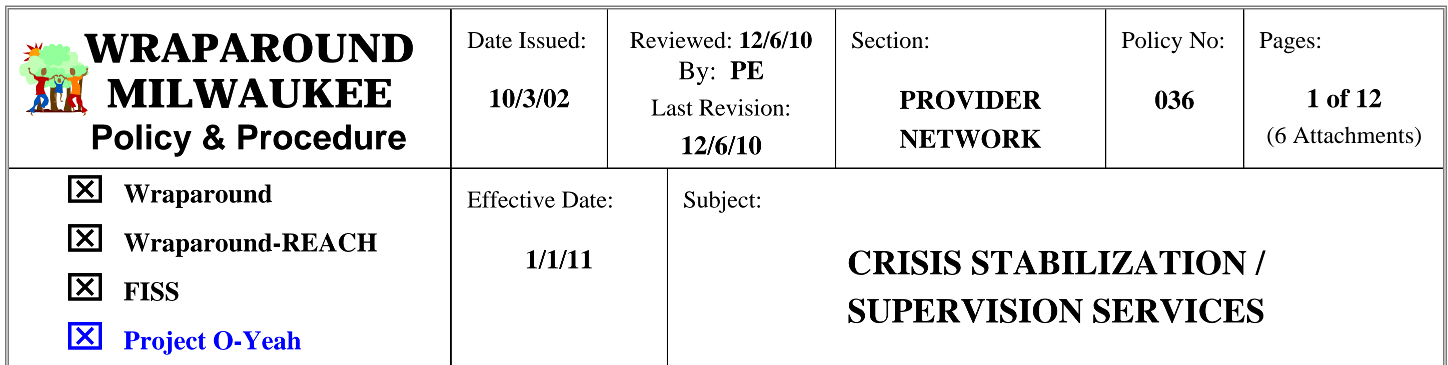

WRAPAROUND MILWAUKEE Policy & Procedure	Date Issued: 10/3/02	Reviewed: **12/6/10** By: **PE** Last Revision: **12/6/10**	Section: **PROVIDER NETWORK**	Policy No: **036**	Pages: **1 of 12** (6 Attachments)
☒ **Wraparound** ☒ **Wraparound-REACH** ☒ **FISS** ☒ **Project O-Yeah**	Effective Date: **1/1/11**	Subject: **CRISIS STABILIZATION / SUPERVISION SERVICES**			

I. POLICY

It is the policy of Wraparound Milwaukee that all Crisis Stabilization/Supervision Providers through the Wraparound Provider Network and Wraparound Care Coordinators for the Wraparound Milwaukee program correctly utilize and implement Crisis Stabilization/Supervision services.

Crisis Stabilization/Supervision is a **one-to-one** service primarily provided to Wraparound enrolled youth who, due to their emotional and/or mental health needs, are at risk of imminent placement in a psychiatric hospital, residential care center or other institutional placement. This service is used to prevent and/or ameliorate a crisis that could ultimately result in an inpatient psychiatric hospitalization or residential placement if the crisis intervention/supervision had not occurred.

Note: All Crisis Stabilization/Supervision Agencies and Providers must follow all applicable standards referenced under HFS 34 *(see Attachment 1)* ***and the Wisconsin Medicaid Update – Crisis Intervention Services, July 2006*** *(see Attachment 2),* ***in addition to the following procedure.***

II. PROCEDURE

A. Definitions and Descriptions.

1. **Crisis Stabilization** is a short-term or ongoing mental health intervention provided in or outside of the youth's home, designed to evaluate, manage, monitor, stabilize and support the youth's well-being and appropriate behavior consistent with the youth's individual Crisis/Safety Plan. The crisis stabilizer helps to insure adherence of the youth and caregiver to the Crisis/Safety Plan, including helping the family to recognize high risk behaviors, modeling and teaching effective interventions to deescalate the crisis, and identifying and assisting the youth with accessing community resources that will aide in the crisis intervention and/or stabilization.

   Per HFS 34.02, Wisconsin Medicaid uses the following definitions:
   Crisis **-** a situation caused by an individual's apparent mental disorder which results in a high level of stress or anxiety for the individual, persons providing care for the individual or the public, that cannot be resolved by the available coping methods of the individual or by the efforts of those providing ordinary care or support for the individual.

   Crisis Plan **-** a plan prepared for an individual at high risk of experiencing a mental health crisis so that, if a crisis occurs, staff responding to the situation will have the information and resources they need to meet the person's individual service needs.

   Emergency Mental Health Services **-** a coordinated system of mental health services that provides an immediate response to assist a person experiencing a mental health crisis.

   Response Plan **-** the plan of action developed by program staff to assist a person experiencing a mental health crisis.

   Stabilization Services **-** optional emergency mental health services that provide short-term, intensive, community-based services to avoid the need for inpatient hospitalization.

Crisis Intervention **-** services provided by an emergency mental health services program to an individual in crisis or in a situation that is likely to develop into a crisis if supports are not provided. All crisis intervention services must conform to the standards in HFS 34, Subchapter 3, Wis. Admin. Code. Crisis Intervention services include:

- Initial Assessment and Planning.
- Crisis Linkage and Follow-up services.
- Optional Crisis Stabilization services *(see page 9 of Attachment 2).*

2. **Crisis Supervision** is generally a short-term mental health intervention, 30 to 90 days in duration, that may require daily/seven-day-per-week contact with the youth (face-to-face or by phone), that is associated with a specific circumstance or situation identified in the youth's crisis and/or safety plan. Supervision services are designed to aid in sustaining the youth safely in the community. Supervision assists youth who are unable to manage routine/daily responsibilities by providing observation, monitoring, direction, and support services for the identified youth in areas such as: attending school, management of curfews, compliance with safety plan requirements identified in the youth's plan of care, attendance at support or therapy sessions, taking prescribed medications or other tasks or events as specified in the individual youth's crisis/safety plan. Supervision services may need to be authorized as part of a Court order.

B. Required Credentials/Responsibilities.

Agency Director

1. Directors themselves must comply with all background check requirements/guidelines.
2. Directors are ultimately responsible for all Crisis Stabilization/Supervision operations ensuring compliance with the Wraparound Milwaukee Fee-for-Service Agreement, all policy and procedure requirements, HFS 34 guidelines and any other relevant documents, memoranda, State mandates.
3. Directors must ensure that those employed to supervise and or provide direct crisis services meet all Wraparound Milwaukee/State employment requirements (i.e., background checks, drivers abstracts/licenses/insurance, training, etc.).
4. Directors must ensure that all human resource, programmatic and clinical staff meet the minimum qualifications identified in this policy and that corresponding job tasks are engaged in a manner ensuring compliance with Wraparound/State expectations and best practice standards.
5. Director oversight of the proper maintenance of client and personnel files is paramount.

Program Supervisor/Crisis Stabilization/Supervisor.

1. Program Supervisors must be affiliated with an agency certified by Wraparound Milwaukee to provide crisis stabilization work with youth with acute and/or intense needs.
2. Program Supervisors must have, at minimum, a B.S. in a Human Services field plus 2,000 hours of experience in working with youth and families preferably in crisis situations.
3. Program Supervisors must have knowledge of/understand crisis intervention strategies and Wraparound and State mandates/policies/guidelines and be able to implement these.
4. Program Supervisors must provide daily programmatic oversight.
5. Program Supervisors must be able to train crisis workers, provide direction and guidance, assign crisis providers based on the identified needs/strengths of the referred youth, review/approve crisis provider notes, maintain organized client files, handle youth/family complaints, attend Child and Family Team meetings as needed, engage in quality assurance activities/tasks to ensure services/care is being provided in an ethical, policy/best practice-driven manner.

Clinical Supervisor

1. The clinician providing clinical supervision must be pre-approved to do so by the Director of the Mobile Urgent Treatment Team and/or his designee. Along with the person's name and credentials, the crisis agency must submit the clinician's resume and proof of current professional liability insurance as required by the Wraparound Milwaukee Fee-for-Service Agreement. The agency is

responsible for monitoring Clinical Supervisor compliance with the Wraparound Milwaukee Fee-for-Service Agreement professional liability insurance requirements.

2. At minimum, the Clinical Supervisor must be a Wisconsin Licensed Psychotherapist.
Important: Clinicians currently providing clinical supervision must comply with the licensing requirement effect 1/1/2012.
3. Clinical supervision of individual crisis workers includes direct review, assessment and feedback regarding each crisis worker's delivery of emergency mental health services.
4. Documentation that supervision occurred with the Crisis/Supervision Worker must be present. This can be in the form of a brief note indicating the name of the Crisis/Supervision Worker, the date that supervision occurred, the length of the supervision session (i.e., one hour), and the content of the interaction/discussion (i.e., what youth(s) was/were discussed, interventions to be employed, strategies to consider). The Supervising Clinician must then sign and date the note with their full name and credentials. It is preferential that the crisis worker who is engaging in the worker/clinician supervisory interaction also sign and date the clinical supervisors note as verification that the supervision took place.
5. Within the first 6 months of hire, the Clinical Supervisor must attend Wraparound Philosophy Training.
Note: The Clinical Supervisor can be the program Supervisor.

Lead Worker

1. Lead Workers must meet all the criteria of the Worker plus have been employed at the Crisis Stabilization/Supervision agency for at least 2,000 hrs. (1 year full-time equivalency) providing crisis stabilization/supervision services. This individual must evidence a clear, thorough understanding of the provision of crisis/stabilization services and provide exemplary services as evidenced by positive agency staff performance evaluations (i.e., positive family surveys/feedback; skill in progress note writing; and leadership/organizational qualities).
2. Lead Workers, under the direct supervision of the Program Supervisor, may assist with identified supervisory tasks, review/approval of peer documentation/performance, quality assurance tasks and/or function as an agency emergency contact.

Note: For the equivalent of every 10 full time crisis/supervision workers, one Lead Worker must be assigned.

Worker

1. Crisis Stabilization/Supervision Workers must be affiliated with an agency certified by Wraparound Milwaukee to provide crisis stabilization work with youth with acute and/or intense needs.
2. Crisis Stabilization/Supervision Workers must possess a High School Diploma or G.E.D. A Bachelor's Degree in a Human Services field is preferable.
3. Agencies must obtain at least two (2) references regarding the worker's professional abilities. References and recommendations can be documented in a letter or in a signed and dated record of a verbal contact with the worker's references. Reference letters are to be maintained in the employees file at the agency.
Note: Crisis agencies that plan to use a record of a verbal contact that is documented on an agency form will need to have the form reviewed and approved by the Wraparound Milwaukee QA Director
4. Crisis Stabilization/Supervision Workers must meet all Wraparound/State requirements/expectations prior to hire and/or providing direct client care (i.e., background checks, drivers abstract, driver's license/insurance, being authorized through the Wraparound Milwaukee Provider Network as evidenced by the start date in Synthesis).
5. Crisis Stabilization/Supervision Workers must engage in initial/ongoing training and supervision as mandated by HFS 34.
6. Crisis Stabilization/Supervision Workers must be able to adequately implement the Crisis Plan/POC strategies and be available as needed by the youth/family.

7. Crisis Stabilization/Supervision Workers must engage with youth/families / all Child & Family Team members and provide crisis services in an ethical, respectful, responsible manner.
8. Crisis Stabilization/Supervision Workers must be able to clearly/thoroughly document all interventions/contact.

C. Criminal History, Criminal Background Check, Caregiver Law and County Resolution.

A Statewide criminal background check must be done by the Agency **prior to the hiring and training** of the Crisis Stabilization/Supervision Worker. There must be adherence to the Wisconsin Caregiver Law/County Resolution. (See Caregiver Background Check Policy # 057 for more details and expectations)

D. Driver's Abstract /Driver's License and Insurance.

The Agency that employs the Crisis Stabilization/Supervision Worker must maintain verification that a Motor Vehicle Abstract was completed prior to the first transport and that the worker has a current, valid Wisconsin Driver's License and current automobile insurance. A motor vehicle abstract check can be done by calling Madison at (608) 261-2566. If there are any violations on the abstract within the last three years, a copy of the abstract must be attached to the Request to Add a Direct Service Provider Form (ADD Slip) for Wraparound Milwaukee review. Abstracts must be completed every 4 years or at any time within that period when the agency believes a new abstract should be obtained. Beyond Wraparound's review/approval of the drivers abstract, the Agency has the discretionary right, when reviewing the abstract, to determine whether or not any driving violations may place the youth/families at risk and can then make the decision as to whether the Crisis Stabilization/Supervision worker should transport youth/be employed.

E. Required Training Hours/Topic Areas.

The Agency must adhere to the following training requirements as specified in HFS 34.21 (8) (*see Attachment 1)* as well as any Wraparound Milwaukee mandated trainings.

1. **Initial Training.**
   a. For staff with **less than 6 months** of prior related work experience, **forty (40) hours** of training must occur and be documented.
   b. For staff with **at least 6 months** of prior related work experience, **twenty (20) hours** of training must occur and be documented.

   Note: The above training MUST occur within the first 3 months of employment.

   Initial training must include Crisis Prevention Intervention (CPI), Managing Aggressive Behavior (MAB) or a similar program along with a thorough review of the Wraparound Milwaukee Crisis Stabilization/Supervision Policy. See other areas of applicable training under the "Ongoing Training" areas below.

Lead Workers will be required to attend Wraparound Milwaukee's Philosophy Provider Training (Level I and Level II or another similar Wraparound sponsored and approved training such as Wraparound 101) within the first six months of employment as a Lead.

2. **Ongoing Training.**

   Staff are required to attend at least eight (8) hours per year of documented, ongoing, job-related training.

   The following job-related trainings should be provided:
   a. Provider job description/agency responsibilities and policies.
   b. Relevant State Statutes and Administrative Rules, including client rights and confidentiality of youth records and an overview of other Wraparound Milwaukee relevant policies.
   c. Basic mental health and psychopharmacology concepts applicable to crisis situations.
   d. Techniques for assessing and responding to persons with emergency mental health needs who are suicidal and/or are experiencing AODA related problems.
   e. Mandatory Reporting requirements.

f. De-escalation techniques.
g. First Aid/CPR.
h. Establishing boundaries/building trust.
i. Family dynamics.
j. Engaging resistive youth/families.
k. Identifying and utilizing youth/family strengths.
l. Conflict resolution.
m. Working with culturally diverse populations.
n. Youth growth and development/human sexuality.
o. Working as a team.
p. Empowering youth/families.
q. Nurturing social and interpersonal growth.
r. Working with high risk youth / managing risky behaviors.
s. Ethical service provision, documentation practices and billing procedures.

Note: Agencies must maintain a record of training topics, dates, times, presenter, attendance signature sheets and certificates of attendance on file at their Agency for each individual provider of Crisis Stabilization/Supervision.

F. Clinical Supervision of Crisis Workers/Lead Workers.

It is required by HFS 34.21(7) (*see Attachment 1)* that all Crisis Stabilization/Supervision Workers receive clinical supervision by, at minimum, a Masters level, Medicaid-certified clinician with 3,000 hours and course work in areas directly related to providing mental health services. "Clinical supervision of individual program staff members includes direct review, assessment and feedback regarding each program staff member's delivery of emergency mental health services." Documentation that supervision occurred with the Crisis/Supervision Worker must be present. This can be in the form of a brief note indicating the name of the Crisis/Supervision Worker, the date that supervision occurred, the length of the supervision session (i.e., one hour), and the content of the interaction/discussion (i.e., what youth(s) was/were discussed, interventions to be employed, strategies to consider). The Supervising Clinician must then sign and date the note with full name and credentials *(see Wraparound Milwaukee Guidelines for Crisis Stabilization/Supervision Meetings – Attachment 3).*

The amount of Supervision that must occur per each Crisis/Supervision Worker is referenced under HFS34.21 (7)(d)(e). **This reads that one-hour of supervision must be documented for every 30 hours of face-to-face contact.** The Clinical Supervisor can determine if the individual Crisis Stabilization/Supervision Worker is in need of further supervision above and beyond the current minimum requirements "to ensure that clients of the program receive appropriate emergency mental health services." If the efforts of the Crisis Stabilization/Supervision Worker are not sufficient, and the recipient of the services continues to experience a high rate of crises, then the Worker shall seek immediate supervision to determine whether and what other interventions are needed.

In addition, Lead Workers must formally meet with the Clinical Supervisor once a month (for a minimum of one hour if in a group of 2 to no more than 6 Leads, or 30 minutes if being seen individually), to process any issues related to their job role, documentation review skills, quality assurance concerns or Worker performance issues. Attendance sheets for these monthly meetings/individual sessions must be kept and must include the date, time frame, purpose of the meeting (i.e., Monthly Lead Supervision Meeting, the issues that were addressed, name of the Clinical Supervisor conducting the meeting/individual session and the signatures of the attendees). This meeting requirement is not to be confused with the supervision that must be provided for the 30 hours of client contact as referenced above.

The Clinical Supervisor must also be available for additional consultation/supervision as needed.

G. <u>Crisis Quality Assurance Guidelines</u>

1. Agency must have a formal/written quality management plan. This plan must address:
   a. Agency staff responsible for implementing the plan.
   b. Staff supervision oversight.
   c. Management of complaints.
   d. Agency hiring practices
   e. Personnel file maintenance procedures – include information about any databases/processes (i.e. driver's abstract, driver's licenses, driver's insurance, background check tracking systems).
   f. Client file maintenance and tracking of required documents (i.e., consents, service logs, etc.).
   g. Plan for obtaining ongoing youth and family input regarding the quality of service delivery. This may be accomplished through a written satisfaction survey, phone surveys or face-to-face contacts by other than the direct service provider.

   Plans must be updated at least every 2 years. Wraparound Milwaukee will require that the written plan be submitted with the Fee-for-Service Renewal and be available upon request.
2. Crisis Workers can only be employed through <u>one</u> Wraparound Provider Network agency and are limited to only providing Crisis Stabilization/Supervision and mentoring services at that agency.
3. Crisis Workers are limited to providing only one service within a family.
   a. Crisis Workers cannot be simultaneously authorized as a Crisis Worker and a Mentor for the same child in the same month.
   b. Crisis workers cannot serve both as a Mentor and a Crisis Worker for the same family for different children in the family.
4. If there is no documented crisis in 2-3 months then the Child and Family Team must consider either reducing the amount of hours authorized for the provision of Crisis Stabilization, or transitioning the youth to a less intense service such as mentoring.
5. Crisis Stabilization/Supervision Agencies must immediately notify Wraparound Milwaukee of any changes in the status of their Crisis Workers, Leads or Supervisors.
6. Crisis Workers may not solicit business for the agency from the family, including asking the family to advocate for additional service hours.

