

 <b>WRAPAROUND MILWAUKEE POLICY &amp; PROCEDURE</b>	Date Issued: <b>10/3/02</b>	Date Revised: <b>6/18/08</b>	Section: <b>PROVIDER NETWORK</b>	Policy No: <b>036</b>	Pages: <b>1 of 7</b> (7 Attachments)
	<input checked="" type="checkbox"/> Wraparound <input checked="" type="checkbox"/> Wraparound/REACH <input checked="" type="checkbox"/> FISS	Effective Date: <b>1/1/09</b>	Subject: <b>CRISIS STABILIZATION / SUPERVISION SERVICES</b>		

## I. POLICY

It is the policy of Wraparound Milwaukee that all Crisis Stabilization/Supervision Providers through the Wraparound Integrated 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 treatment 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 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 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. **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.**

1. Crisis Stabilization/Supervision Providers 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 Providers must possess a High School Diploma or G.E.D. A Bachelor's Degree in a Human Services field is desirable.
3. Agencies must obtain two (2) letters of reference regarding the Provider's professional abilities. Reference letters are to be maintained in the employees file at the agency.

**C. Required Training.**

Training must include Crisis Prevention Intervention (CPI), Managing Aggressive Behavior (MAB) or a similar program along with the following related in-service training:

1. De-escalation techniques.
2. Crisis regulations.
3. Wraparound crisis intervention policies and procedures.
4. Provider job responsibilities.
5. Relevant State Statutes and Administrative Rules, including patient rights and confidentiality of youth records.
6. Basic mental health and psychopharmacology concepts applicable to crisis situations.
7. Techniques for assessing and responding to persons with emergency mental health needs who are suicidal and/or are experiencing AODA related problems.
8. Mandatory Reporting Requirements.
9. First Aid/CPR .

**D. Required Training Hours.**

The Agency must adhere to the following training requirements as specified in HFS 34.21 (8) (*see Attachment 1*).

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: All necessary training MUST occur within the first 3 months of employment.*

2. **Ongoing Training.**

Staff are required to attend at least eight (8) hours per year of ongoing in-service training on topics such as emergency mental health services, rules and procedures relevant to providing crisis services, compliance with State and Federal regulations, cultural competency in mental health services or current issues on youth rights and youth services.

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.

**E. Supervision of Providers.**

It is required by HFS 34.21(7) (*see Attachment 1*) that all Crisis Stabilization/Supervision Providers are supervised 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 Providers must be present. This can be in the form of a brief note indicating the name of the Crisis/Supervision Provider, the date that supervision occurred, the length of the supervision session (i.e., one hour), and the content of the interaction/discussion. The supervising Clinician must then sign and date the note with full name and credentials.

The amount of Supervision that must occur per each Crisis/Supervision Provider is referenced under HFS34.21 (7)(d)(e). **This reads that one-hour of supervision must be documented for every 30 hours of documented client contact.** The Clinical Supervisor can determine if the individual Crisis Stabilization/Supervision Provider 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 Provider are not sufficient, and the recipient of the services continues to experience a high rate of crises, then the Provider shall seek immediate supervision to determine whether and what other interventions are needed.

**F. Accessibility/Referrals.**

Agencies providing Crisis Stabilization/Supervision must have a 24-hour/7-day-a-week coverage plan in place to handle referrals both as an Agency and for the individual Crisis Stabilization/Supervision Provider, such as a rotating on-call pager system. There must be a response to a written (faxed), Synthesis generated or telephoned Provider Referral within 24 hours and then a face-to-face contact must occur within three (3) days (72 hours) unless otherwise specified by the Child & Family Team and in the Plan of Care. The written / Synthesis generated referral should be submitted / electronically sent to the Agency on the Wraparound Integrated Provider Network PROVIDER REFERRAL FORM (*see Attachments 3A & 3B*).

