where a skill/strategy is developed to minimize a symptom or improve the way the client is handling a situation at school/work.. • Review Client file to determine if Symptoms are framed as barriers to goals. Strategies for managing symptoms and relapse preventions should be discussed and written down with the client and the effectiveness of these strategies should be reviewed at future visits or follow up phone calls in between visits. • Review Client file to determine if Skills related to housing such as developing a chore check list, setting boundaries with neighbors, system for paying bills, managing feelings related to being alone are present in the service plan and CSW notes. •Service plan documented Goals/objectives should be in the actual words of the client/family. Revisions to the plan should be expected especially if the plan did not facilitate the stated outcome. •CCSS agency should have a standardized recovery plan defined in its policies and procedures to be used for all clients that is written with the client and family. •Agencies that serve both kids and adults should develop a plan for each population
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CCSS CRISIS PLAN/RISK ASSESSMENT REQUIREMENTS:	Document	Yes	No	N/A	Comments
<p>() <u>Risk assessment</u>: The CCSS team performed an assessment of the client’s potential risk and documented a specific algorithm of community resources to address by risk level that ranges from immediate (i.e. 911 or first responders) to intermediate (e.g. call to crisis line) to moderate (call for a clinic appointment).</p> <p>() The CCSS team specified and documented benchmarks in the client’s crisis plan that indicated when a crisis is appropriately reconciled for this client and family.</p> <p>() The client’s documented crisis plan included the following requirements, which were formulated <u>on admission to CCSS</u> by the CCSS team, client, family, legal guardian and other interested parties:</p> <p>() <u>Client/family education</u>: The CCSS team documents its client and family education on community resources to be accessed during crisis situations. The family and client were provided basic verbal communication techniques to help de-escalate a potential crisis situation.</p> <p>() The client’s crisis management plan addressed and documented potential after-hours crisis situations and included actions to be taken by client, family and natural supports;</p> <p>() <u>Research past crisis situations</u>: The CCSS team assessed the client’s collateral documentation for antecedent, precipitant, and consequent behaviors to identify strategies or objectives likely to prevent crises. The strategies and/or objectives were discussed with the client and family.</p> <p>() <u>Identify alternative interventions</u>: The CCSS team identified alternative interventions that may be initiated during crisis situations, including pre-crisis or crisis instructions identified by the client or family.</p> <p>() <u>Internal communication</u>: Crisis events are discussed in the CCSS team meeting to ensure all risk factors are identified and known by all team members.</p> <p>() <u>Face-to-face assessment</u>: CCSS team member makes a face-to-face visit as soon as possible, but no more than 48 hours after notification of a crisis, and complete an updated assessment for presentation to the team.</p> <p>() Incorporate client and family outcomes as benchmarks or measures of when the crisis is over.</p>					<ul style="list-style-type: none"> •Each CCSS agency should develop internal written policies and procedures for the creation of a standardized client-specific the crisis plan • Review Client file to determine if there is a documented risk assessment carefully evaluating carefully client’s individual risk factors from agency’s assessment, past crisis situations, and collateral materials. • Review Client file to determine if there is evidenced that the documented initial crisis plan was developed and provided to client on day of admission with client and stakeholders involvement. • Review Client file to determine if Comprehensive Crisis Plan was developed by the end of 30-days from admission • Review Client File to determine if Crisis Plan documents for each risk level, linkage to resources for client and family to utilize after business hours. Individual actions are defined for each party based upon identified strategies. •Client/family should be able to describe their crisis plan during interviews giving specific examples of crises, resources, and individual’s roles • Review Client file to determine if CSW note describes the review of the crisis plan with client/family and if verbal communication techniques or other crisis de-escalation techniques were used per the crisis plan. •Agencies could develop a crisis plan hand out that could be reviewed and provided to

<p>() If the client has or requests an advance directive, the crisis plan is incorporated into the advance directive.</p> <p>() CCSS Team revises the written crisis plan over time based on newly identified triggers and what is known to be effective. Included is documentation of behavioral benchmarks (e.g., number of runs, self-injury, assaults, etc., and what worked).</p> <p>() The negotiated crisis plan triages for differing levels of intensity and severity of crisis events and may identify other types of service interventions.</p> <p>() The individualized crisis plan provides support to the client and family in the management of crisis situations outside of regular business hours to develop or enhance the client's ability to make informed and independent choices.</p> <p>() CCSS services are coordinated and provided with the necessary services and resources, as defined in the service plan, to promote recovery, rehabilitation, and resiliency.