H. <u>Agency and Worker Accessibility/ Provider Referrals</u>.

Agencies providing Crisis Stabilization/Supervision must have a 24-hour/7-day-a-week coverage plan in place to handle incoming referrals both as an Agency and for the individual Crisis Stabilization/Supervision Provider, such as a rotating on-call pager system. There must be an agency response to a written (faxed), Synthesis-generated or telephoned Provider Referral within 24 hours. If the agency is able to accept the referral, a face-to-face contact with the family must occur within three (3) days (72 hours) of the acceptance unless otherwise specified by the Child & Family Team and in the Plan of Care. The written, Synthesis-generated referral must be sent to the Agency on the Wraparound Provider Network PROVIDER REFERRAL FORM (*see Attachments 4A & 4B*). <u>The Provider Referral Form must be received by the Crisis Stabilization Agency **prior to the provision of services**</u>.

When a Crisis Stabilization/Supervision Worker is matched with a family, the Crisis Agency Director or Administrative Representative <u>must</u> call the Care Coordinator to inform them who the Worker is, so that the first visit can be arranged with the Care Coordinator. **Crisis Stabilization/Supervision Workers should <u>not</u> be going to a youth's/family's home and/or calling a youth/family prior to that first collaborative meeting.**

I. <u>Confidentiality/Client Files/Consents/Release of Information.</u>

The Crisis Stabilization/Supervision Workers must comply with the Wraparound Milwaukee confidentiality and HIPAA policies. All information about the youth and family they work with is strictly confidential and will not be discussed with any person outside of the Child & Family Team, Agency affiliated Consultants, supervisory personnel or Wraparound Milwaukee staff. The right to confidentiality applies not only to

written and electronic records, but also to videos, pictures, or use of names of clients or legal or custodial guardians in Agency publications.

A Consent Form that permits the Agency to serve a youth must be in each client's file. The "CONSENT FOR SERVICE" must be signed and dated by the parent/legal guardian **prior to** the provision of services. The Agency is expected to create their own Consent for Service form.

Prior to a Crisis Stabilization/Supervision Provider transporting a youth, a "TRANSPORTATION CONSENT FORM" (*see Attachment 5)* must be signed and dated by the parent/legal guardian. If the Provider Agency has their own Transportation Consent Form that includes the same elements as the Wraparound Milwaukee Transportation Consent Form*,* then it is permissible for the Agency to continue to use their own form. The Transportation Consent Form must be signed **prior to** the provision of the first transport.

Information about a youth may be released to other individuals or organizations only upon presentation of an authorized "AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION" form, appropriately signed by the youth's parent/legal guardian. The Agency is expected to create their own form.

Client records must be respected and maintained in a secure cabinet or room and are to be maintained at the Agency until the client becomes 19 years of age or until 7 years after services have been completed, whichever is longer. The documents can then be appropriately disposed of/shredded.

The Agency must maintain a current copy of the POC and all previous POC's, applicable to the duration of services, in the client file.

J. Collaboration – Care Coordinators and Crisis Workers/Agencies.

The Care Coordinator must attend the first visit to introduce the Crisis Stabilization/Supervision Worker to the family/youth.

As a member of the Child & Family Team, the Care Coordinator must inform and request attendance of the Crisis Stabilization/Supervision Worker at all relevant meetings (i.e., Plan of Care meetings, Child & Family Team meetings, meetings with youth and family and other systems as they pertain to the youth's crisis intervention and crisis plan needs).

If there is a change in the Care Coordinator assigned to work with the family, the Care Coordination Agency must immediately inform the Crisis Worker, the Crisis Agency and other Child & Family Team members. If during the time a Crisis Worker is matched with a youth, if there is any change in the youth's status (i.e., living situation, family relocation, psychological or physical health, behavioral concerns/incidents, school concerns/incidents, court related issues, etc.), the Care Coordinator must make every effort to inform the Crisis Worker and/or the Crisis Agency Director or designee. This must be done as soon as possible.

K. Transporting Youth.

The motor vehicle in which the youth is transported must have working seat belts and the youth must wear the seat belt at all times when being transported. If the Crisis Stabilization/Supervision Worker is to pick up the youth at his/her home for a session/activity, it is mandatory that at least one responsible adult be at home when the youth is picked up and when the youth is dropped off. If that is not possible (i.e., the client is being picked up at school or directly from an activity), the Crisis Stabilization/Supervision Worker must carry a copy of the pre-signed Transportation Consent form giving him/her the permission to transport the youth.

No youth should ever be left at home alone when being returned from a Crisis Stabilization/Supervision session unless the Child & Family Team has discussed and approved this practice. The team should take into account things such as chronological and cognitive age of the youth, the youth's ability to make good decisions and use good judgment, environmental safety, time of day, etc., when discussing the possibility of dropping a youth off unattended. Attempts should be made to call the parent/legal guardian/caregiver/emergency contact at the numbers listed on the Referral Form. If unsuccessful, the Care

Coordinator should be called. The Care Coordinator needs to ensure that parents/guardians, crisis workers and youth know that a responsible adult must be available to receive a youth at all times unless otherwise indicated**.**

L. Touching.

Use the following guidelines related to touching a child/youth:

- Touching should be in response to the need of the child and not the need of the Crisis Stabilization/Supervision Worker.
- Touching should be with the child's/youth's permission - resistance from the child/youth must be respected.
- Touching of private parts is prohibited.
- Avoid touching that might be seen as being provocative.
- Touching or other physical contact should be governed by the age and developmental stage of the child/youth. For example, sitting in an adult's lap may be appropriate for a three-year-old, but less so for an eight-year old, unless the adult is the child's parent.

It is always better to error on the side of caution regarding physical contact.

M. Covered Service Recipients

Generally, **only the enrolled youth** in Wraparound can be covered and billed for under Crisis Stabilization/ Supervision. If another family member is in need of this service, then the Care Coordinator must seek Wraparound Administrative approval through the Director of the Mobile Urgent Treatment Team (or his designee). Justification for this service must then be referenced in the time-applicable Plan of Care. ***(See Section I. Billing, 1-3, for additional information related to covered services.)***

Note: There is no limit on the length of time that crisis services are covered for a given recipient, but Providers must use the Crisis/Safety Plan and Plan of Care to document service needs and to justify the need for continued services. If there is no documented crisis in 2-3 months then the Child and Family Team must consider either decreasing the amount of hours authorized for the provision of Crisis Stabilization or transitioning the youth to a less intense service such as mentoring.

N. Covered Services.

1. **Allowable Service Time for Crisis Stabilization.**
   a. Face-to-face contact and supervision of the youth.
   b. Face-to-face crisis-related contact and/or teaching crisis prevention or crisis stabilization skills to the parent/caregiver/collateral contact.
   c. Travel time and record-keeping time related to the direct service. Travel time and record keeping time are not billed separately, but are billed as part of the covered service provided. ***Example: If a Provider spends 20 minutes traveling to and from a recipient's home, one hour providing covered crisis intervention services, and 10 minutes completing record keeping associated with those services, the Provider must bill all of this time together as l.5 hours.***
   d. Handling a crisis over the telephone.
   e. Face-to-face contact at any location where the recipient is experiencing a crisis or receiving services to respond to a crisis.
   f. Meetings in which the youth is present and the youth's crisis intervention and crisis plan needs are being discussed (i.e., Plan of Care Meetings, Child & Family Team Meetings).
   g. Multiple staff crisis intervention and staff time - Wisconsin Medicaid covers more than one staff person providing crisis intervention services to one recipient simultaneously if multiple staff are needed to ensure the recipient's or the Provider's safety (i.e., the recipient is threatening to hurt others). Providers must clearly document the number of staff involved when billing for more than one staff person and the rationale for the need for more than one staff person.

2. **Allowable Service Time for Supervision.**
   a. Face-to-face contact and supervision of the youth.
   b. Face-to-face crisis-related contact with the parent/caregiver/collateral contact related to supervision/safety issues within the youth's Crisis/Safety Plan or safety domain within the Plan of Care.
   c. Travel time and record-keeping time related to the face-to-face service. Travel time and record keeping time are not billed separately, but are billed as part of the covered service provided.
   Example: If a Provider spends 30 minutes traveling to the location of the recipient, provides 15 minutes of supervision intervention services, and 15 minutes completing record keeping associated with those services, the Provider must bill all of this time together as l.0 hours.
   d. Contacting and speaking with AND/OR attempting to contact but not speaking with the youth by phone, as indicated by the supervision/safety plan. Documentation text must indicate if an attempt was made but no contact actually occurred. **The documentation text needs to address what follow-up action was taken in the event that the Provider was not able to make telephone contact with the youth.**
   e. Meetings in which the youth is present and the youth's supervision/safety plan needs are being discussed (i.e., Plan of Care Meetings, Child & Family Team Meetings).

3. **Other Service Time Circumstances for Crisis Stabilization and Supervision.**
   a. **No Show** – A "No Show" is defined as a situation in which the youth is not available as expected (i.e., the client was not available when the Provider arrived at the place of contact). In the event of a "No Show" situation, the Provider is still expected to document this in the text of their progress note, indicate "No Show" as the progress note Service Type, "No Show" as the contact location and enter the total travel time (if applicable) and documentation time/hrs. under the "Non-Medicaid Billable" area.
   b. **Secure Detention or Jail** – When a youth may be seen while in Secure Detention or Jail, the Provider is expected to document these contacts as usual, choose applicable service type codes, identify "Detention" as the contact location and enter the total travel time and documentation time.

4. **Non-Covered and Non-Permissible Services (Crisis and/or Supervision).**
   a. Crisis Worker time spent in programmatic or clinical supervision or trainings at the Crisis Agency or Wraparound Milwaukee.
   b. Room and Board.
   c. Overnights – Crisis Stabilization/Supervision Providers cannot personally arrange for a youth to be placed overnight in any setting. Overnight stays outside of the identified legal guardian's/caregiver's home must be arranged through the legal guardian/caregiver and the Care Coordinator.
   d. Out of State trips are not permitted for any reason.
   e. Services that are purely social and/or recreational in nature where there is no link to the activity being used as a strategy for supervision or crisis prevention, intervention or stabilization.
   Note: A crisis intervention strategy that uses a social/recreational type activity to prevent, intervene in and/or stabilize a crisis situation is permissible, but it must be a documented strategy within the Plan of Care under the Safety Domain or within the context of the Reactive Crisis Plan.

   Example: An example of the use of a social/recreational type of activity being used to intervene in or stabilize a crisis situation would be if a youth is in a stressful situation where he/she is escalating to the point that he/she may resort to physical aggression to

deal with the issue. The Crisis Stabilization/Supervision Provider is called to intervene. The Provider may remove the youth from the situation and take him/her down to the neighborhood park to play some basketball, as this could be an effective, preventative crisis strategy identified in the Plan of Care.

f. Volunteer services not meeting the qualifications in HFS 34.21(3), Wis. Admin. Code.
g. Taking a youth to the Crisis Worker's home or the homes of relatives or significant others.
h. Crisis is a youth-focused one-to-one interaction. Crisis Workers cannot engage in interactions with friends, relatives or others during the time they are with a youth.
i. A Crisis Worker cannot take a youth to his/her place of employment.
j. A Crisis Worker cannot take a youth to the worker's or youth's church/place of worship.
k. A Crisis Worker may not involve youth in their personal activities, whether paid or voluntary (i.e., performing chores for Crisis Worker, running personal errands), while with the youth.

Note: If any of these interactions are occurring and being billed for, Wraparound Milwaukee has the right to recoup monies for the hours spent in these interactions.

O. Providing Crisis Stabilization/Supervision while a Youth is in Residential Care.
If a youth is in a Residential Care Center (RCC), there must be documentation (either in the time-applicable Plan of Care or a time-applicable Care Coordinator Progress Note) that addresses the need or justification for the continued support of a Crisis Stabilization/Supervision Provider.

Crisis Stabilization/Supervision Providers can be used in the following situations while the youth is physically in the Residential Care Center:

1. Any interactions related to the development of the Crisis Plan.
2. Any interactions/services to assist the youth with transitioning to a lesser restrictive level of care.

It is permissible to use a Crisis Stabilization/Supervision Provider during times that the youth may be on pass from the RCC, as long as the time spent is **not** one of "Respite" type care. If "Respite" is needed while the youth is on pass, then a Respite Provider should be sought.

P. Documentation.
Documentation must be completed in Synthesis - Wraparound Milwaukee's secure internet-based IT system.

Depending on the service that was authorized, documentation must either reflect that the recipient is in need of supervision OR is in a crisis or in a situation that may develop into a crisis if support is not provided, and that the Provider can expect to reduce the need for institutional care (inpatient or residential) or improve the recipient's level of functioning. In accordance with HFS 34.23(8), documentation must include the following:

1. If the contact with the youth and/or caregivers was a face-to-face, phone, or written contact.
2. The time, place and nature of the contact and the person initiating the contact.
3. The staff person or persons involved and any non-staff persons present or involved.
4. The assessment of the youth's need for supervision OR emergency mental health services and the response plan developed based on the assessment.
5. The supervision OR emergency mental health services provided to the youth and the outcomes achieved.
6. Any Provider, Agency or Individual to whom a referral was made on behalf of the youth experiencing the crisis/being supervised (Service Referrals must go through the Child & Family Team/Care Coordinator).
7. Follow-up and linkage of services provided on behalf of the youth.
8. Amendments to the Plan of Care/Crisis Safety/Supervision Plan in light of the results of the response to the request for services as approved by the Child & Family Team.
9. If it was determined that the youth was not in need of supervision/emergency mental health services, any suggestions or referrals provided on behalf of the youth.

Coverage Documentation – When an unauthorized Provider provides **periodic** coverage for the identified/authorized Provider (i.e., during holidays, late evening hours, etc.), the covering Provider must document as identified above in # 1-9. For these periodic episodes of coverage the time can be billed under the identified/authorized Providers name.

If the coverage episode is going to be a more extended period of time (i.e., medical leave, one or more weeks of vacation), then the identified covering Provider should be formally authorized/entered onto the youth's Service Authorization Request (SAR). The Provider and/or Provider Agency will be responsible for informing the Child & Family Team of their extended absence and who the identified coverage person will be. The Care Coordinator is then responsible for entering the information in on the SAR.

Q. Service Verification Logs

The use of a monthly Service Verification Log is mandatory. The agency may use their own Log as long as it contains, at minimum, the elements noted below:

- Agency name.
- Client name (name of enrollee).
- Month/Year of service.
- Date of Contact.
- Service Recipient Name.
- Name of Service Provider.
- Length of Session (i.e., face-to-face – 4:00p.m.- 6:00p.m.).
- Travel Time.
- Location seen.
- Client/Guardian Signature and date of signing.
- If someone other than client signs, what is the relationship of that signer to the client?
- Column in which a "No Show" can be identified.

Service Verification Logs must be signed by the service recipient or primary caregiver after every face-to-face contact, whether it be a one-to-one situation or at a POC/Child & Family Team/other meeting in which the youth is present. Signatures are not required for phone contacts. **Signatures are to be obtained at the conclusion of every contact.**

Monthly logs are to be completed in full. Logs cannot be pre-signed nor should the crisis worker be asking the service recipient/primary caregiver to sign at the end of the month verifying all the contacts that occurred for that month. Having the service recipient/guardian pre-sign the Service Verification Log is fraudulent behavior and may be terms for termination form any/all County provider Networks and may prohibit future contractual agreements with the County.

For "No Show" situations, all information on that line should be entered including marking the column identifying the entry as being a "No Show". Travel time should be recorded for the "No Show", but no verification signature is required.

Service Logs time/date on the Service Verification Logs should be **cross-checked with the worker's notes before billing occurs**. The agency staff checking the logs should be cognizant of any irregularities (i.e., variance in the same person's signature, appearance that all signatures may have been gotten at one time, etc.).

R. Completing and Filing Notes.

All notes must be entered into Synthesis as soon as possible, but no later than four (4) calendar days after the contact occurred. In those instances where the contact poses to be one of a critical nature, the Provider must document this contact immediately.

As the Provider Notes are in the electronic medical record, printing and filing notes in the agency client file is OPTIONAL (***See Attachment 6 for guidance for on-line documentation procedures/requirements*****.)**

An agency may choose to still print out the notes if they desire. The agency should consider implementing the practice of printing out all Provider Notes at the closure of service so that a hard copy can be maintained at the agency for future immediate access.

S. Mandatory Reporting of Abuse.
All Crisis Stabilization/Supervision Providers are mandated by law (Wisconsin Statute 48.981 (2)) to immediately report to the Care Coordinator and/or the Police, Child Protective Services and or State Bureau of Child Welfare Services any suspected, reported or observed neglect or any physical, sexual and/or emotional abusive situation. The family should be made aware from day one that this is expected and required of the Crisis Stabilization/Supervision Provider. The telephone number of Child Protective Services is 220-SAFE (7233).

T. Liability Issues.
Milwaukee County will NOT be liable in the circumstances where a youth/family may steal from a Provider and/or cause damage to the Crisis Stabilization/Supervision Workers person or property.

U. Termination.
Crisis Stabilization/Supervision Workers terminated for JUST CAUSE from one Agency in the Wraparound Provider Network may not provide service for another Agency in the Network. An Agency's failure to abide by this could lead to their suspension or termination from the Network.

Reviewed & Approved by: Bruce Kamradt
Bruce Kamradt, Director

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Chapter DHS 34

EMERGENCY MENTAL HEALTH SERVICE PROGRAMS

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Note: Corrections in this chapter made under s. 13.93 (2m) (b) 1., 6., 7., Stats., Register, September, 1996, No. 489. **Chapter HFS 34 was renumbered to chapter DHS 34 under s. 13.92 (4) (b) 1., Stats., and corrections made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635.**

Subchapter I — General Provisions

DHS 34.01 Authority, scope and purpose. (1) This chapter is promulgated under the authority of s. 51.42 (7) (b), Stats., to establish standards and procedures for certification of county and multi–county emergency mental health service programs. Section 51.42 (1) (b), Stats., requires every county to provide emergency mental health services to persons within the county in need of those services. The persons who need those services are persons who are experiencing a mental health crisis or are in a situation likely to turn into a mental health crisis if supportive services are not provided. A county may comply with s. 51.42 (1) (b), Stats., by operating or contracting for the operation of an emergency mental health program certified under this subchapter and either subch. II or III of ch. DHS 34.