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

**G. Collaboration and Consultation.**

The Care Coordinator must go out on the first visit to introduce the Crisis Stabilization/Supervision Provider to the family/youth.

As a member of the Child & Family Team, the Crisis Stabilization/Supervision Provider must be informed of and attend 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).

The Crisis Stabilization/Supervision Provider should seek consultation through their Agency beyond the regularly designated Supervision requirements when there are high risk and safety concerns that may be beyond their ability to handle successfully. The Mobile Urgent Treatment Team is also available for consultation and support for these high-risk situations.

**H. Covered Services.**

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.*

## I. Billing.

### 1. “NON-MEDICAID BILLABLE” Time for Crisis Stabilization AND Supervision.

- a. No Show - Travel time and record keeping time are NOT Medicaid billable if no covered service was provided (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 write this in the text of their progress note, indicating “No Show” as the progress note Service Type and put the total travel time (if applicable) and recordkeeping time/hrs. under the “Non-Medicaid Billable” area.
- b. Secure Detention or Jail - Any and all services provided/contacts made when the youth is in secure detention or jail are NOT Medicaid billable. The Provider is expected to document these contacts as usual, but must put all applicable time/hrs. spent under the “Non-Medicaid Billable” area.

### 2. “MEDICAID-BILLABLE” 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 1.5 billing units.*

- 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.

### 3. “MEDICAID-BILLABLE” 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 1.0 hrs.*

- 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. **In order to bill this time under Medicaid, 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).

#### 4. NON-COVERED Services (Crisis and/or Supervision).

- a. Room and Board.
- b. 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.
- c. Out of State trips for any reason.
- d. 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.*

- e. Volunteer services not meeting the qualifications in HFS 34.21(3), Wis. Admin. Code.

#### J. 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.

**K. 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 the 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, 1 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.

**L. 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.

All notes must be completed, finalized, printed and filed in the youth’s chart by the 10<sup>th</sup> day of the following month (i.e., June notes must be filed by July 10<sup>th</sup>). Youth charts may NOT contain any progress notes in DRAFT form. (*See Attachment 4 for guidance for on-line documentation procedures.*)

**M. Mandatory Reporting of Abuse.**

All Crisis Stabilization/Supervision Provider’s 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 neglectful or any physical, sexual and/or emotional



Removed by Register, December 2004, No. 588. For current adm. code see: <http://www.legis.state.wi.us/rsb/code>.

## Chapter HFS 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.

#### Subchapter I — General Provisions

**HFS 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. HFS 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.

#### HFS 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. HFS 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. HFS 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 and family 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. 880, 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. HFS 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

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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 propranolol (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. HFS 34.23 (5) (a) to assist a person experiencing a mental health crisis.

**(21)** "Stabilization services" means optional emergency mental health services under s. HFS 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.

**HFS 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 Supportive Living, 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. HFS 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. HFS 34.22 (1) (a) or amended under s. HFS 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. HFS 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

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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 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).

Removed by Register December 2004, No. 588. For current adm. code see: <http://www.legis.state.wi.us/rsb/code>.

**(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. HFS 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) (e) 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.

**HFS 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. HFS 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 waiver 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.

## Subchapter II — Standards for Basic Emergency Service Programs

**HFS 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.

**HFS 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. HFS 34.21 (3) (b) 1. to 15. may be assigned to emergency duty. Staff qualified under s. HFS 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. HFS 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.

Removed by Register, December 2004, No. 588. For current adm. code see: <http://www.legis.state.wi.us/rsb/code>.

(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.

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

**HFS 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.

**HFS 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. HFS 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.

Removed by Register December 2004, No. 588. For current adm. code see: <http://www.legis.state.wi.us/rsb/code>.

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. HFS 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. HFS 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. HFS 34.26, the review of the coordinated community services plan under s. HFS 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. HFS 92 regarding confidentiality of treatment records.

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

Removed by Register, December 2004, No. 588. For current adm. code see: <http://www.legis.state.wi.us/rsb/code>.