</p> <p>() The community support worker provided follow-up to determine if the services accessed have adequately met the consumer's treatment needs;</p> <p>() For consumers and/or their families: The community support worker made every effort to engage the client in achieving treatment/recovery goals;</p> <p>() Majority of activities delivered by the CSW are directly related to CCSS and consistent with CCSS definition; <u>or</u></p> <p>() Majority of services/activities were not in the CCSS definition</p>					<p>the client/family after initial discussion of the individualized plan at admission</p> <ul style="list-style-type: none"> •Need to compare progress notes to the plan to determine if and when crisis occurred. Confirm the crisis plan was reviewed and updated by the CCSS Staff and client after each crisis. CCSS Staff and client need to sign and date the revisions to the plan . • Review Client file to determine if a detailed progress note for the post-crisis visit within 48 hours is present. Determine if there is documentation of the post-crisis assessment and if it was presented to the team. •Advanced Directives are not mandatory but if the client/family has an AD or expresses an interest in making an AD this should be incorporated into the service plan objectives. •Review Client file to determine if Team meeting minutes or progress note summarizing the team meeting are present in the client chart. •Review Client file crisis plan and crisis notes to see how situations are handled that occurred after hours as applicable. •Review Client file to if CSW notes demonstrate actual implementation of the service plan. •Review Client file to determine if CSW documents his contacts and follow up calls to the identified service providers listed on the service plan. •Review Client file to determine if the CSW's efforts to engage the client are clearly documented in the progress notes.
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					<ul style="list-style-type: none"> •Review Client file to determine if the service plan and services delivered by the e CSW correlate to CCSS. •All CCSS activities and services should directly related to the assessment’s functional limitations and the service plan interventions to address those limitations as well as the client’s defined goals and outcomes.
QUALITY/ COMPLIANCE REQUIREMENTS:	Document	Yes	No	N/A	Comments
<p>() CSW client to staff ratio of 1:20 on average, are monitored and documented through the agency’s internal quarterly CQI program thru defined review activities such as peer chart reviews.</p> <p>() The agency documented its implementation of timely corrective action when it was identified that staff ratio averages are not in compliance .</p> <p>() The agency documented, through its internal Quality/Compliance plan, its quarterly review process for demonstrating that on average (60% or more) of CCSS services are delivered face-to-face and in vivo (where client is in the community).</p> <p>() The agency documented its implementation of timely corrective action when it was identified that the agency, on average, did not conform to 60% or more of its CCSS services were delivered face-to-face and in vivo (where client is in the community).</p> <p>() The agency internally monitors, thru its CQI functions at least quarterly, the CCSS service plan and service delivery documentation for full compliance with the CCSS Certification standards. Timely corrective action of deficiencies identified through the internal reviews are documented in the agency’s quarterly CQI program documentation.</p>					<ul style="list-style-type: none"> •The Agency’s CQI program must include a documented mechanism for internal quarterly monitoring for compliance with all defined regulatory CCSS documentation requirements (elements listed in next section) • Review Client file to determine if Clear articulation of medical necessity and recovery language are present in all progress notes and the linkages between the assessment, service plan and notes. •The agency CQI plan must include mechanisms such as policies and procedures, tracking mechanisms, and formal processes that address the regular aggregate monitoring of the 60% in vivo and 1:20 or 1:30 ratio requirements. •CQI plan includes provision for Timely Corrective actions and the results of the action (did the deficiencies improve) to be an integral part of the internal monitoring documentation.
CCSS DOCUMENTATION REQUIREMENTS	Document	Yes	No	N/A	Comments
<p>In the client record review, the CCSS provider consistently documents all service delivery with each of these elements:</p> <p>() Date of Service</p>					<ul style="list-style-type: none"> •The progress notes should clearly document the specific recovery goal addressed at each client/CSW encounter. • Review Client file to determine if each

<input type="checkbox"/> Service Location <input type="checkbox"/> Service time span (e.g.3:15-3:30pm) <input type="checkbox"/> Documentation links CCSS service to the Service Plan Goal <input type="checkbox"/> Individual's name and credential delivering service <input type="checkbox"/> DAP or SOAP note elements (Adult only) <input type="checkbox"/> Documentation is legible <input type="checkbox"/> Services being delivered are consistent with service definition <input type="checkbox"/> Signature of the individual making the entry					<p>CCSS service note complies with documenting these specified elements</p> <p>•Review of CSW notes and the required elements should be included in the CQI activities. The CCSS Program Supervisor or Clinical Supervisor may be used for periodic, random chart reviews for compliance.</p>
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