(2) This chapter applies to the department, to counties that request certification or are certified to provide emergency mental health services and to county–contracted agencies that request certification or are certified to provide emergency mental health services.

(3) This chapter relates only to the certification of programs providing emergency mental health services. It is not intended to regulate other mental health service programs or other emergency service programs.

History: Cr. Register, September, 1996, No. 489, eff. 10–1–96; correction in (1) made under s. 13.93 (2m) (b) 7., Stats, Register, April, 2000, No. 532.

DHS 34.02 Definitions. In this chapter:

(1) "Certification" means the approval granted by the department that a county's emergency mental health services program meets the requirements of this chapter.

(2) "Client" means a person receiving emergency mental health services from a program.

(3) "Coordinated emergency mental health services plan" means a plan prepared under s. DHS 34.22 (1) by an emergency mental health services program to ensure that emergency mental health services will be available that are appropriate to the specific conditions and needs of the people of the county in which the program operates.

(4) "County department" means a county department of human services under s. 46.23, Stats., or a county department of community programs under s. 51.42 (1) (b), Stats.

(5) "Crisis" means a situation caused by an individual's apparent mental disorder which results in a high level of stress or anxiety for the individual, persons providing care for the individual or the public which cannot be resolved by the available coping methods of the individual or by the efforts of those providing ordinary care or support for the individual.

(6) "Crisis plan" means a plan prepared under s. DHS 34.23 (7) for an individual at high risk of experiencing a mental health crisis so that, if a crisis occurs, staff responding to the situation will have the information and resources they need to meet the person's individual service needs.

(7) "Department" means the Wisconsin department of health services.

(8) "Emergency mental health services" means a coordinated system of mental health services which provides an immediate response to assist a person experiencing a mental health crisis.

(9) "Guardian" means the person or agency appointed by a court under ch. 54, Stats., to act as the guardian of a person.

(10) "Medical assistance" means the assistance program under 42 USC 1396 and ss. 49.43 to 49.475 and 49.49 to 49.497, Stats.

(11) "Medication administration" means the physical act of giving medication to a client by the prescribed route.

(12) "Medication monitoring" means observation to determine and identify any beneficial or undesirable effects which could be related to taking psychotropic medications.

(13) "Medically necessary" has the meaning prescribed under s. DHS 101.03 (96m).

(14) "Mental disorder" means a condition listed in the Diagnostic and Statistical Manual of Mental Disorders IV (4th edition), published by the American psychiatric association, or in the International Classification of Diseases, 9th edition, Clinical Modification, ICD–9–CM, Chapter 5, "Mental Disorders," published by the U.S. department of health and human services.

(15) "Minor deficiency" means a determination by a representative of the department that while an aspect of the operation of the program or the conduct of the program's personnel deviates from the requirements of this chapter, the deviation does not substantially interfere with the delivery of effective treatment to clients, create a risk of harm to clients, violate the rights of clients created by this chapter or by other state or federal law, misrepresent the nature, amount or expense of services delivered or offered, or the qualifications of the personnel offering those services, or impede effective monitoring of the program by the department.

(16) "Mobile crisis service" means a mental health service which provides immediate, on–site, in–person mental health service for individuals experiencing a mental health crisis.

(17) "Parent" means a biological parent, a husband who has consented to the artificial insemination of his wife under s. 891.40, Stats., a male who is presumed to be the father under s. 891.41, Stats., or has been adjudicated the child's father by final order or judgment of a court of competent jurisdiction in this state or another state, or an adoptive parent, but does not include a person whose parental rights have been terminated.

(18) "Program" means an emergency mental health services program certified under this chapter.

(19) "Psychotropic medication" means an antipsychotic, an antidepressant, lithium carbonate or a tranquilizer or any other drug used to treat, manage or control psychiatric symptoms or disordered behavior.

Note: Examples of drugs other than an antipsychotic or antidepressant, lithium carbonate or tranquilizer used to treat, manage or control psychiatric symptoms or disordered behavior include, but are not limited to, carbamazepine (Tegretol), which is typically used for control of seizures but may be used to treat a bi–polar disorder, and propanolol (Inderal), which is typically used to control high blood pressure but may be used to treat explosive behavior or anxiety state.

(20) "Response plan" means the plan of action developed by program staff under s. DHS 34.23 (5) (a) to assist a person experiencing a mental health crisis.

(21) "Stabilization services" means optional emergency mental health services under s. DHS 34.22 (4) which provide short–term, intensive, community–based services to avoid the need for inpatient hospitalization.

(22) "Telephone services" means telephone response services to provide callers with immediate information, counseling, support and referral and to screen for situations which require in–person responses.

(23) "Walk–in services" means emergency mental health services provided at one or more locations in the county where a person can come and receive information and immediate, face–to–face counseling, support and referral.

History: Cr. Register, September, 1996, No. 489, eff. 10–1–96; **corrections in (7), (9) and (13) made under s. 13.92 (4) b) 6. and 7., Stats., Register November 2008 No. 635.**

DHS 34.03 Certification. (1) APPLICATION. (a) A county department seeking to have its emergency mental health services program certified or recertified under this chapter, or a private agency contracting with a county department to operate an emergency mental health services program, shall submit a written application to the department.

(b) The application shall contain information and supporting documents required by the department.

Note: For a copy of the application form, write to the Program Certification Unit, Division of Disability and Elder Services, P.O. Box 2969, Madison, WI, 53701–2969.

(2) CERTIFICATION PROCESS. (a) On receipt of an application for initial certification or renewal of certification, the department shall do all of the following:

1. Review the application and its supporting documents.

2. Designate a representative to conduct an on–site survey of the program, including interviewing program staff.

(b) The department's designated representative shall do all of the following:

1. Interview a representative sample of present or former participants in the program, if any, provided that the participants indicate a willingness to be contacted.

2. Review the results of any grievances filed against the program pursuant to s. DHS 94.27 during the preceding period of certification.

3. Review a randomly selected, representative sample of client service records.

4. Review program policies and operational records, including the coordinated community services plan developed under s. DHS 34.22 (1) (a) or amended under s. DHS 34.22 (1) (c), and interview program staff to a degree sufficient to ensure that staff have knowledge of the statutes, administrative rules and standards of practice that may apply to the program and its participants.

(c) The certification survey under par. (b) shall be used to determine the extent of the program's compliance with the standards specified in this chapter. Certification decisions shall be based on a reasonable assessment of the program. The indicators by which compliance with the standards is determined shall include all of the following:

1. Statements made by the applicant or the applicant's designated agent, administrative personnel and staff members.

2. Documentary evidence provided by the applicant.

3. Answers to questions concerning the implementation of program policies and procedures, as well as examples of implementation provided to assist the department in making a judgment regarding the applicant's compliance with the standards in this chapter.

4. On–site observations by surveyors from the department.

5. Reports by participants regarding the program's operations.

6. Information from grievances filed by persons served by the program.

(d) The applicant shall make available for review by the designated representative of the department all documentation necessary to establish whether the program is in compliance with the standards in this chapter, including the written policies and procedures of the program, work schedules of staff, program appointment records, credentials of staff and treatment records.

(e) The designated representative of the department who reviews the documents under pars. (a) to (d) and interviews participants under par. (b) 1. shall preserve the confidentiality of all participant information contained in records reviewed during the certification process, in compliance with ch. DHS 92.

(3) ISSUANCE OF CERTIFICATION. (a) Within 60 days after receiving a completed application for initial certification or renewal of certification, the department shall do one of the following:

1. Certify the program if all requirements for certification are met.

2. Provisionally certify the program under sub. (10) if only minor deficiencies are found.

3. Deny certification if one or more major deficiencies are found.

(b) 1. If an application for certification is denied, the department shall provide the applicant reasons in writing for the denial and identify the requirements for certification which the program has not met.

2. A notice of denial shall state that the applicant has a right to request a hearing on that decision under sub. (12) and a right to submit a plan under par. (c) to correct program deficiencies in order to begin or continue operation of the program.

(c) 1. Within 10 days after receiving a notice of denial under par. (a), an applicant may submit to the department a plan to correct program deficiencies.

2. The plan of correction shall indicate the date on which the applicant will have remedied the deficiencies of the program. Within 60 days after that date, the department shall determine whether the corrections have been made. If the corrections have been made, the department shall certify the program.

(d) The department may limit the initial certification of a program to a period of one year.

(4) CONTENT OF CERTIFICATION. Certification shall be issued only for the specific program named in the application and may not be transferred to another entity. An applicant shall notify the department of all changes of administration, location, program name, services offered or any other change that may affect compliance with this section, no later than the effective date of the change.

(5) DATE OF CERTIFICATION. (a) The date of certification shall be the date that the department determines, by means of an on–site survey, that an applicant is in compliance with this section.

(b) The department may change the date of certification if the department has made an error in the certification process. A date of certification which is adjusted under this paragraph may not be

earlier than the date the written application under sub. (1) was submitted to the department.

(6) RENEWAL. (a) Upon application and the successful completion of a recertification survey under sub. (2) (b), the department may renew the program's certification for a period of up to 3 years unless sooner suspended or revoked or unless a shorter period of time is specified under sub. (3) (d) at the time of approval.

(b) The department shall send written notice of expiration and an application for renewal of certification to a certified program at least 30 days prior to expiration of the certification. If the department does not receive an application for renewal of certification before the expiration date, the program's certification shall be terminated.

(c) Upon receipt of an application for renewal of certification, the department shall conduct a survey as provided in sub. (2) (b) to determine the extent to which the program continues to comply with the requirements of this chapter.

(7) FEE FOR CERTIFICATION. The department shall establish an annual fee structure for the certification and recertification processes.

(8) ACTIONS AGAINST A CERTIFIED PROGRAM. The department may terminate, suspend, or refuse to renew a program's certification after providing the program with prior written notice of the proposed action which shall include the reason for the proposed action and notice of opportunity for a hearing under sub. (12), whenever the department finds that any of the following has occurred:

(a) A program staff member has had sexual contact, as defined in s. 940.225 (5) (b), Stats., or sexual intercourse, as defined in s. 940.225 (5) (c), Stats., with a client.

(b) A staff member of the program requiring a professional license or certificate claimed to be licensed or certified when he or she was not, has had his or her license or certificate suspended or revoked, or has allowed his or her license or certificate to expire.

(c) A program staff member has been convicted of a criminal offense related to the provision of or claiming reimbursement for services under the medicare program under 42 CFR 430 to 456, or under this state's or any other state's medical assistance program or any other third party payer. In this paragraph, "convicted" means that a judgment of conviction has been entered by a federal, state or local court, regardless of whether an appeal from that judgment is pending.

(d) A staff member has been convicted of a criminal offense related to the provision of care, treatment or services to a person who is mentally ill, developmentally disabled, alcoholic or drug dependent; or has been convicted of a crime against a child under ch. 948, Stats.

(e) The program has submitted, or caused to be submitted, statements for purposes of obtaining certification under this chapter which it knew or should have known to be false.

(f) The program failed to maintain compliance with or is in substantial non–compliance with one or more of the requirements set forth in this section.

(g) A program staff member signed billing or other documents as the provider of service when the service was not provided by the program staff member.

(h) There is no documentary evidence in a client's services file that the client received services for which bills had been submitted to a third party payer.

(9) INSPECTIONS. (a) The department may make announced and unannounced inspections of the program to verify continuing compliance with this chapter or to investigate complaints received regarding the services provided by the program.

(b) Inspections shall minimize any disruption to the normal functioning of the program.

(c) If the department determines during an inspection that the program has one or more major deficiencies, or it finds that any of the conditions stated in sub. (8) or (11) exist, it may suspend or terminate the program's certification.

(d) If the department determines during an inspection that the program has one or more minor deficiencies, it may issue a notice of deficiency to the program and offer the program provisional certification pursuant to sub. (10).

(e) If the department terminates or suspends the certification of a program, the department shall provide the program with a written notice of the reasons for the suspension or termination and inform the program of its right to a hearing on the suspension or termination as provided under sub. (12).

(10) PROVISIONAL CERTIFICATION PENDING IMPLEMENTATION OF A PLAN OF CORRECTION. (a) If, during a survey for renewal or an inspection, the department determines that minor deficiencies exist, the department shall issue a notice of deficiency to the program and offer the program a provisional certificate pending correction of the identified deficiencies.

(b) If a program wishes to continue operation after the issuance of a notice of deficiency under an offer for provisional certification, it shall, within 30 days of the receipt of the notice of deficiency, submit a plan of correction to the department identifying the specific steps which will be taken to remedy the deficiencies and the timeline in which these steps will be taken.

(c) If the department approves the plan of correction, it shall issue the program a provisional certificate for up to 60 days of operation, pending the accomplishment of the goals of the plan of correction.

(d) Prior to the expiration of the provisional certification, the department shall conduct an on–site inspection of the program to determine whether the proposed corrections have occurred.

(e) Following the on–site inspection, if the department determines that the goals of the approved plan of correction have been accomplished, it shall restore the program to full certification and withdraw the notice of deficiency.

(f) If the goals of the plan of correction have not been accomplished, the department may deny the application for renewal, suspend or terminate the program's certification or allow the program one extension of no more than 30 additional days to complete the plan of correction. If after this extension the program has still not remedied the identified deficiencies, the department shall deny the application for renewal, or suspend or terminate the certification.

(g) If the department denies the application for renewal or suspends or terminates the certification, the department shall provide the program with a written notice of the reasons for the action and inform the program of its right to a hearing under sub. (12).

(11) IMMEDIATE SUSPENSION. (a) The department may immediately suspend the certification of a program or bar from practice in a certified program any program staff member, pending a hearing on the matter, if any of the following has occurred:

1. Any of the licenses, certificates or required local, state or federal approvals of the program or program staff member have been revoked, suspended or expired.

2. The health or safety of a client is in imminent danger because of knowing failure of the program or a program staff member to comply with requirements of this chapter or any other applicable local, state or federal statute or regulation.

3. A staff member of the program has had sexual contact as defined in s. 940.225 (5) (b), Stats., or sexual intercourse, as defined in s. 940.225 (5) (c), Stats., with a client.

4. A staff member of the program has been convicted of client abuse under s. 940.285, 940.29 or 940.295, Stats.

(b) The department shall provide written notice to the program or program staff member of the nature of the immediate suspension, the acts or conditions on which the suspension is based, any

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additional remedies which the department will be seeking and information regarding the right of the program or the person under the suspension to a hearing pursuant to sub. (12).

(12) RIGHT TO A HEARING. (a) In the event that the department denies, terminates, suspends or refuses to renew certification, or gives prior notice of its intent to do so, an applicant or program may request a hearing under ch. 227, Stats.

(b) The request for a hearing shall be submitted in writing to and received by the department of administration's division of hearings and appeals within 30 days after the date on the notice required under sub. (3), (8), (9), (10) or (11).

Note: The mailing address of the Division of Hearings and Appeals is P.O. Box 7875, Madison, WI 53707.

(13) DISSEMINATION OF RESULTS. Upon completing action on an application for certification, staff of the department responsible for certification shall provide a summary of the results of the process to the applicant program, to the subunit within the department responsible for monitoring community mental health programs and to the county department in the county in which the program is located.

(14) VIOLATION AND FUTURE CERTIFICATION. A person with direct management responsibility for a program and all practitioners of a program who were knowingly involved in an act or acts which served as a basis for immediate termination shall be barred from providing service in a certified program for a period not to exceed 5 years. This applies to the following acts:

(a) Acts which result in termination of certification under s. DHS 106.06.

(b) Acts which result in conviction for a criminal offense related to services provided under s. 632.89, Stats.

(c) Acts involving an individual staff member who has terminated affiliation with a program and who removes or destroys participant records.

History: Cr. Register, September, 1996, No. 489, eff. 10–1–96; correction in (12) (b) made under s. 13.93 (2m) (b) 6., Stats., Register, September, 1996, No. 489; correction in (2) (c) and (14) (a) made under s. 13.93 (2m) (b) 7., Stats., Register, April, 2000, No. 532; correction in (11) (a) 3. made under s. 13.93 (2m) (b) 7., Stats., Register October 2004 No. 586; **corrections in (2) (b) 2., (c) and (14) (a) made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635.**

DHS 34.04 Waivers. (1) POLICY. (a) Except as provided in par. (b), the department may grant a waiver of any requirement in this chapter when the department determines that granting the waiver would not diminish the effectiveness of the services provided by the program, violate the purposes of the program or adversely affect clients' health, safety or welfare, and one of the following applies:

1. Strict enforcement of a requirement would result in unreasonable hardship on the provider or on a participant.

2. An alternative to a rule, including a new concept, method, procedure or technique, new equipment, new personnel qualifications or the implementation of a pilot project is in the interests of better participant care or program management.

(b) The department may not grant a waiver of client confidentiality or rights under this chapter, ch. DHS 92 or 94 or under other administrative rules, state statutes or federal regulations.

(2) APPLICATION. An application for a waiver under this section shall be made in writing to the department and shall specify all of the following:

(a) The requirement to be waived.

(b) The time period for which the waiver is requested.

(c) Any alternative action which the program proposes.

(d) The reason for the request.

(e) Assurances that the requested waiver would meet the requirements of sub. (1).

(3) GRANT OR DENIAL. (a) The department may require additional information from the program before acting on the request for a waiver.

(b) The department shall grant or deny each request for wavier in writing. Notice of denial shall contain the reasons for denial. If a notice of a denial is not issued within 60 days after the receipt of a completed request, the waiver shall be automatically approved.

(c) The department may impose any condition on the granting of a waiver which it deems necessary.

(d) The department may limit the duration of a waiver.

(e) No waiver may continue beyond the period of certification without a specific renewal of the waiver by the department.

(f) The department's decision to grant or deny a waiver shall be final.

History: Cr. Register, September, 1996, No. 489, eff. 10–1–96; correction in (1) (b) made under s. 13.93 (2m) (b) 7., Stats., Register, April, 2000, No. 532; **correction in (1) (b) made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635.**

Subchapter II — Standards for Basic Emergency Service Programs

DHS 34.10 Applicability. (1) A county may operate or contract for the operation of a basic emergency mental health services program.

(2) A basic emergency mental health services program operated by a county or under contract for a county shall comply with subch. I and this subchapter.

History: Cr. Register, September, 1996, No. 489, eff. 10–1–96.

DHS 34.11 Standards. (1) GENERAL. A basic emergency service mental health program shall:

(a) Provide immediate evaluation and mental health care to persons experiencing a mental health crisis.

(b) Make emergency services available within the county's mental health outpatient programs, mental health inpatient program or mental health day treatment program and shared with the other 2 programs.