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.

**HFS 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. 55.06 (11), 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. HFS 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. HFS 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. HFS 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.

Removed by Register December 2004, No. 588. For current adm. code see: <http://www.legis.state.wi.us/rsb/code>.

(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. HFS 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. HFS 34.21 (3) (b) 9. to 19., a mental health professional qualified under s. HFS 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. HFS 34.21 (3) (b) 1. to 15., except that staff qualified under s. HFS 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. HFS 34.21 (3) (b) 1. to 14. A mental

health professional qualified under s. HFS 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. HFS 34.21 (3) (b) 1. to 14. However, persons qualified under s. HFS 34.21 (3) (b) 9. to 14. shall work under the supervision of a mental health professional qualified under s. HFS 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 assis-

Removed by Register, December 2004, No. 588. For current adm. code see: <http://www.legis.state.wi.us/rsb/code>.

tance 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. HFS 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. HFS 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. HFS 34.21 (3) (b) 1. to 19., with those staff qualified under s. HFS 34.21 (3) (b) 9. to 19. supervised by a person qualified under s. HFS 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.

**HFS 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.

Removed by Register December 2004, No. 588. For current adm. code see: <http://www.legis.state.wi.us/rsb/code>.

(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. HFS 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. HFS 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

Removed by Register, December 2004, No. 588. For current adm. code see: <http://www.legis.state.wi.us/rsb/code>.

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. HFS 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.

**HFS 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. HFS 34.23 (8) and crisis plans developed under s. HFS 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. HFS 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.

**HFS 34.25 Client rights. (1) POLICIES AND PROCEDURES.** All programs shall comply with s. 51.61, Stats., and ch. HFS 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. HFS 94.27 for a grievance resolution system.

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

**HFS 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. HFS 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. HFS 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 and BadgerCare update

June 2006 • No. 2006-58

Wisconsin Medicaid and BadgerCare Information for Providers

## Wisconsin Medicaid Reimburses Selected Services Provided Through Telemedicine

To: Adult Mental Health Day Treatment Providers, Ambulatory Surgery Centers, Child/Adolescent Day Treatment Providers, Community Support Programs, Comprehensive Community Service Programs, Crisis Intervention Providers, End-Stage Renal Disease Service Providers, Family Planning Clinics, Federally Qualified Health Centers, HealthCheck Providers, HealthCheck "Other Service" Providers, Hospice Providers, Inpatient Hospital Providers, Master's Level Psychotherapists, Nurse Midwives, Nurse Practitioners, Nursing Homes, Outpatient Hospital Providers, Outpatient Mental Health Clinics, Outpatient Substance Abuse Clinics, Ph.D. Psychologists, Physician Assistants, Physician Clinics, Physicians, Psychiatrists, Rural Health Clinics, Substance Abuse Counselors, Substance Abuse Day Treatment Providers, HMOs and Other Managed Care Programs

Effective for dates of service on and after July 1, 2006, Wisconsin Medicaid will cover certain services delivered via telemedicine (also known as "Telehealth"). Providers at remote locations receive the same reimbursement as they would for face-to-face contacts. The originating site where the recipient is located may be reimbursed a facility fee.

### Telemedicine Definition

Telemedicine services (also known as "Telehealth") are services provided from a remote location using a combination of interactive video, audio, and externally acquired images through a networking environment between a recipient (i.e., the originating site) and a Medicaid-certified provider at a remote location (i.e., distant site). The services must be of sufficient audio and visual fidelity and clarity as to be functionally equivalent to a face-to-face contact. Telemedicine services do not include telephone conversations or Internet-based communication between providers or between providers and recipients.

All applicable Health Insurance Portability and Accountability Act of 1996 confidentiality requirements apply to telemedicine encounters.