(c) Be organized with assigned responsibility, staff and resources so that it is a clearly identifiable program.

(2) PERSONNEL. (a) Only psychiatrists, psychologists, social workers and other mental health personnel who are qualified under s. DHS 34.21 (3) (b) 1. to 15. may be assigned to emergency duty. Staff qualified under s. DHS 34.21 (3) (b) 16. to 19. may be included as part of a mobile crisis team if another team member is qualified under s. DHS 34.21 (3) (b) 1. to 15.

(b) Telephone emergency service may be provided by volunteers after they are carefully selected for aptitude and after a period of orientation and with provision for inservice training.

(c) A regular staff member of the program shall be available to provide assistance to volunteers at all times.

(d) Medical, preferably psychiatric, consultation shall be available to all staff members at all times.

(3) PROGRAM OPERATION AND CONTENT. (a) Emergency services shall be available 24 hours a day and 7 days a week.

(b) A program shall operate a 24–hour crisis telephone service staffed by mental health professionals or paraprofessionals, or by trained mental health volunteers backed up by mental health professionals. The crisis telephone service shall have a published telephone number, and that number shall be widely disseminated to community agencies and the public.

(c) A program shall provide face to face contact for crisis intervention. Face to face contact for crisis intervention may be provided as a function of the county's outpatient program during regular hours of outpatient program operation, with an on–call system for face to face contact for crisis intervention at all other times. A program shall have the capability of making home visits or seeing patients at other off–headquarter locations, and shall have the resources to carry out on–site interventions when this is clinically desirable.

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(d) When appropriate, emergency service staff may transfer clients to other county mental health programs.

History: Cr. Register, September, 1996, No. 489, eff. 10–1–96; correction in (2) (a) made under s. 13.93 (2m) (b) 7., Stats., Register October 2004 No. 586.

Subchapter III — Standards for Emergency Service Programs Eligible for Medical Assistance Program or Other Third Party Reimbursement

DHS 34.20 Applicability. (1) A county may operate or contract for the operation of an emergency mental health services program that is eligible for medical assistance program reimbursement or eligible for third–party payments under policies governed by s. 632.89, Stats.

(2) An emergency mental health services program eligible for medical assistance program reimbursement or eligible for third–party payments under policies governed by s. 632.89, Stats., that is operated by a county or under contract for a county shall comply with subch. I and this subchapter.

History: Cr. Register, September, 1996, No. 489, eff. 10–1–96.

DHS 34.21 Personnel. (1) POLICIES. (a) An emergency mental health services program shall have written personnel policies.

(b) A program shall maintain written documentation of employee qualifications and shall make that information available upon request for review by clients and their guardians or parents, where guardian or parent consent is required for treatment, and by the department.

(2) GENERAL QUALIFICATIONS. (a) Each employee shall have the ability and emotional stability to carry out his or her assigned duties.

(b) 1. An applicant for employment shall provide references regarding professional abilities from at least 2 people and, if requested by the program, references or transcripts from any post secondary educational institution attended and employment history reports or recommendations from prior employers.

2. References and recommendations shall be documented either by letter or in a signed and dated record of a verbal contact.

(c) A program shall review and investigate application information carefully to determine whether employment of the individual is in the best interests of the program's clients. This shall include a check of relevant and available conviction records. Subject to ss. 111.322 and 111.335, Stats., an individual may not have a conviction record.

Note: See s. 165.82, Stats., relating to the fee charged by the Wisconsin department of justice for a criminal records check.

(d) A program shall confirm an applicant's current professional licensure or certification if that licensure or certification is a condition of employment.

(3) QUALIFICATIONS OF CLINICAL STAFF. (a) In this subsection, "supervised clinical experience" means a minimum of one hour per week of supervision by a mental health professional qualified under par. (b) 1. to 9., gained after the person being supervised has received a master's degree.

(b) Program staff retained to provide mental health crisis services shall meet the following minimum qualifications:

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

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

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

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

5. Certified independent clinical social workers shall meet the qualifications established in ch. 457, Stats., and be certified by the examining board of social workers, marriage and family therapists and professional counselors.

6. Psychiatric nurses shall be licensed under ch. 441, Stats., as a registered nurse, have completed 3000 hours of supervised clinical experience and hold a master's degree in psychiatric mental health nursing from a graduate school of nursing accredited by the national league for nursing.

7. Professional counselors and marriage and family therapists shall meet the qualifications required established in ch. 457, Stats., and be certified by the examining board of social workers, marriage and family therapists and professional counselors.

8. Master's level clinicians shall be persons with a master's degree and coursework in areas directly related to providing mental health services, including clinical psychology, psychology, school or educational psychology, rehabilitation psychology, counseling and guidance or counseling psychology. Master's level clinicians shall have 3000 hours of supervised clinical experience or be listed in the national registry of health care providers in clinical social work, the national association of social workers register of clinical social workers, the national academy of certified mental health counselors or the national register of health service providers in psychology.

9. Post–master's level clinician interns shall have obtained a master's degree as provided in subd. 8. and have completed 1500 hours of supervised clinical experience, documented as provided in subd. 4.

10. Physician assistants shall be certified and registered pursuant to ss. 448.05 and 448.07, Stats., and chs. Med 8 and 14 and shall have had at least one year of experience working in a clinical mental health facility, or there shall be a specific plan for the person to acquire equivalent training and skills within 3 months after beginning employment.

11. Registered nurses shall be licensed under ch. 441, Stats., as a registered nurse, and shall have had training in psychiatric nursing and at least one year of experience working in a clinical mental health facility, or there shall be a specific plan for the person to acquire equivalent training and skills within 3 months after beginning employment.

12. Occupational therapists shall have obtained a bachelors degree and have completed a minimum of one year of experience working in a mental health clinical setting, and shall meet the requirements of s. DHS 105.28 (1).

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

14. Other qualified mental health professionals shall have at least a bachelor's degree in a relevant area of education or human services and a minimum of one year of combined experience providing mental health services, or work experience and training equivalent to a bachelor's degree including a minimum of 4 years of work experience providing mental health services.

Unofficial Text (See Printed Volume). Current through date and Register shown on Title Page.

15. Specialists in specific areas of therapeutic assistance, such as recreational and music therapists, shall have complied with the appropriate certification or registration procedures for their profession as required by state statute or administrative rule or the governing body regulating their profession, and shall have at least one year of experience in a mental health clinical setting.

16. Certified occupational therapy assistants shall have at least one year of experience in a mental health clinical setting and shall meet the requirements of s. DHS 105.28 (2).

17. Licensed practical nurses shall be licensed under ch. 441, Stats., as a licensed practical nurse and have had either training in psychiatric nursing or one year of experience working in a clinical mental health setting.

18. Mental health technicians shall be paraprofessionals who are employed on the basis of personal aptitude and life experience which demonstrates their ability to provide effective emergency mental health services.

19. Clinical students shall be students currently enrolled in an academic institution and working toward a degree in a professional area identified in this subsection who are providing services to the program under the supervision of a staff member meeting the qualifications under this subsection for that professional area.

(4) REQUIRED STAFF. (a) *Program administrator.* A program shall designate a program administrator, or equivalently titled person, who shall have overall responsibility for the operation of the program and for compliance of the program with this chapter.

(b) *Clinical director.* 1. The program shall have on staff a clinical director or similarly titled person qualified under sub. (3) (b) 1. or 2. who shall have responsibility for the mental health services provided by the program.

2. Either the clinical director or another person qualified under sub. (3) (b) 1. to 8. who has been given authority to act on the director's behalf shall be available for consultation in person or by phone at all times the program is in operation.

(5) ADDITIONAL STAFF. A program shall have staff available who are qualified under sub. (3) (b) 1. to 19. to meet the specific needs of the community as identified in the emergency mental health services plan under s. DHS 34.22 (1).

(6) VOLUNTEERS. A program may use volunteers to support the activities of the program staff. Volunteers who work directly with clients of the program or their families shall be supervised at all times by a program staff member qualified under sub. (3) (b) 1. to 8.

(7) CLINICAL SUPERVISION. (a) Each program shall develop and implement a written policy for clinical supervision to ensure that:

1. The emergency mental health services being provided by the program are appropriate and being delivered in a manner most likely to result in positive outcomes for the program's clients.

2. The effectiveness and quality of service delivery and program operations are improved over time by applying what is learned from the supervision of staff under this section, the results of client satisfaction surveys under s. DHS 34.26, the review of the coordinated community services plan under s. DHS 34.22 (1) (b), comments and suggestions offered by staff, clients, family members, other providers, members of the public and similar sources of information.

3. Professional staff have the training and experience needed to carry out the roles for which they have been retained, and receive the ongoing support, supervision and consultation they need in order to provide effective services for clients.

4. Any supervision necessary to enable professional staff to meet requirements for credentialing or ongoing certification under ch. 455, Stats. and related administrative rules and under other requirements promulgated by the state or federal government or professional associations is provided in compliance with those requirements.

(b) The clinical director is accountable for the quality of the services provided to participants and for maintaining appropriate supervision of staff and making appropriate consultation available for staff.

(c) Clinical supervision of individual program staff members includes direct review, assessment and feedback regarding each program staff member's delivery of emergency mental health services.

(d) Program staff providing emergency mental health services who have not had 3000 hours of supervised clinical experience, or who are not qualified under sub. (3) (b) 1. to 8., receive a minimum of one hour of clinical supervision per week or for every 30 clock hours of face to face mental health services they provide.

(e) Program staff who have completed 3000 hours of supervised clinical experience and who are qualified under sub. (3) (b) 1. to 8., participate in a minimum of one hour of peer clinical consultation per month or for every 120 clock hours of face-to-face mental health services they provide.

(f) Day to day clinical supervision and consultation for individual program staff is provided by mental health professionals qualified under sub. (3) (b) 1. to 8.

(g) Clinical supervision is accomplished by one or more of the following means:

1. Individual sessions with the staff member to review cases, assess performance and let the staff member know how he or she is doing.

2. Individual side-by-side sessions in which the supervisor is present while the staff person provides emergency mental health services and in which the supervisor assesses, teaches and gives advice regarding the staff member's performance.

3. Group meetings to review and assess staff performance and provide staff advice or direction regarding specific situations or strategies.

4. Other professionally recognized methods of supervision, such as review using videotaped sessions and peer review, if the other methods are approved by the department and are specifically described in the written policies of the program.

(h) Clinical supervision provided for individual program staff is documented in writing.

(i) Peer clinical consultation is documented in either a regularly maintained program record or a personal diary of the mental health professional receiving the consultation.

(j) The clinical director is permitted to direct a staff person to participate in additional hours of supervision or consultation beyond the minimum identified in this section in order to ensure that clients of the program receive appropriate emergency mental health services.

(k) A mental health professional providing clinical supervision is permitted to deliver no more than 60 hours per week of face-to-face mental health services and supervision in any combination of clinical settings.

(8) ORIENTATION AND ONGOING TRAINING. (a) *Orientation program.* Each program shall develop and implement an orientation program for all new staff and regularly scheduled volunteers. The orientation shall be designed to ensure that staff and volunteers know and understand all of the following:

1. Pertinent parts of this chapter.

2. The program's policies and procedures.

3. Job responsibilities for staff and volunteers in the program.

4. Applicable parts of chs. 48, 51 and 55, Stats., and any related administrative rules.

5. The provisions of s. 51.30, Stats., and ch. DHS 92 regarding confidentiality of treatment records.

6. The provisions of s. 51.61, Stats., and ch. DHS 94 regarding patient rights.

7. Basic mental health and psychopharmacology concepts applicable to crisis situations.

8. Techniques and procedures for assessing and responding to the emergency mental health service needs of persons who are suicidal, including suicide assessment, suicide management and prevention.

9. Techniques for assessing and responding to the emergency mental health service needs of persons who appear to have problems related to the abuse of alcohol or other drugs.

10. Techniques and procedures for providing non–violent crisis management for clients, including verbal de–escalation, methods for obtaining backup, and acceptable methods for self–protection and protection of the client and others in emergency situations.

(b) *Orientation training requirement.* 1. Each newly hired staff person who has had less than 6 months of experience in providing emergency mental health services shall complete a minimum of 40 hours of documented orientation training within 3 months after beginning work with the program.

2. Each newly hired staff person who has had 6 months or more of prior experience in providing emergency mental health service shall complete a minimum of 20 hours of documented orientation training within 3 months after beginning work with the program.

3. Each volunteer shall receive at least 40 hours of orientation training before working directly with clients or their families.

(c) *Ongoing training program.* Each program shall develop and implement an ongoing training program for all staff, which may include but is not limited to:

1. Time set aside for in–service training.

2. Presentations by community resource staff from other agencies.

3. Attendance at conferences and workshops.

4. Discussion and presentation of current principles and methods of providing emergency mental health services.

(d) *Ongoing training requirement.* 1. Each professional staff person shall participate in at least the required number of hours of annual documented training necessary to retain certification or licensure.

2. Staff shall receive at least 8 hours per year of inservice training on emergency mental health services, rules and procedures relevant to the operation of the program, compliance with state and federal regulations, cultural competency in mental health services and current issues in client's rights and services. Staff who are shared with other community mental health programs may apply inservice hours received in those programs toward this requirement.

(e) *Training records.* A program shall maintain as part of its central administrative records updated, written copies of its orientation program, evidence of current licensure and certification of professional staff, and documentation of orientation and ongoing training received by program staff and volunteers.

History: Cr. Register, September, 1996, No. 489, eff. 10–1–96; corrections in (3) (b) 12., (8) (a) 5. and 16. made under s. 13.93 (2m) (b) 7., Stats., Register, April, 2000, No. 532; **corrections in (3) (b) 12., 16., (8) (a) 5. and 6. made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635.**

DHS 34.22 Services. **(1)** PLAN FOR COORDINATION OF SERVICES. (a) Each emergency mental health services program shall prepare a written plan for providing coordinated emergency mental health services within the county. The coordinated emergency mental health services plan shall include all of the following:

1. A description of the nature and extent of the emergency mental health service needs in the county.

2. A description of the county's overall system of care for people with mental health problems.

3. An analysis of how the services to be offered by the program have been adapted to address the specific strengths and needs of the county's residents.

4. A description of the services the program offers, the criteria and priorities it applies in making decisions during the assessment and response stages, and how individuals, families and other providers and agencies can obtain program services.

5. A description of the specific responsibilities, if any, which other mental health providers in the county will have in providing emergency mental health services, and a process to be used which addresses confidentiality and exchange of information to ensure rapid communication between the program and the other providers and agencies.

6. Any formal or informal agreements to receive or provide backup coverage which have been made with other providers and agencies, and any role the program may play in situations in which an emergency protective placement is being sought for a person under s. 55.135, Stats.

7. Criteria for selecting and identifying clients who present a high risk for having a mental health crisis, and a process for developing, maintaining and implementing crisis plans under s. DHS 34.23 (7) on their behalf.

8. A description of the agreements, including any written memoranda of understanding which the program has made with law enforcement agencies, hospital emergency rooms within the county, the Winnebago or Mendota mental health institute, if used for hospitalization by the county, or the county corporation counsel, which do all of the following:

a. Outline the role program staff will have in responding to calls in which a person may be in need of hospitalization, including providing on–site and over the phone assistance.

b. Describe the role staff will have in screening persons in crisis situations to determine the need for hospitalization.

c. Provide a process for including the emergency mental health services program in planning to support persons who are being discharged from an inpatient stay, or who will be living in the community under a ch. 51, Stats., commitment.

(b) If a program provides emergency services in conjunction with alcohol and other drug abuse (AODA) services, child protective services or any other emergency services, the coordinated emergency mental health services plan shall describe how the services are coordinated and delivered.

(c) Prior to application for recertification under s. DHS 34.03 (6), a program shall review its coordinated emergency mental health services plan and adjust it based on information received through surveys under s. DHS 34.26, consultation with other participants in the plan's development and comments and suggestions received from other resources, including staff, clients, family members, other service providers and interested members of the public.

(2) GENERAL OBJECTIVES FOR EMERGENCY MENTAL HEALTH SERVICES. A program providing emergency mental health services shall have the following general objectives:

(a) To identify and assess an individual's immediate need for mental health services to the extent possible and appropriate given the circumstances in which the contact with or referral to the program was made.

(b) To respond to that need by providing a service or group of services appropriate to the client's specific strengths and needs to the extent they can be determined in a crisis situation.

(c) When necessary and appropriate, to link an individual who is receiving emergency mental health services with other community mental health service providers for ongoing treatment and support.

(d) To make follow–up contacts, as appropriate, in order to determine if needed services or linkages have been provided or if additional referrals are required.

(3) REQUIRED EMERGENCY MENTAL HEALTH SERVICES. An emergency mental health services program shall provide or contract for the delivery of all of the following services:

(a) *Telephone service.* A telephone service providing callers with information, support, counseling, intervention, emergency service coordination and referral for additional, alternative or ongoing services. The telephone service shall do all of the following:

1. Be directed at achieving one or more of the following outcomes:

a. Immediate relief of distress in pre–crisis and crisis situations.

b. Reduction of the risk of escalation of a crisis.

c. Arrangements for emergency onsite responses when necessary to protect individuals in a mental health crisis.

d. Referral of callers to appropriate services when other or additional intervention is required.

2. Be available 24 hours a day and 7 days a week and have a direct link to a mobile crisis service, a law enforcement agency or some other program which can provide an immediate, onsite response to an emergency situation on a 24 hour a day, 7 day a week basis.

3. Be provided either by staff qualified under s. DHS 34.21 (3) (b) 1. to 19. or by fully trained volunteers. If the telephone service is provided by volunteers or staff qualified under s. DHS 34.21 (3) (b) 9. to 19., a mental health professional qualified under s. DHS 34.21 (3) (b) 1. to 8. shall be on site or constantly available by telephone to provide supervision and consultation.

4. If staff at a location other than the program, such as a law enforcement agency or a 911 center, are the first to answer calls to the telephone service, ensure that those staff are trained by program staff in the correct way to respond to persons in need, are capable of immediately transferring the call to an appropriate mental health professional and identify themselves as being part of the emergency mental health services system rather than the law enforcement agency or other organization where the calls are being picked up.

(b) *Mobile crisis service.* A mobile crisis service that can provide onsite, in–person intervention for individuals experiencing a mental health crisis. The mobile crisis service shall do all of the following:

1. Be directed at achieving one or more of the following outcomes:

a. Immediate relief of distress in crisis situations.

b. Reduction in the level of risk present in the situation.

c. Assistance provided to law enforcement officers who may be involved in the situation by offering services such as evaluation criteria for emergency detention under s. 51.15, Stats.

d. Coordination of the involvement of other mental health resources which may respond to the situation.

e. Referral to or arrangement for any additional mental health services which may be needed.

f. Providing assurance through follow up contacts that intervention plans developed during the crisis are being carried out.

2. Be available for at least 8 hours a day, 7 days a week during those periods of time identified in the emergency mental health services plan when mobile services would be most needed.

3. Have the capacity for making home visits and for seeing clients at other locations in the community. Staff providing mobile services shall be qualified under s. DHS 34.21 (3) (b) 1. to 15., except that staff qualified under s. DHS 34.21 (3) (b) 15. to 19. may be included as part of a mobile crisis team if another team member is qualified under s. DHS 34.21 (3) (b) 1. to 14. A mental health professional qualified under s. DHS 34.21 (3) (b) 1. to 8. shall either provide in–person supervision or be available to provide consultation by phone.

(c) *Walk–in services.* A walk–in service that provides face–to–face support and intervention at an identified location or locations on an unscheduled basis. A walk–in service shall do all of the following:

1. Be directed at achieving one or more of the following outcomes:

a. Immediate relief of distress and reducing the risk of escalation in pre–crisis and crisis situations.

b. Referral to or arrangement for any additional mental health services which may be needed.

c. Self–directed access to mental health services.

2. Be available for at least 8 hours a day, 5 days a week, excluding holidays. The specific location or locations where walk–in services are to be offered and the times when the services are to be offered shall be based on a determination of greatest community need as indicated in the coordinated emergency mental health services plan developed under sub. (1).

3. Be provided by the program or through a contract with another mental health provider, such as an outpatient mental health clinic. If the walk–in services are delivered by another provider, the contract shall make specific arrangements to ensure that during the site's hours of operation clients experiencing mental health crises are able to obtain unscheduled, face to face services within a short period of time after coming to the walk–in site.

4. Be provided by persons qualified under s. DHS 34.21 (3) (b) 1. to 14. However, persons qualified under s. DHS 34.21 (3) (b) 9. to 14. shall work under the supervision of a mental health professional qualified under s. DHS 34.21 (3) (b) 1. to 8.

(d) *Short–term voluntary or involuntary hospital care.* Short–term voluntary or involuntary hospital care when less restrictive alternatives are not sufficient to stabilize an individual experiencing a mental health crisis. Short–term voluntary or involuntary hospital care shall do all of the following:

1. Be directed at achieving one or more of the following objectives:

a. Reduction or elimination of the symptoms of mental illness contributing to the mental health crisis.

b. Coordination of linkages and referrals to community mental health resources which may be needed after the completion of the inpatient stay.

c. Prevention of long–term institutionalization.

d. Assistance provided in making the transition to a less restrictive living arrangement when the emergency has passed.

2. Be available 24 hours a day and 7 days a week.

3. Be available for both voluntary admissions and for persons under emergency detention under s. 51.15, Stats., or commitment under s. 51.20, Stats.

(e) *Linkage and coordination services.* Linkage and coordination services to support cooperation in the delivery of emergency mental health care in the county in which the program operates. Linkage and coordination services shall do all of the following:

1. Be provided for the purpose of achieving one or more of the following outcomes:

a. Connection of a client with other programs to obtain ongoing mental health treatment, support and services, and coordination to assist the client and his or her family during the period of transition from emergency to ongoing mental health services.

b. Coordination with other mental health providers in the community for whom the program is designated as crisis care backup, to ensure that adequate information about the other providers' clients is available if a crisis occurs.

c. Coordination with law enforcement, hospital emergency room personnel and other county service providers to offer assistance and intervention when other agencies are the initial point of contact for a person in a mental health crisis.

2. Be available 24 hours a day, 7 days a week as a component of the services offered under pars. (a) to (d).

3. Be provided by persons qualified under s. DHS 34.21 (3) (b) 1. to 19.

(f) *Services for children and adolescents and their families.* Each program shall have the capacity to provide the services identified in pars. (a) to (e) in ways that meet the unique needs of young children and adolescents experiencing mental health crises and their families. Services for young children and adolescents and their families shall do all of the following:

1. Be provided for the purpose of achieving one or more of the following outcomes:

a. Resolution or management of family conflicts when a child has a mental health crisis and prevention of out–of–home placement of the child.

b. Improvement in the young child's or adolescent's coping skills and reduction in the risk of harm to self or others.

c. Assistance given the child and family in using or obtaining ongoing mental health and other supportive services in the community.

2. Include any combination of telephone, mobile, walk–in, hospitalization and stabilization services determined to be appropriate in the coordinated emergency mental health services plan developed under sub. (1), which may be provided independently or in combination with services for adults.

3. Be provided by staff who either have had one year of experience providing mental health services to young children or adolescents or receive a minimum of 20 hours of training in providing the services within 3 months after being hired, in addition to meeting the requirements for providing the general type of mental health services identified in pars. (a) to (e).

4. Be provided by staff who are supervised by a staff person qualified under s. DHS 34.21 (3) (b) 1. to 8. who has had at least 2 years of experience in providing mental health services to children. A qualified staff person may provide supervision either in person or be available by phone.

(4) OPTIONAL STABILIZATION SERVICES. (a) In addition to services required under sub. (3), a program may provide stabilization services for an individual for a temporary transition period, with weekly reviews to determine the need for continued stabilization services, in a setting such as an outpatient clinic, school, detention center, jail, crisis hostel, adult family home, community based residential facility (CBRF) or a foster home or group home or child caring institution (CCI) for children, or the individual's own home. A program offering stabilization services shall do all of the following:

1. Provide those services for the purpose of achieving one or more of the following outcomes:

a. Reducing or eliminating an individual's symptoms of mental illness so that the person does not need inpatient hospitalization.

b. Assisting in the transition to a less restrictive placement or living arrangement when the crisis has passed.

2. Identify the specific place or places where stabilization services are to be provided and the staff who will provide the services.

3. Prepare written guidelines for the delivery of the services which address the needs of the county as identified in the coordinated emergency mental health services plan developed under sub. (1) and which meet the objectives under subd. 1.

4. Have staff providing stabilization services who are qualified under s. DHS 34.21 (3) (b) 1. to 19., with those staff qualified under s. DHS 34.21 (3) (b) 9. to 19. supervised by a person qualified under s. DHS 34.21 (3) (b) 1. to 8.

(b) If a program elects to provide stabilization services, the department shall provide or contract for on–site consultation and support as requested to assist the program in implementing those services.

(c) The county department of the local county may designate a stabilization site as a receiving facility for emergency detention under s. 51.15, Stats., provided that the site meets the applicable standards under this chapter.

(5) OTHER SERVICES. Programs may offer additional services, such as information and referral or peer to peer telephone support designed to address needs identified in the coordinated emergency mental health services plan under sub. (1), but the additional services may not be provided in lieu of the services under sub. (3).

(6) SERVICES PROVIDED UNDER CONTRACT BY OTHER PROVIDERS. If any service under subs. (3) to (5) is provided under contract by another provider, the program shall maintain written documentation of the specific person or organization who has agreed to provide the service and a copy of the formal agreement for assistance.

(7) SERVICES IN COMBINED EMERGENCY SERVICES PROGRAMS. Counties may choose to operate emergency service programs which combine the delivery of emergency mental health services with other emergency services, such as those related to the abuse of alcohol or other drugs, those related to accidents, fires or natural disasters, or those for children believed to be at risk because of abuse or neglect, if the services identified in sub. (3) are available as required and are delivered by qualified staff.

History: Cr. Register, September, 1996, No. 489, eff. 10–1–96; correction in (3) (c) 4. made under s. 13.93 (2m) (b) 7., Stats., Register October 2004 No. 586; **correction in (1) (a) 6. made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635.**

DHS 34.23 Assessment and response. (1) ELIGIBILITY FOR SERVICES. To receive emergency mental health services, a person shall be in a mental health crisis or be in a situation which is likely to develop into a crisis if supports are not provided.

(2) WRITTEN POLICIES. A program shall have written policies which describe all of the following:

(a) The procedures to be followed when assessing the needs of a person who requests or is referred to the program for emergency mental health services and for planning and implementing an appropriate response based on the assessment.

(b) Adjustments to the general procedures which will be followed when a person referred for services has a sensory, cognitive, physical or communicative impairment which requires an adaptation or accommodation in conducting the assessment or delivering services or when a person's language or form of communication is one in which staff of the program are not fluent.

(c) The type of information to be obtained from or about a person seeking services.

(d) Criteria for deciding when emergency mental health services are needed and for determining the type of service to be provided.

(e) Procedures to be followed for referral to other programs when a decision is made that a person's condition does not constitute an actual or imminent mental health crisis.

(f) Procedures for obtaining immediate backup or a more thorough evaluation when the staff person or persons making the initial contact require additional assistance.

(g) Procedures for coordinating referrals, for providing and receiving backup and for exchanging information with other mental health service providers in the county, including the development of crisis plans for individuals who are at high risk for crisis.

(h) Criteria for deciding when the situation requires a face–to–face response, the use of mobile crisis services, stabilization services, if available, or hospitalization.

(i) Criteria and procedures for notifying other persons, such as family members and people with whom the person is living, that he or she may be at risk of harming himself or herself or others.

(j) If the program dispenses psychotropic medication, procedures governing the prescription and administration of medications to clients and for monitoring the response of clients to their medications.

(k) Procedures for reporting deaths of clients which appear to be the result of suicide, reaction to psychotropic medications or the use of physical restraints or seclusion, as required by s. 51.64 (2), Stats., and for:

1. Supporting and debriefing family members, staff and other concerned persons who have been affected by the death of a client.

2. Conducting a clinical review of the death which includes getting the views of a mental health professional not directly involved in the individual's treatment who has the training and experience necessary to adequately examine the specific circumstances surrounding the death.

(3) INITIAL CONTACT. During an initial contact with an individual who may be experiencing a mental health crisis, staff of the program shall gather sufficient information, as appropriate and possible given the nature of the contact, to assess the individual's need for emergency mental health services and to prepare and implement a response plan, including but not limited to any available information regarding:

(a) The individual's location, if the contact is by telephone.

(b) The circumstances resulting in the contact with the program, any events that may have led up to the contact, the apparent severity of the immediate problem and the potential for harm to self or others.

(c) The primary concerns of the individual or a person making the initial contact on behalf of the individual.

(d) The individual's current mental status and physical condition, any over-the-counter, prescription or illicit drugs the individual may have taken, prior incidents of drug reaction or suicidal behavior and any history of the individual's abuse of alcohol or other drugs.

(e) If the individual is threatening to harm self or others, the specificity and apparent lethality of the threat and the availability of the means to carry out the threat, including the individual's access to any weapon or other object which may be used for doing harm.

(f) If the individual appears to have been using alcohol or over-the-counter, prescription or illicit drugs, the nature and amount of the substance ingested.

(g) The names of any people who are or who might be available to support the individual, such as friends, family members or current or past mental health service providers.

(4) DETERMINATION OF NEED. (a) Based on an assessment of the information available after an initial contact, staff of the program shall determine whether the individual is in need of emergency mental health services and shall prepare and implement any necessary response.

(b) If the person is not in need of emergency mental health services, but could benefit from other types of assistance, staff shall, if possible, refer the person to other appropriate service providers in the community.

(5) RESPONSE PLAN. (a) If the person is in need of emergency mental health services, staff of the program shall prepare and initiate a response plan consisting of services and referrals necessary to reduce or eliminate the person's immediate distress, de-escalate the present crisis, and help the person return to a safe and more stable level of functioning.

(b) The response plan shall be approved as medically necessary by a mental health professional qualified under s. DHS 34.21 (3) (b) 1. or 2. either before services are delivered or within 5 days after delivery of services, not including Saturdays, Sundays or legal holidays.

(6) LINKAGE AND FOLLOW UP. (a) After a response plan has been implemented and the person has returned to a more stable level of functioning, staff of the program shall determine whether any follow-up contacts by program staff or linkages with other providers in the community are necessary to help the person maintain stable functioning.

(b) If ongoing support is needed, the program shall provide follow-up contacts until the person has begun to receive assistance from an ongoing service provider, unless the person does not consent to further services.

(c) Follow-up and linkage services may include but are not limited to all of the following:

1. Contacting the person's ongoing mental health providers or case manager, if any, to coordinate information and services related to the person's care and support.

2. If a person has been receiving services primarily related to the abuse of alcohol or other drugs or to address needs resulting from the person's developmental disability, or if the person appears to have needs in either or both of these areas, contacting a service provider in the area of related need in order to coordinate information and service delivery for the person.

3. Conferring with family members or other persons providing support for the person to determine if the response and follow-up are meeting the client's needs.

4. Developing a new crisis plan under sub. (7) or revising an existing plan to better meet the person's needs based on what has been learned during the mental health crisis.

(7) CRISIS PLAN. (a) The program shall prepare a crisis plan for a person who is found to be at high risk for a recurrent mental health crisis under the criteria established in the coordinated community services plan under s. DHS 34.22 (1) (a) 7.

(b) The crisis plan shall include whenever possible all of the following:

1. The name, address and phone number of the case manager, if any, coordinating services for the person.

2. The address and phone number where the person currently lives, and the names of other individuals with whom the person is living.

3. The usual work, school or activity schedule followed by the person.

4. A description of the person's strengths and needs, and important people or things in the person's life which may help staff to develop a rapport with the person in a crisis and to fashion an appropriate response.

5. The names and addresses of the person's medical and mental health service providers.

6. Regularly updated information about previous emergency mental health services provided to the person.

7. The diagnostic label which is being used to guide treatment for the person, any medications the person is receiving and the physician prescribing them.

8. Specific concerns that the person or the people providing support and care for the person may have about situations in which it is possible or likely that the person would experience a crisis.

9. A description of the strategies which should be considered by program staff in helping to relieve the person's distress, de-escalate inappropriate behaviors or respond to situations in which the person or others are placed at risk.

10. A list of individuals who may be able to assist the person in the event of a mental health crisis.

(c) A person's crisis plan shall be developed in cooperation with the client, his or her parents or guardian where their consent is required for treatment, the case manager, if any, and the people and agencies providing treatment and support for the person, and shall identify to the extent possible the services most likely to be

effective in helping the person resolve or manage a crisis, given the client's unique strengths and needs and the supports available to him or her.

(d) The crisis plan shall be approved as medically necessary by a mental health professional qualified under s. DHS 34.21 (3) (b) 1. or 2.

(e) Program staff shall use a method for storing active crisis plans which allows ready access in the event that a crisis arises, but which also protects the confidentiality of the person for whom a plan has been developed.

(f) A crisis plan shall be reviewed and modified as necessary, given the needs of the client, but at least once every 6 months.

(8) SERVICE NOTES. As soon as possible following a client contact, program staff shall prepare service notes which identify the person seeking a referral for emergency mental health services, describe the crisis and identify or describe all of the following:

(a) The time, place and nature of the contact and the person initiating the contact.

(b) The staff person or persons involved and any non–staff persons present or involved.

(c) The assessment of the person's need for emergency mental health services and the response plan developed based on the assessment.

(d) The emergency mental health services provided to the person and the outcomes achieved.

(e) Any provider, agency or individual to whom a referral was made on behalf of the person experiencing the crisis.

(f) Follow–up and linkage services provided on behalf of the person.

(g) If there was a crisis plan under sub. (7) on file for the person, any proposed amendments to the plan in light of the results of the response to the request for services.

(h) If it was determined that the person was not in need of emergency mental health services, any suggestions or referrals provided on behalf of the person.

History: Cr. Register, September, 1996, No. 489, eff. 10–1–96.

DHS 34.24 Client service records. (1) MAINTENANCE AND SECURITY. (a) A program shall maintain accurate records of services provided to clients, including service notes prepared under s. DHS 34.23 (8) and crisis plans developed under s. DHS 34.23 (7).

(b) The program administrator is responsible for the maintenance and security of client service records.

(2) LOCATION AND FORMAT. Client service records shall be kept in a central place that is not accessible to persons receiving care from the program, shall be held safe and secure, shall be managed in accordance with standard professional practices for the maintenance of client mental health records, and shall be arranged in a format which provides for consistent recordkeeping within the program and which facilitates accurate and efficient record retrieval.

(3) DISPOSITION UPON PROGRAM CLOSING. An organization providing emergency mental health services under contract with the county shall establish a written plan for maintenance and disposition of client service records in the event that the program loses its certification or otherwise terminates operations. The plan shall include a written agreement with the county department to have the county department act as the repository and custodian of the client records for the required retention period or until the records have been transferred to a new program.

(4) CONFIDENTIALITY. Maintenance, release, retention and disposition of client service records shall be kept confidential as required under s. 51.30, Stats., and ch. DHS 92.

History: Cr. Register, September, 1996, No. 489, eff. 10–1–96; correction in (4) made under s. 13.93 (2m) (b) 7., Stats., Register, April, 2000, No. 532; **correction in (4) made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635.**

DHS 34.25 Client rights. (1) POLICIES AND PROCEDURES. All programs shall comply with s. 51.61, Stats., and ch. DHS 94 on the rights of clients.

(2) CONFLICT RESOLUTION. (a) A program shall inform clients and their parents or guardian, where the consent of the parent or guardian is required for services, that they have the option of using either formal or informal procedures for resolving complaints and disagreements.

(b) A program shall establish a process for informal resolution of concerns raised by clients, family members and other agencies involved in meeting the needs of clients.

(c) A program shall establish a grievance resolution system which meets the requirements under s. DHS 94.27 for a grievance resolution system.

History: Cr. Register, September, 1996, No. 489, eff. 10–1–96; **corrections in (1) and (2) (c) made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635.**

DHS 34.26 Client satisfaction. (1) Each program shall have a process for collecting and recording indications of client satisfaction with the services provided by the program. This process may include any of the following:

(a) Short in–person interviews with persons who have received emergency services.

(b) Evaluation forms to be completed and returned by clients after receiving services.

(c) Follow–up phone conversations.

(2) Information about client satisfaction shall be collected in a format which allows the collation and comparison of responses and which protects the confidentiality of those providing information.

(3) The process for obtaining client satisfaction information shall make allowance for persons who choose not to respond or are unable to respond.

(4) Prior to a recertification survey under s. DHS 34.03 (6) (c), the program administrator shall prepare and maintain on file a report summarizing the information received through the client satisfaction survey process and indicating:

(a) Any changes in program policies and operations or to the coordinated community services plan under s. DHS 34.22 (1) made in response to client views.