### Reimbursable Telemedicine Services

Wisconsin Medicaid already allows certain mental health and substance abuse service providers to be reimbursed for telemedicine services when performed by organizations certified by the Bureau of Quality Assurance (BQA). All existing BQA certification requirements and claim submission instructions for these BQA-certified providers remain applicable. These providers should refer to the General Information section of the Mental Health and Substance Abuse Services Handbook for certification information, allowable providers and procedures, and claim submission requirements.

Effective for dates of service (DOS) on and after July 1, 2006, Wisconsin Medicaid will reimburse the following additional individual

providers for selected telemedicine-based services:

- Physicians and physician clinics.
- Rural health clinics (RHCs).
- Federally qualified health centers (FQHCs).
- Physician assistants.
- Nurse practitioners.
- Nurse midwives.
- Psychiatrists in private practice.
- Ph.D. psychologists in private practice.

Wisconsin Medicaid will reimburse these providers, as appropriate, for the following services provided through telemedicine:

- Office or other outpatient services (*Current Procedural Terminology* [CPT] procedure codes 99201-99205, 99211-99215).
- Office or other outpatient consultations (CPT codes 99241-99245).
- Initial inpatient consultations (CPT codes 99251-99255).
- Outpatient mental health services (CPT codes 90801-90849, 90862, 90875, 90876, and 90887 and Healthcare Common Procedure Coding System [HCPCS] code H0046).
- Health and behavior assessment/intervention (CPT codes 96150-96152, 96154-96155).
- End-stage renal disease-related services (HCPCS codes G0308-G0309, G0311-G0315, G0317-G0318).
- Outpatient substance abuse services (HCPCS codes H0022, H0047, T1006).

Reimbursement for these services is subject to the same restrictions as face-to-face contacts (e.g., place of service [POS], allowable providers, multiple service limitations, prior authorization [PA]).

Claims for services performed via telemedicine must include HCPCS modifier “GT” (Via interactive audio and video telecommunication systems) with the appropriate procedure code and must be submitted on the 837 Health Care Claim: Professional (837P) transaction or CMS 1500 paper claim form. Reimbursement is the same for these services whether they are performed face-to-face or through telemedicine.

Only one eligible provider may be reimbursed per recipient per DOS for a service provided through telemedicine unless it is medically necessary for the participation of more than one provider. Justification for the participation of the additional provider must be included in the recipient’s medical record.

Separate services provided by separate specialists for the same recipient at different times on the same DOS may be reimbursed separately.

#### *Services Provided by Ancillary Providers*

Claims for services provided through telemedicine by ancillary providers should continue to be submitted under the supervising physician’s Medicaid provider number using the lowest appropriate level office or outpatient visit procedure code or other appropriate CPT code for the service performed. These services must be provided under the direct on-site supervision of a physician and documented in the same manner as face-to-face services. Coverage is limited to procedure codes 99211 or 99212, as appropriate.

#### *Federally Qualified Health Centers and Rural Health Clinics*

Wisconsin Medicaid will include telemedicine services in the cost settlements for FQHCs and RHCs only if the recipient is an established

**R**eimbursement is the same for these services whether they are performed face-to-face or through telemedicine.

patient of the FQHC or RHC at the time of the telemedicine encounter.

#### *Recipients Located in Nursing Homes*

Claims for telemedicine services where the originating site is a nursing home should be submitted with the appropriate level office visit or consultation procedure code.

#### *Out-of-State Providers*

Out-of-state providers, except border-status providers, are required to obtain PA before delivering telemedicine-based services to Wisconsin Medicaid recipients.

### **Documentation Requirements**

All telemedicine services must be thoroughly documented in the recipient's medical record in the same way as if it was performed face-to-face.

### **Eligible Recipients**

All Medicaid recipients are eligible to receive services through telemedicine. Providers may not require the use of telemedicine as a condition of treating the recipient. Providers should develop their own methods of informed consent verifying that the recipient agrees to receive services via telemedicine.