(b) Any suggestions for changes in the requirements under this chapter which would permit programs to improve services for clients.

History: Cr. Register, September, 1996, No. 489, eff. 10–1–96.

wisconsin Medicaid update
and BadgerCare
July 2006 • No. 2006-55
Wisconsin Medicaid and BadgerCare Information for Providers

To:
Crisis Intervention Providers
HMOs and Other Managed Care Programs

Crisis Intervention Services

This *Wisconsin Medicaid and BadgerCare Update* consolidates all of the information for crisis intervention services. Providers should use this *Update* in conjunction with the General Information section of the Mental Health and Substance Abuse Services Handbook and the All-Provider Handbook.

The purpose of this *Wisconsin Medicaid and BadgerCare Update* is to consolidate all of the information for crisis intervention services. This *Update* replaces the following crisis intervention services publications:

- The October 2005 *Update* (2005-63), titled "Rate Changes for Services Receiving Only Federal Funds."
- The March 2004 *Update* (2004-11), titled "Billing policy change for crisis intervention services provided to recipients enrolled in the Independent Care Health Plan and Medicaid-contracted HMOs."
- The August 2003 *Update* (2003-82), titled "Changes to local codes and paper claims for crisis intervention services as a result of HIPAA."
- The September 2000 *Update* (2000-40), titled "Change to crisis intervention covered services."
- Part H, Division VI, the Mental Health Crisis Intervention Services Handbook.

Guidelines for Crisis Stabilization Services

Wisconsin Medicaid is introducing guidelines for stabilization services effective upon receipt of this *Update*.

These guidelines were developed in collaboration with the statewide crisis network. Refer to Attachment 2 of this *Update* for the guidelines.

Medicaid State Share Paid by County/Tribal Social or Human Services Agency

The county/tribal social or human services agency pays the nonfederal share for this benefit.

Certification

According to s. 49.45(41), Wis. Stats., Wisconsin Medicaid may pay only county/tribal social or human services agencies to provide crisis intervention services. County/tribal social or human services agencies, or the agencies

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with which they contract to actually provide crisis intervention services, must be certified under HFS 34, Wis. Admin. Code.

Division of Disability and Elder Services Certification

To be reimbursed for providing this benefit to Medicaid recipients, a provider is first required to be certified by the Department of Health and Family Services (DHFS), Division of Disability and Elder Services (DDES), Bureau of Quality Assurance (BQA) for crisis intervention under HFS 34, Subchapter III, Wis. Admin. Code. For information regarding this certification, providers may contact the DHFS, DDES by telephone at (608) 243-2025 or by mail at the following address:

> Division of Disability and Elder Services
> Bureau of Quality Assurance
> Program Certification Unit
> 2917 International Ln Ste 300
> Madison WI 53704

A provider meeting DHFS, DDES certification may apply for Medicaid certification.

Wisconsin Medicaid Certification

Agencies should complete the Wisconsin Medicaid Mental Health/Substance Abuse Agency Certification Packet. Refer to Attachment 1 for Medicaid certification requirements and provider numbers assigned for agencies providing crisis intervention services.

A county/tribal social or human services agency wishing to receive Medicaid reimbursement for crisis intervention is required to obtain an agency resolution. The resolution must state that the county/tribal social or human services agency agrees to make available the nonfederal share needed for Medicaid reimbursement of crisis intervention services. Agency resolutions, such as 51.42 or human services board resolutions, meet this requirement.

Providers may initiate Medicaid certification for crisis intervention by doing one of the following:

- Downloading the Wisconsin Medicaid Mental Health/Substance Abuse Agency Certification Packet from the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/*.
- Calling Provider Services at (800) 947-9627 or (608) 221-9883.
- Writing to the following address:

> Wisconsin Medicaid
> Provider Maintenance
> 6406 Bridge Rd
> Madison WI 53784-0006

Refer to the General Information section of the Mental Health and Substance Abuse Services Handbook for more information about provider certification, provider numbers, and provider responsibilities.

Subcontracting for Crisis Intervention Services

A Medicaid-certified crisis intervention provider, as part of its certification under HFS 34, Subchapter III, Wis. Admin. Code, may contract with other qualified providers for any part of its crisis intervention service. However, the Medicaid-certified provider retains all legal and fiscal responsibility for the services provided by subcontractors.

Wisconsin Medicaid sends provider materials to Medicaid-certified providers only. It is the certified provider's responsibility to ensure that the contractor is qualified and provides services and maintains records in accordance with the Medicaid requirements for the provision of crisis intervention services. For more information on documentation as it relates to crisis intervention services, refer to Attachment 2.

A Medicaid-certified crisis intervention provider, as part of its certification under HFS 34, Subchapter III, Wis. Admin. Code, may contract with other qualified providers for any part of its crisis intervention service.

The Medicaid-certified provider is responsible for ensuring that its contractors do the following:

- Meet all program requirements.
- Receive copies of Medicaid publications.

Although the contracted crisis intervention agency may submit claims to Wisconsin Medicaid using the certified provider's Medicaid number if the provider has authorized this, Wisconsin Medicaid payment is made only to the certified provider.

Billing and Nonbilling Provider Numbers

When the county is the crisis intervention agency, a billing/performing provider number is issued to the county that is used to submit claims to Wisconsin Medicaid, and no additional provider number is required on the claim form. Individuals providing services within the crisis intervention agency do not need to be individually certified.

Wisconsin Medicaid covers an initial contact and assessment for any recipient contacting the crisis intervention provider.

Counties that have been assigned more than one crisis intervention billing provider number prior to this *Update* may submit claims as normal; no other counties will be assigned more than one billing provider number for crisis intervention services.

Recipient Eligibility for Crisis Intervention Services

Initial Contact and Assessment

Wisconsin Medicaid covers an initial contact and assessment for any recipient contacting the crisis intervention provider. For recipients not in crisis, the length of the assessment must be no longer than what is necessary to determine that no crisis or emergency exists and to make appropriate referrals, when indicated.

All Other Crisis Intervention Services

Wisconsin Medicaid covers all other crisis intervention services only if the provider documents that both of the following are true:

- The recipient is in a crisis or situation that may develop into a crisis if professional supports are not provided.
- The provider can expect to reduce the need for institutional treatment or improve the recipient's level of functioning.

Recipients in Certified Community Support Programs

Wisconsin Medicaid covers crisis intervention services for recipients receiving Medicaid-funded community support program (CSP) services when any of the following is true:

- The crisis intervention program has a formal arrangement with the CSP to provide crisis services to CSP enrollees.
- The crisis intervention services are delivered according to a crisis plan developed by the crisis intervention program and the CSP.
- The crisis intervention services do not duplicate CSP services.

The crisis intervention program may not claim Medicaid reimbursement if reimbursement for the crisis intervention services is claimed through the CSP.

Recipients in Nursing Facilities

Recipients in nursing facilities are eligible for all crisis intervention covered services.

Recipients Being Discharged from a Hospital or Residential Care Centers for Children and Youth

Recipients being discharged from a hospital or residential care center are eligible for crisis intervention services only if the provider documents the following in the recipient's records:

- Why the recipient is likely to experience an emergency or a crisis if the crisis intervention services are not provided.
- Why other services, which might maintain the recipient in the community, are not available and when such services are likely to be available.

The following are the only covered crisis intervention services for recipients in an inpatient hospital or a residential child care center:

- Development of a crisis plan.
- Services to assist the recipient in making the transition to the least restrictive level of care.

When Recipients Are Ineligible for Crisis Intervention Services

Recipients are not eligible for any Medicaid services, including crisis intervention, during periods of time when they are in jail or secure detention. This includes when recipients receive a day or overnight pass from these facilities. Also, recipients between ages 21 and 64 are not eligible for any Medicaid services while they are in an institution that is deemed an "institute for mental disease" (IMD). Providers may provide services during these periods; however, they are not Medicaid reimbursable.

Recipients Enrolled in State-Contracted Managed Care Organizations

Wisconsin Medicaid and BadgerCare recipients enrolled in state-contracted managed care organizations may receive crisis intervention services on a fee-for-service basis. These services are not part of the HMO's capitation rate. If a recipient is in need of crisis intervention services, recipients should be referred to their county/tribal social or human services agency that may provide these services on a fee-for-service basis.

If a recipient enrolled in Children Come First or Wraparound Milwaukee is in need of crisis intervention, the recipient may receive the service on a fee-for-service basis since this service is not part of the capitation rate. Recipients should be referred to their county/ tribal social or human services agency that may provide this service on a fee-for-service basis.

Recipients are not eligible for any Medicaid services, including crisis intervention, during periods of time when they are in jail or secure detention.

Definitions

Wisconsin Medicaid uses the following definitions from HFS 34, Wis. Admin. Code:

- A *"crisis"* is a situation caused by a recipient's apparent mental disorder that results in a high level of stress or anxiety for the recipient, persons providing care for the recipient, or the public that cannot be resolved by the available coping methods of the recipient or by the efforts of those providing ordinary care or support for the recipient (HFS 34.02[5], Wis. Admin. Code).
- A *"crisis plan"* is a plan prepared under HFS 34.23(7), Wis. Admin. Code, for a recipient at high risk of experiencing a mental health crisis so that, if a crisis occurs, staff responding to the situation will have the information and resources they need to meet the recipient's individual service needs (HFS 34.02[6], Wis. Admin. Code).
- *"Emergency mental health services"* are a coordinated system of mental health services that provide an immediate response to assist a recipient experiencing

a mental health crisis (HFS 34.02[8], Wis. Admin. Code).

- A *"response plan"* is a plan of action developed by program staff under HFS 34.23(5)(a), Wis. Admin. Code, to assist a recipient experiencing a mental health crisis (HFS 34.02[20], Wis. Admin. Code).
- *"Stabilization services"* are optional emergency mental health services under HFS 34.22(4), Wis. Admin. Code, that provide short-term, intensive, community-based services to avoid the need for inpatient hospitalization (HFS 34.02[21], Wis. Admin. Code).

Crisis intervention services are services provided by a BQA-certified crisis provider to a recipient in crisis or in a situation that may develop into a crisis if professional supports are not provided.

Covered Crisis Intervention Services

Crisis intervention services are services provided by a BQA-certified crisis provider to a recipient in crisis or in a situation that may develop into a crisis if professional supports are not provided. All crisis intervention services must conform to the standards in HFS 34, Wis. Admin. Code. Crisis intervention services include the following:

- Initial assessment and planning.
- Crisis linkage and follow-up services.
- Optional crisis stabilization services.

Crisis intervention services do not include those services normally provided by providers of mental health and substance abuse services who routinely deal with crises while providing services (e.g., a psychotherapist who helps a recipient through a crisis during their scheduled psychotherapy session).

Initial Assessment and Planning

According to HFS 34.23, Wis. Admin. Code, this service includes the following:

1. The initial contact and assessment (including referral to other services and resources, as necessary), even if further crisis intervention services are not required. If the recipient is not in need of further crisis intervention services, but could benefit from other types of assistance, staff should refer the recipient to other appropriate service providers in the community.
2. The response plan's development and initiation, when required. A response plan is required if it is determined after the initial contact that the recipient is in need of emergency mental health services.
   - ✓ If this is the case, staff must prepare and implement a response plan consisting of services and referrals necessary to reduce or eliminate the recipient's immediate distress, de-escalate the present crisis, and help the recipient return to a safe and more stable level of functioning.
   - ✓ The response plan must be approved by a psychiatrist or a psychologist either before services are delivered or within five days after delivery of services, not including Saturdays, Sundays, or legal holidays.

Crisis Linkage and Follow-Up Services

According to HFS 34.23, Wis. Admin. Code, crisis linkage and follow-up services include the following:

1. Reviewing and updating the response plan and developing, reviewing, and updating the crisis plan.
2. Follow-up interventions prescribed in a response plan or crisis plan or other interventions approved by a psychiatrist or psychologist to meet the following goals:
   - ✓ Relieve the recipient's immediate distress in a crisis or pre-crisis.
   - ✓ Reduce the risk of a worsening crisis.
   - ✓ Reduce the level of risk of physical harm to the recipient or others.
   - ✓ Resolve or manage family crises to prevent out-of-home placements of

children, improve the child's and family's coping skills, and assist the family in using or obtaining ongoing mental health and other supportive services.
- ✓ Assist the recipient in making the transition to the least restrictive level of care.

3. Follow-up interventions include, but are not limited to, the following:
   - ✓ Providing evaluations, referral options, and other information to a recipient or others involved with the recipient.
   - ✓ Coordinating the resources needed to respond to the situation, including the following:
     - Contacting the recipient's ongoing mental health service providers or case manager, if any, to coordinate information and services related to the recipient's care and support.
     - Contacting a service provider in the area of related need to coordinate information and service delivery for the recipient if the recipient has been receiving services primarily related to substance abuse, to address needs resulting from the recipient's developmental disability, or if the recipient appears to have needs in either or both of these areas.
     - Conferring with family members or other persons providing support for the recipient to determine if the response and follow-up are meeting the recipient's needs.
   - ✓ Assisting in the recipient's transition to the least restrictive level of care required.
   - ✓ Following up to ensure that intervention plans are carried out and meeting the recipient's needs.
   - ✓ Resolving or managing family crises to prevent out-of-home child placements, improving the child's and family's coping skills, and helping the family use or obtain ongoing mental health and other supportive services.
   - ✓ Determining whether any follow-up contacts by program staff or linkages with other providers in the community are necessary to help the recipient maintain stable functioning after a response plan has been implemented and the recipient has returned to a more stable level of functioning.
   - ✓ Providing follow-up contacts until the recipient has begun to receive assistance from an ongoing service provider, unless the recipient does not consent to further services if ongoing support is needed.
   - ✓ Developing a new crisis plan under HFS 34.23(7), Wis. Admin. Code, or revising an existing plan to better meet the recipient's needs based on what has been learned during the mental health crisis. A crisis plan must meet the following requirements:
     - The crisis plan is for a recipient who is found to be at high risk for a recurrent mental health crisis under the criteria established in the coordinated community services plan under HFS 34.22(1)(a)7, Wis. Admin. Code.
     - A crisis plan shall be developed in cooperation with the recipient, his or her parents or guardians where their consent is required for treatment, the case manager, if any, and the people and agencies providing treatment and support for the recipient, and the plan shall identify to the extent possible the

services most likely to be effective in helping the recipient resolve or manage a crisis, given the recipient's unique strengths and needs and the supports available to him or her.

Optional Crisis Stabilization Services

In addition to services required under HFS 34, Subchapter III, Wis. Admin. Code, a program may provide stabilization services for a recipient for a temporary transition period with weekly reviews to determine the need for continued stabilization services. Refer to Attachment 2 for a copy of the review elements.

In addition to services required under HFS 34, Subchapter III, Wis. Admin. Code, a program may provide stabilization services for a recipient for a temporary transition period with weekly reviews to determine the need for continued stabilization services.

Wisconsin Medicaid covers only those stabilization services necessary for the following:

- Reducing or eliminating a recipient's symptoms of mental illness so that the recipient does not need inpatient hospitalization.
- Assisting in the transition to a less restrictive placement or living arrangement when the crisis has passed.

Crisis stabilization services include professional supports identified on the response plan or crisis plan provided in any of the following settings:

- Recipient's own home.
- Outpatient clinic.
- School.
- Crisis hostel.
- Adult family home.
- Community-based residential facility (CBRF).
- Foster or group home.
- Other community nonresidential settings.

1. Crisis Intervention Program Professional Staff Not Staffing a 24-Hour In-Residence Program — When professional staff of the crisis intervention program who are not staffing a 24-hour in-residence stabilization program provide stabilization services, the crisis intervention program must submit claims for stabilization services using the procedure code and modifiers listed in Attachment 4. Wisconsin Medicaid reimburses these codes on an hourly basis.

2. Individuals Staffing a 24-hour In-Residence Stabilization Program — Wisconsin Medicaid covers crisis intervention services provided by individuals staffing a 24-hour in-residence stabilization program only in the following settings: licensed CBRF, licensed adult family home, licensed children's group home, licensed children's foster home, or licensed children's treatment foster home. Wisconsin Medicaid *does not reimburse for any room and board* costs in these settings. Also, Wisconsin Medicaid does not reimburse individuals staffing 24-hour in-residence programs in any other centers, including nursing facilities, hospitals, or residential care centers for children and youth.

   Wisconsin Medicaid reimburses residential staff for crisis services either hourly or per day (per diem). Providers may choose to bill hourly or per day, but not both, for all recipients.

When Psychiatrist or Ph.D. Psychologist Approval Is Required

As stated in HFS 34, Wis. Admin. Code, approval is required by a psychiatrist or Ph.D. psychologist at various times during service delivery. The following is detailed information about these requirements.

Initial Contact and Assessment, Including Initial Response Plan Development

No approval is needed by a psychiatrist or Ph.D. psychologist.

Approval of All Other Services

A psychiatrist or Ph.D. psychologist must approve all services other than the initial contact and assessment including the initial response plan development. The psychiatrist or psychologist must document his or her approval with one of the following methods:

- Signing the response plan and the crisis plan if a crisis plan was developed.
- Signing or cosigning contact notes. The psychiatrist or Ph.D. psychologist does not need to sign individual contact notes if the service provided was identified on a response plan or crisis plan that the psychiatrist or Ph.D. psychologist signed according to the following requirements. If the response plan or crisis plan was not signed, the psychiatrist or Ph.D. psychologist must sign a contact note within five working days of when the documented service was provided.

Further Information About Initial Response Plan and Monthly Reviews

According to HFS 34.23(5), Wis. Admin. Code, a psychiatrist or Ph.D. psychologist must approve the initial response plan within five working days after services are first delivered. After the initial response plan has been approved, signed, and implemented, the psychiatrist or Ph.D. psychologist must review and sign the response plan at least monthly, even if changes are made more often. Wisconsin Medicaid covers all services identified in the response plan that meet the covered service requirements outlined previously if the response plan has been reviewed, updated, and signed by a psychiatrist or Ph.D. psychologist within the past month.

Further Information About Crisis Plans and Six-Month Reviews

Wisconsin Medicaid covers services identified on the crisis plan that meet the covered service requirements outlined previously if the crisis plan has been reviewed, updated, and signed by a psychiatrist or Ph.D. psychologist within the past six months. The psychiatrist or Ph.D. psychologist must review and sign the crisis plan at least once every six months, even if the changes are made more often.

According to HFS 34.23(5), Wis. Admin. Code, a psychiatrist or Ph.D. psychologist must approve the initial response plan within five working days after services are first delivered.

Special Circumstances

Crisis Intervention Services Provided in Various Ways

Providers may provide Medicaid-covered crisis intervention services by the following means:

- Over the telephone.
- In person at any location where a recipient is experiencing a crisis or receiving services to respond to a crisis (including, but not limited to, mobile crisis services, and walk-in services), but does not include jail, secure detention, or services provided to IMD recipients between ages 21 and 64.

Providers are required to document the means and place of service (POS) in the recipient's record.

Travel

Wisconsin Medicaid covers staff travel time to deliver covered crisis intervention services. Travel is included in the time counted as a part of the covered services.

Multiple Crisis Intervention Staff and Staff Time

Wisconsin Medicaid covers more than one staff person providing crisis intervention services to one recipient simultaneously if this ensures the recipient's or the provider's safety (e.g., the recipient is threatening to hurt others). Providers are required to clearly identify the number of staff involved when billing for more than one staff person and the rationale for multiple staff in their documentation.

In addition, Wisconsin Medicaid covers stabilization services by residential staff as noted previously in this *Update* and, if necessary, by outside professional staff who come into the facility for a limited time at the same time.

Crisis Service Hours

Wisconsin Medicaid does not limit the number of crisis service hours provided to a recipient per day. Also, there is no limit to the length of time that crisis intervention services are covered for a given recipient. Providers are required to use the response and crisis plans to document service needs and to justify the need for continued services. All services must be directed toward solving and preventing crises. Providers must use the crisis plan or response plan to document how services are related to these goals. Wisconsin Medicaid monitors use retrospectively through data analysis and auditing.

Wisconsin Medicaid does not limit the number of crisis service hours provided to a recipient per day.

Limitations

Wisconsin Medicaid covers crisis intervention services provided to Medicaid recipients only and covers crisis intervention contacts with only the following individuals:

- The recipient.
- Family member(s), guardian(s), friend(s), or other individual(s) assisting the recipient.
- Professionals, paraprofessionals, or others providing resources required to respond to the crisis.

Services Provided via Telehealth

Crisis intervention services may be provided via Telehealth. Refer to the General Information section of the Mental Health and Substance Abuse Services Handbook for information about Telehealth requirements and claims submission.

Noncovered Services

The following are not covered by Wisconsin Medicaid as crisis intervention services:

- Room and board.
- Volunteer services not meeting the qualifications in HFS 34.21(3), Wis. Admin Code.
- Services other than those listed in this *Update*.
- Services that are social or recreational in nature.

Documentation Requirements

Refer to Attachment 3 for documentation requirements for all mental health and substance abuse service providers, including crisis intervention providers. For additional information regarding documentation requirements, refer to the General Information section of the Mental Health and Substance Abuse Services Handbook.

Wisconsin Medicaid reimburses the provision of services. Documenting the services provided is part of the provision of services and not separately reimbursable.

Prior Authorization

Prior authorization is not required for crisis intervention services.

Copayment

Wisconsin Medicaid does not require copayment for crisis intervention services.

Claims Submission

Coordination of Benefits

Except for a few instances, Wisconsin Medicaid is the payer of last resort for any Medicaid-covered service. Therefore, the provider is required to make a reasonable effort to exhaust all existing other health insurance

sources before submitting claims to Wisconsin Medicaid.

Refer to the Coordination of Benefits section of the All-Provider Handbook for more information about services that require other health insurance billing, exceptions, claims submission procedures for recipients with other health insurance, and the Other Coverage Discrepancy Report, HCF 1159 (Rev. 08/05). This Other Coverage Discrepancy Report is also available on the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/*.

"V" Codes

"V" codes describe circumstances that do not lend themselves to diagnosis. "V" Codes from the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) coding structure, rather than diagnosis codes, must be used for submitting claims for crisis intervention services. Claims received without a current ICD-9-CM "V" code are denied. Do not use diagnosis codes, including mental health and substance abuse codes, when submitting claims.

Refer to Attachment 4 for a list of allowable "V"- code ranges for crisis intervention services.

Procedure Codes and Modifiers

Providers are required to use Healthcare Common Procedure Coding System (HCPCS) codes on all claims for crisis intervention services. Claims or adjustments received without a HCPCS code are denied. Refer to Attachment 4 for allowable procedure codes and modifiers. Refer to Attachment 5 for rounding guidelines.

Place of Service Codes

Allowable POS codes for crisis intervention services are included in Attachment 4.

Electronic Claims Submission

Providers are encouraged to submit claims electronically since electronic claims submission usually reduces claim errors. Claims for crisis intervention services may be submitted using the 837 Health Care Claim: Professional transaction. Electronic claims may be submitted *except* when Wisconsin Medicaid instructs the provider to submit additional documentation with the claim. In these situations, providers are required to submit paper claims.

Refer to the Informational Resources section of the All-Provider Handbook for more information about electronic transactions.

Providers are required to use Healthcare Common Procedure Coding System (HCPCS) codes on all claims for crisis intervention services.

Paper Claims Submission

Paper claims for crisis intervention services must be submitted using the CMS 1500 claim form dated 12/90. Wisconsin Medicaid denies claims for crisis intervention services submitted on any paper claim form other than the CMS 1500.

Wisconsin Medicaid does not provide the CMS 1500 claim form. The form may be obtained from any federal forms supplier.

Refer to Attachment 6 for claim form instructions and Attachment 7 for a sample of a claim for crisis intervention services.

Reimbursement Limits

Wisconsin Medicaid reimburses county/tribal social or human services agencies only for the federal share of the Medicaid reimbursement rate for crisis intervention services. County/tribal social or human services agencies are required to provide the nonfederal share of the Medicaid reimbursement rate for crisis intervention services as specified in s. 49.45(45)(b), Wis. Stats.

The federal share may change in October of each year with some exceptions. Providers will be notified of changes in future *Updates*.

Wisconsin Medicaid sends a quarterly report to each county/tribal social or human services agency indicating the federal share amount that the agency has received thus far in a calendar year.

If a county/tribal social or human services agency contracts with other Medicaid-certified providers for these services, the county/tribal social or human services agency pays those providers according to the terms of their contracts with them.

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *dhfs.wisconsin.gov/medicaid/*.

PHC 1250

ATTACHMENT 2
Crisis Stabilization Guidelines
Documentation of Factors That Support Continued Crisis Stabilization

Wisconsin Medicaid requires that providers document, at least weekly, the factors that support a consumer continuing to receive crisis stabilization services.

Factors that support continued crisis stabilization include all of the following:
- Continued risk of self-harm.
- Continued risk of harm to others.
- Impaired functioning due to symptoms of a mood and/or thought disorder.
- Recent failure of less restrictive options (independent living, community support program, group living).
- Lack of available/effective supports (including family) to maintain functioning and safety (e.g., "If supports are withdrawn, the person would be at high risk for relapse, which would lead to a more restrictive placement").
- Need for intensive monitoring of symptoms and/or response to recent medication change.
- Recent history of the above that supports the belief that if supports are withdrawn, the risk for a more restrictive setting would be imminent.

The provider's documentation should support the above. If the consumer does not meet one of the above, then interventions should be coded as "nonbillable," since there may be an alternative to crisis stabilization. The treatment team should be notified as well.

ATTACHMENT 3
Mental Health and Substance Abuse Services Documentation Requirements

Providers are responsible for meeting Medicaid's medical and financial documentation requirements. Refer to HFS 106.02(9)(a), Wis. Admin. Code, for preparation and maintenance documentation requirements and HFS 106.02(9)(c), Wis. Admin. Code, for financial record documentation requirements.

The following are Wisconsin Medicaid's medical record documentation requirements (HFS 106.02[9][b], Wis. Admin. Code) as they apply to all mental health and substance abuse services. In each element, the applicable administrative code language is in parentheses. The provider is required to include the following written documentation in the recipient's medical record, as applicable:

1. Date, department or office of the provider (as applicable), and provider name and profession.
2. Presenting Problem (chief medical complaint or purpose of the service or services).
3. Assessments (clinical findings, studies ordered, or diagnosis or medical impression).
   a. Intake note signed by the therapist (clinical findings).
   b. Information about past treatment, such as where it occurred, for how long, and by whom (clinical findings).
   c. Mental status exam, including mood and affect, thought processes — principally orientation X3, dangerousness to others and self, and behavioral and motor observations. Other information that may be essential depending on presenting symptoms includes thought processes other than orientation X3, attitude, judgment, memory, speech, thought content, perception, intellectual functioning, and general appearance (clinical findings and/or diagnosis or medical impression).
   d. Biopsychosocial history, which may include, depending on the situation, educational or vocational history, developmental history, medical history, significant past events, religious history, substance abuse history, past mental health treatment, criminal and legal history, significant past relationships and prominent influences, behavioral history, financial history, and overall life adjustment (clinical findings).
   e. Psychological, neuropsychological, functional, cognitive, behavioral, and/or developmental testing as indicated (studies ordered).
   f. Current status, including mental status, current living arrangements and social relationships, support system, current activities of daily living, current and recent substance abuse usage, current personal strengths, current vocational and educational status, and current religious attendance (clinical findings).
4. Treatment plans, including treatment goals, which are expressed in behavioral terms that provide measurable indices of performance, planned intervention, mechanics of intervention (frequency, duration, responsible party[ies]) (disposition, recommendations, and instructions given to the recipient, including any prescriptions and plans of care or treatment provided).
5. Progress notes (therapies or other treatments administered) must provide data relative to accomplishment of the treatment goals in measurable terms. Progress notes also must document significant events that are related to the person's treatment plan and assessments and that contribute to an overall understanding of the person's ongoing level and quality of functioning.

WRAPAROUND MILWAUKEE
GUIDELINES FOR CRISIS STABLIZATION SUPERVISON MEETINGS

As required by Wraparound Milwaukee policy, one hour of supervision must be provided by a master's prepared or above clinician for every 30 hours of face-to-face contact provided by each Crisis Stabilization/Supervision direct service provider. (See Wraparound Milwaukee Policy #036 – Crisis Stabilization/Supervision Services for detailed information regarding the provision of this service.)

Supervision sessions should be used to seek consultation related to individual service recipient's needs. Agencies are encouraged to establish routine supervision times so that direct service providers may obtain consultation and supervision for each service recipient as needed but at least once every 30 days.

Supervision can be provided individually or in a group. In either situation, the content of the review must be youth specific regarding the youth's plan, youth's response to the plan, strategies that might be appropriate to the specific youth, etc. Meetings may not be "topic" specific such as an in-service on working with youth with ADHD. It is recommended that group sessions be limited to a maximum of 8 direct service providers. Service providers may only be credited for actual time in attendance at the meeting.

For individual supervision, the agency is to maintain a record of:
- Date of the meeting
- Beginning and end times for each meeting
- Name(s) of the youth discussed at the meeting
- Name of the direct service provider
- Summary of the content of the supervision (ie: current status of the youth, barriers to achieving POC goals, clinical recommendations
- Signature of supervisor and direct service provider.

For group supervision, the agency is to maintain a record of:
- Date of the meeting
- Beginning and end times for each meeting
- A sign-in sheet for all staff in attendance at the meeting
- List of the names of the youth discussed at the meeting
- Brief statement as to the content of the supervision.

Wraparound Milwaukee recommends that the agency maintain Crisis Stabilization/ Supervision – Clinical Supervision Records in a location that can be readily accessed by agency staff and Wraparound Milwaukee staff for review such as a three ring binder with the binder organized by month and by provider with the most recent note on top.

Agency records related to supervision meetings are to be retained for a period of at least 5 years.

WRAPAROUND MILWAUKEE

PROVIDER REFERRAL FORM

Reminder: Providers please assure that the initial visit is done with the Care Coordinator.

Referral Completion Date ____________________________

Referred by:

____ ____
Name of Care Coordinator   Name of Care Coordination Agency

Phone (___)_________________ Pager (____)_________________ Cell Phone (____)___________________

Name of Provider/Agency being referred to:____

Address ____

City ____ State_________________ Zip _________________

Name of Provider Contact Person ___________________________________ Phone (____)_______________

1. **Service being requested**:____ Service Code ______________
   Frequency / Days & Times being requested: ____
2. **Service being requested**:____ Service Code _____________________
   Frequency / Days & Times being requested: ____
3. **Service being requested**:____Service Code _____________________
   Frequency / Days & Times being requested: ____
4. **Service being requested**:____Service Code _____________________
   Frequency / Days & Times being requested: ____

Name of Client being Referred:____ Phone (____)______________

Address ____

City____ State_________________ Zip______________

Name of associated WM Enrollee (if different than client being referred) ________________________________

Relationship of Referred Client to WM Enrollee (if not the same – i.e., mother, sibling, etc.)_____________________

Client Lives With:____ **Relationship:**_________________________

Ethnicity: ☐ African American ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Asian ☐ Other _______________

Gender: ☐ Male ☐ Female **DOB**: ____________________ **SSN:** ___________________________________

Special Accommodation Needs, if any *(i.e., physical and sensory disabilities, medical needs, limitations, etc):*

____

FAMILY/SCHOOL INFORMATION

Mother/Legal Guardian ____ Home Phone (____)__________________

Address ____ Work Phone (____)__________________

City____ State_________________ Zip _________________

Father/Legal Guardian ____ Home Phone (____)__________________

Address ____ Work Phone (____)__________________

City____ State _______________ Zip __________________

Other Emergency Contact _______________________________________ Home Phone (____)________________

Address ____ Work Phone (____)_________________

City____ State_________________ Zip _________________

Relationship to Client _______________________________

Siblings/Children: (*Not required for transportation services if only transporting identified client.*)

1. _______________________________________ **DOB** _______________________

2. _______________________________________ **DOB** _______________________

3. _______________________________________ **DOB** _______________________

4. _______________________________________ **DOB** _______________________

School ____ ☐ Not Attending ☐ Not Enrolled ☐ N/A

Grade ______________ **Special Education:** ☐ Yes ☐ No

GENERAL INFORMATION

Diagnosis: *(Required only if referring to medical or mental health providers.)*

____

Currently on Medication? ☐ **Yes** ☐ **No** **If yes, what type?** ___________________________________

Strengths/Interests: (*Not required for transportation referrals.)*

____

____

____

Needs/Reason for Referral: (*Not required for transportation referrals.)*

____

____

____

Safety Concerns: ____

____

____

____

....

(For Provider Agency Use Only)

Date Referral was Received ______________________

WRAPAROUND MILWAUKEE
Crisis Stabilization Policy
Attachment 4B

Wraparound Milwaukee

PROVIDER REFERRAL FORM

SYNTHESIS ON-LINE FORM

Referral Date: 7/1/06
Referred by: Aggie Hale - Wraparound Milwaukee
Phone Number(s):

Wraparound Milwaukee Enrollee Name Client, Sample

DOB: 1/1/91 Ethnicity: Bi-racial
Gender: Male

Current Placement:

Date	*Type*	*Location*
12/1/04	RCC	Homme Home - Neilsville
2/1/05	Home	Parent

Contact Information

Youth	Sample Client	1234 Any Strreet Milwaukee, WI 53201
Mother	Mary Client	5858 S. 5th St. Milwaukee, WI 55555
Father	Unknown ,	No address listed

Siblings / Children (not required for transportation services if only transporting identified client)

Name	*Relationship*	*DOB*
No siblings/children listed		

School Information

School Name	*Grade*	*Special Education?*

Diagnoses:

Axis	*Description*
I (R/O)	Oppositional Defiant Disorder
I (Primar	Attention Deficit Dis, combined typ
II	Communication Disorder NOS

Axis	*Description*
III	asthma
IV	divorce of parents
V	45

Diagnosed By: Dr. Jones
Diagnoses Date: 5/1/2005

Current Medications

Type	**Used For**	**Dosage/Frequency**	**Prescribed By**	**Phone**
ritalin	hyperactivity	5mg - 2X daily	Dr. Smith	555-8989
Albuteral inhaler	asthma	3 puffs - as needed	unknown	
Orthonovum	birth control	1 pill - daily	unknown	

Safety Concerns
Safety concerns are ...

Name of Provider/Agency Being Referred to:
Acme Clinic
555 S. 5th St.
Milwaukee, WI 55555

Strengths/Interests
Youth's strengths/interests are ...

Needs/Reason for Referral
Reason for referral is ...

Service(s) Being Requested
5160, In-Home Therapy, 2X a week - Mon, Wed or Thurs preferred

Special Accommodation Needs, if any
Special accommodation needs are ....

TRANSPORATION CONSENT FORM

YOUTH/CLIENT NAME: ____ DOB: _______________
(Print)

____ OF _____________________________________
(Provider's Name) (Name of Provider Agency)

HAS PERMISSION TO PICK UP AND TRANSPORT ____
(Name of Youth/Client)

FROM ________________________ THROUGH THE TERMINATION OF SERVICES FROM THIS AGENCY.
(Effective Date)

SPECIAL CONSIDERATIONS/MEDICAL-MEDICATION ISSUES/LIMITATIONS:

____

____

____

_______________________________________ _______________________ __________________
Signature of Legal Guardian Relationship to Youth Date

_______________________________________ ______________________
Signature of Youth (should sign if age 14 or over) Date

WITNESSED BY:

____
Print Name of Witness

____ ______________________
Signature of Witness Date Witnessed

____ _______________________
Agency Address Agency Phone

EMERGENCY CONTACT:
Name:____

Address: ____

State:_______________ Zip:________________ Phone:____________________________________

Unless otherwise specified, this consent will expire 12 months from the date it was signed. This consent or any part of this consent may be canceled at any time with written notification.

Crisis Provider Note Entry Instructions

Rev: 6/2010

STEPS TO THE PROCESS

1) Entering the Note
2) Signing the Note
3) Supervisory Approval
4) Printing Notes (OPTIONAL)

STEP 1: Entering the Note

Select "Provider Notes" from the Table of Content (TOC) area

Provider Notes
Reports
Logoff

Enrollee List Search: Last Name [Search]

* *Names appearing in italics are not currently enrolled.*

Select	Last Name	First Name	DOB	Program
	Anderson	Helga	11/11/1997	Wraparound
	Cleveland	Joe	2/22/2000	Wraparound
	Feinstein	Jim	2/2/1988	Wraparound
	Pulliam	Candace	5/15/2001	Wraparound
	Wegher	Janet	5/5/1975	Wraparound
	Zipple	Eva	1/1/1990	Wraparound

Select the Youth's Name. To look up the youth's name – type part of the last name in the Search box and click "Search." Click on the envelope to open that record.

A screen similar to the one below will appear. (If no notes exist for the youth – a blank data entry screen appears.)

Provider Notes
Sign Notes | Add Note | Link to SAR | Unlink from SAR
Print Notes | Print POC | Print Crisis Plan
Search for a Provider Note
Start Date: End Date: [Search]

Click on **Add Note**.

The screen below will appear. It lists all of the Service Authorizations for that youth for the past 3 months. Select which Service Line this Note relates to, and press "Select." (If no Service Line yet exists, simply pres "Select Without SAR." You will link this note to a SAR Line later in the process.)

Select a SAR Line [Select] [Select Without SAR] [Cancel]

Select	Service Month	Service Recipient	Physician	Provider	Units Auth'd	Units Entered
◉	December-2009	Annie Anderson	Peter Pan	Better Conc	4	
○	November-2009	Annie Anderson	MANUELA EVANS	Better Conc	9	

Data Entry Screen for Provider Notes:

Date of Contact: (mm/dd/yyyy)

Recipient: Helga Anderson

Contact Start Time: (hh:mm am/pm)

Contact End Time: (hh:mm am/pm)

Contact Location: Community / Detention / Home / No Show / Phone

Service Type: Multiple Types Permitted — Crisis Stabilization / Crisis Supervision / Collateral Contact / Enrollee Contact / Meetings / No Show / Recordkeeping / Travel

Contact Time 0 hrs

Travel Time 0.0

Documentation Time 0.0

Total Hours 0.0 hrs

* Enter numbers and decimal points; no text.

** Use the minutes to hours conversion below.

1-6 m = 0.1 h	31-36 m = 0.6 h
7-12 m = 0.2 h	37-42 m = 0.7 h
13-18 m = 0.3 h	43-48 m = 0.8 h
19-24 m = 0.4 h	49-54 m = 0.9 h
25-30 m = 0.5 h	55-60 m = 1.0 h

PROVIDER NOTE TEXT

Date of Contact: The date the contact occurred. Multiple contacts for one day CAN BE recorded in a single note (but this is not required), as long as the text of the note covers those multiple contacts.

Recipient: Generally, this will be the youth. However, it may be a family member OTHER THAN the identified Wraparound child if that is what was authorized on the SAR.

Start and End Times: Wraparound Milwaukee **requires** these fields to be entered. The start time and end time is reflective of either the start time and end time of the face-to face contact being made or the phone contact being made. The time must reference a.m. or p.m. If you are documenting a no-show and want to indicate the time of the no-show, you can enter a 1-minute time frame (9:00 – 9:01 pm),or you can leave both fields blank. Entering the time will result in 0.1 contact time calculating, which is allowable; you would just adjust your documentation time accordingly.

Contact Location: Select the location where the contact occurred. If the youth is in Detention, and the contact was a phone or face-to-face contact with a family member, the location should still be listed as Detention to ensure that contact time is not billed to Medicaid.

Service Type: You must ALWAYS indicate if it is a Crisis Supervision or Crisis Stabilization contact. Then you ALSO select what type of contact was made (Enrollee, Collateral, Travel, etc.). You can select multiple types for one note.

- Enrollee Contact: ANY type of contact with the identified youth alone or with collaterals.
- Collateral Contact: ANY type of contact with COLLATERALS ONLY. Collaterals may be family members, caregivers, other team members, the care coordinator, school personnel, etc. If the youth was a part of the contact, use the "Enrollee Contact" code. Coincidental collateral contacts where a planned contact with the enrollee resulted in a "No Show" should be documented as a "No

Show" unless the contact results in a discussion related to the youth's crisis/safety plan or POC safety domain.

- Meetings: Used to document the monthly Child and Family Team meetings and/or Plan of Care meetings or other meetings in which the provider's attendance is requested, i.e., IEP meetings, staffings. The youth must be present.
- No Show: Use this code when no covered service was provided, i.e.- the youth was not available when the provider arrived at the place of contact.
- Release of Information: Use this code when written material is released from an enrollee's record and/or for disclosure of protected health information. The Release of Information note text must include the following:
    - Reason for release (i.e., "As part of ongoing crisis stabilization communication …")
    - Who the information was released to (i.e., name of person, agency, address and/or phone number)
    - What was released (i.e., crisis stabilization documentation)

  Example: "As part of ongoing crisis stabilization communication, crisis stabilization progress notes from 3/1/07 to 3/31/07 were mailed to James Smith, probation officer of Children's Court Center, 9800 Watertown Plank Road, Milwaukee, WI 53226."
- Other: Use this code if service time you are documenting cannot be identified as any other service type (i.e., preparing written crisis stabilization related letters/documents to be given to the youth/family.)

Service Hour Reporting:

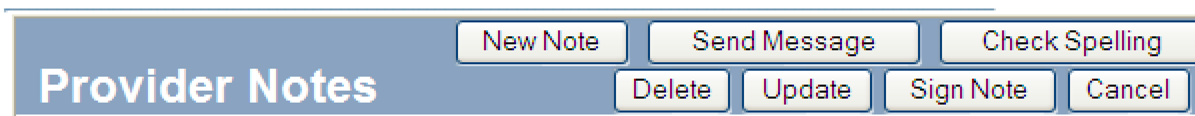
Contact Time:
This will auto-calculate based on the Start and End Times entered.

Travel Time:
Enter the amount of time spent in travel for this contact. (If a phone contact, enter 0 or leave blank)

Documentation Time:
Enter the amount of time documentation of this note took.

Provider Note Text
See Section II, K of Policy #036, Crisis Stabilization/Supervision Services, for a detailed description of what needs to be included within the text of all notes.

After you're done entering the note, click on Insert. The blue bar area at the top changes to the following:



You can use the Spell Check feature at any time during data entry. However, **Spell Check DOES NOT SAVE YOUR ENTRY. You must always click "Insert" to save your note. If you insert your note first and then do a Spell Check – you must click "Update" to save any changes.**

You can make any edits or corrections to the note. Simply make your changes and click "Update"

Linking the Note to a Service Line and Signing Notes.

Both of these functions can be done from the main screen.

LINKING NOTES

If the Service Line did not exist when you entered the Note (which would occur if the Care Coordinator had not entered a Service Authorization for the youth for the month), you'll need to go back to any Notes that you did not link to a Service Line at the time you entered the Note. You do this from the main Provider Notes screen.

Approve Notes | Send Notes Back | Add Note | Link to SAR | Unlink from SAR | Print Notes | Print POC | Print Crisis Plan

Provider Notes

Search for a Provider Note

Start Date: End Date: Search

Sign	Add Link	Del Link	Note Information	Billing Status
☐	☐	☐	4/2/2010 - Jane Doe (Approved): testing	Not Linked
☐	☐	☐	4/1/2010 - Jane Doe (Approved): alsdfj	Linked, Not Billed
☐	☐	☐	3/9/2010 - Jane Doe (Approved): adf	Linked, Billed

A Billing Status will appear next to each note:
Not Linked: The note is not linked to a SAR and thus can't be billed;
Linked, Not Billed,: The Note is linked to a SAR but has not yet been billed.
Linked, Billed: The Note has been linked to a SAR and billed for. No changes can be made.

Then just select which SAR line the Notes relate to and click "Select." Those Notes are now linked to the Service Authorization so your agency can bill for them.

Select a SAR Line Select | Select Without SAR | Cancel

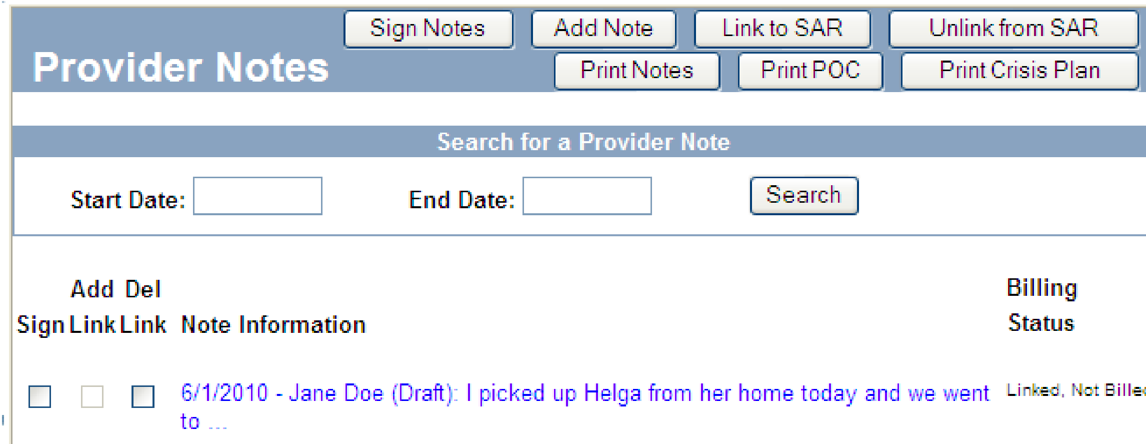
Select	Service Month	Service Recipient	Physician	Provider	Units Auth'd	Units Entered
◉	December-2009	Annie Anderson	Peter Pan	Better Conc	4	
○	November-2009	Annie Anderson	MANUELA EVANS	Better Conc	9	

SIGNING NOTES

Notes must be signed. After you sign a note – it is no longer editable by you. (NOTE: Supervisors will later Reject or Approve each note; if a note is Rejected, the note will become editable again.) Notes can be signed individually, or in a batch for an enrollee.

To sign an individual note, simply click the "Sign Note" button on the Progress Note screen.

Signing a batch of notes for a youth is done from the initial display screen shown after you select a specific youth's name.



Select which notes you want to sign by putting checkmarks in the Sign column, and then press "Sign Notes."

For the Crisis Worker – this is the final step in the process unless your Supervisor rejects your note. If you have Notes rejected by your supervisor, you will receive a login message informing you of that Rejection, which will contain a link to the Note(s) that need to be edited. You will be able to edit those notes, and will need to re-sign them when done.

Rejected note – press "Click to View" to see which notes were rejected

Good Morning GEORGE BENZ

You have Progress Notes Message(s) - Click to View

After "Click to View," a list of any rejected notes will appear. Click on youth name to link to note.

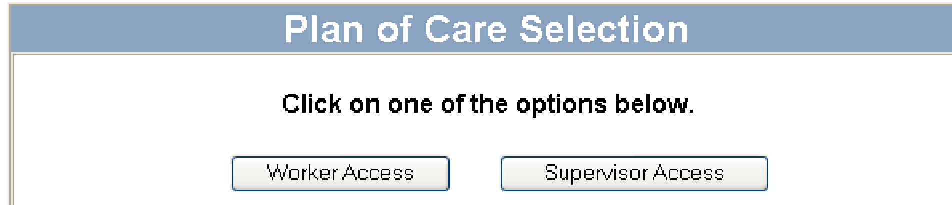
PROGRESS NOTES MESSAGES Back

Aggie Hale:
A Progress Note for Theresa Anderson was rejected by Aggie Hale.

If you are a Supervisor, you will be responsible for approving all of the crisis workers notes. You can do this by individual enrollee (as described above for the workers), or you can do a group of supervisees and all of their notes for a specific time frame.

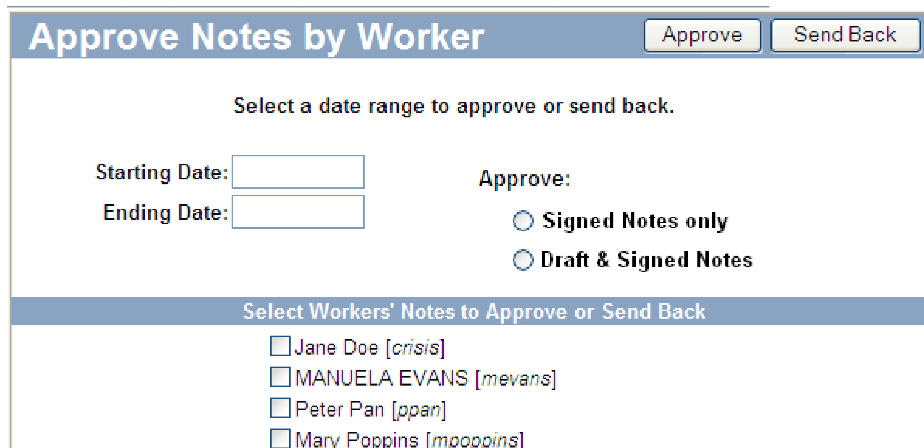
To approve notes for multiple workers/youth/dates at one time:

After you click on the Provider Progress Notes in the TOC area, the following screen appears. Select "Supervisor Access."



The screen that follows will allow you to approve or reject groups of notes for groups of workers. Simply enter the date range you want to approve, select the provider(s) that you want to approve notes for, select which types of notes you want to approve, and click "Approve." (You can also Reject batches of notes this way. If you Reject note(s), the note becomes editable by the worker again, and a login message is sent to that worker to update the note.). After you approve the notes, they are no longer editable, and are ready for billing.

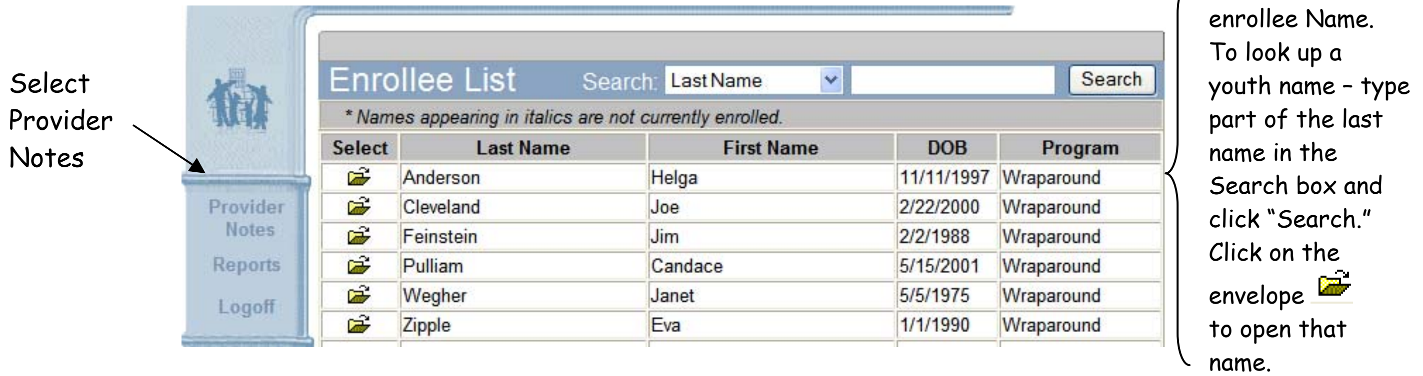
NOTE: Synthesis serves as the medical record for our youth, which is why you cannot edit or delete a note after it has been signed. However – there are times when the NON-TEXT portions of a note can be updated. This would occur if a note was dated wrong, if the wrong service type or location was chosen or if other billing information is incorrect. To request these types of corrections – **agency supervisory staff** (not individual staff members) **should send an email to Aggie.Hale@milwcnty.com and specify what changes need to be made.** She can make an amendment note in the medical record and makes the changes.



STEP 4: Printing Notes (OPTIONAL)

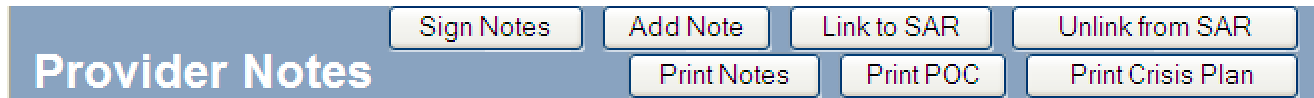
To print Provider Notes, first click on Provider Notes in the TOC area.

Then, select the enrollee name you wish to print notes for:

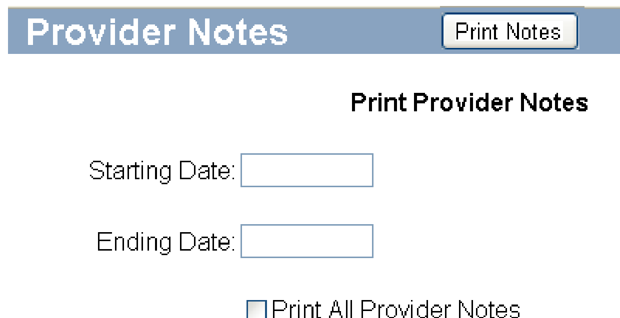


Select	Last Name	First Name	DOB	Program
	Anderson	Helga	11/11/1997	Wraparound
	Cleveland	Joe	2/22/2000	Wraparound
	Feinstein	Jim	2/2/1988	Wraparound
	Pulliam	Candace	5/15/2001	Wraparound
	Wegher	Janet	5/5/1975	Wraparound
	Zipple	Eva	1/1/1990	Wraparound

Click on "Print Notes"



The following screen appears. Enter the date range you wish to print, and click "Print Notes."



Printing Plans of Care (POCs) and Crisis Plans

The most current APPROVED POC and Crisis Plan can be printed from the initial display screen shown after you select a name. You can sign your notes from this screen, or print POCs and/or Crisis Plans.

Provider Notes

Sign Notes | Add Note | Link to SAR | Unlink from SAR

Print Notes | Print POC | Print Crisis Plan

Search for a Provider Note

Start Date: | End Date: | Search

Sign	Add Link	Del Link	Note Information	Billing Status
☐	☐	☐	6/1/2010 - Jane Doe (Draft): I picked up Helga from her home today and we went to ...	Linked, Not Billed

Simply choose "Print POC" or "Print Crisis Plan," and a screen similar to the one displayed below will appear:

Simply click the Printer icon to send the document to your printer.

Save a Copy | Search | Select | 121% | Adobe Reader

Wraparound Milwaukee

PLAN OF CARE

CONFIDENTIAL INFORMATION: Per Wis. Admin. Code 92.03, disclosure of this information without client/guardian consent or statutory authorization is prohibited by law.

Youth: Anderson, Ola | Enrolled: 4/3/04 | POC Status: Completed
DOB: 1/1/91 | POC Date: 12/19/06 | POC Number: 16

Youth Address
1234 Any Street
Milwaukee, WI 53201

Family/Guardian Address(es):
Aggie Hale
4753 S. 22nd Place
Milwaukee, WI 53225

2nd Family Member(i.e. mom, etc.)
Street Address
City, State Zip

O:\catc\wrapcmn\Synthesis\CrisisProviderEntryInstructions