Wisconsin Medicaid covers common carrier transportation through the counties as well as specialized medical vehicle (SMV) services for recipients who would rather meet with the provider face-to-face. As a reminder, recipients eligible to receive SMV services are required to have a completed Certification of Need for Specialized Medical Vehicle Transportation form, HCF 1197 (Rev. 03/03).

### **Telemedicine and Enhanced Reimbursement**

Providers may receive enhanced reimbursement for pediatric services (services for recipients 18 years of age and under) and Health Professional Shortage Area (HPSA)-eligible services performed via telemedicine in the same manner as face-to-face contacts. As with face-to-face visits, HPSA-enhanced reimbursement is allowed when either the recipient resides in or the provider is located in a HPSA-eligible ZIP code. Providers may submit claims for services performed through telemedicine that qualify for pediatric or HPSA-enhanced reimbursement with both modifier "GT" and the applicable pediatric or HPSA modifier. Refer to the Medicine and Surgery section of the Physician Services Handbook and *Wisconsin Medicaid and BadgerCare Updates* for more information about procedures that qualify for enhanced reimbursement.

### **Originating Site Facility Fee**

Effective for DOS on and after July 1, 2006, Wisconsin Medicaid will reimburse an originating site a facility fee. The originating site is a facility at which the recipient is located during the telemedicine-based service. It may be a physician's office, a hospital outpatient department, an inpatient facility, or any other appropriate POS with the requisite equipment and staffing necessary to facilitate a telemedicine service. The originating site may not be an emergency room.

#### *Claim Submission*

The originating site is required to submit claims for the facility fee with HCPCS code Q3014 (Telehealth originating site facility fee). These claims must be submitted on an 837P transaction or a CMS 1500 paper claim form with a POS code appropriate to where the

Effective for DOS on and after July 1, 2006, Wisconsin Medicaid will reimburse an originating site a facility fee.

service was provided. Refer to the Attachment of this *Update* for a list of allowable POS codes. Modifier “GT” is *not* required.

### *Outpatient Hospital Reimbursement*

Wisconsin Medicaid will reimburse outpatient hospitals only the facility fee (Q3014) for the service. Wisconsin Medicaid will not separately reimburse an outpatient hospital the rate-per-visit for that recipient unless other covered outpatient hospital services are also provided beyond those included in the telemedicine service on the same DOS. Professional services provided in the outpatient hospital are separately reimbursable.

### **Store and Forward Services**

Wisconsin Medicaid does not separately reimburse for “store and forward” services (meaning the asynchronous transmission of medical information to be reviewed at a later time by a physician or nurse practitioner at the distant site).

### **Information Regarding Medicaid HMOs**

This *Update* contains Medicaid fee-for-service policy and applies to providers of services to recipients on fee-for-service Medicaid only. For Medicaid HMO or managed care policy, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

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/](http://dhfs.wisconsin.gov/medicaid/).

PHC 1250

# ATTACHMENT

## Allowable Place of Service Codes for Telemedicine Services

The following table lists the allowable place of service codes that may serve as the originating site for services performed through telemedicine. The originating site is the location at which the recipient is located.

Code	Description
03	School
04	Homeless Shelter
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
24	Ambulatory Surgical Center
25	Birth Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility — Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57	Nonresidential Substance Abuse Treatment Facility
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End-Stage Renal Disease Treatment Facility
71	Public Health Clinic
72	Rural Health Clinic
99	Other Place of Service

 PROVIDER REFERRAL FORM

Referral Completion Date \_\_\_\_\_

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

**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 \_\_\_\_\_

# PROVIDER REFERRAL FORM

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

# SYNTHESIS

Wraparound Milwaukee Enrollee Name: Client, Sample  
DOB: 1/1/91 Ethnicity: Bi-racial  
Gender: Male  
Current Placement:  
Date Type Location  
12/1/04 RCC Home Home - Neilsville  
2/1/05 Home Parent

# ON-LINE

# FORM

### Contact Information

Youth Sample Client 1234 Any Street  
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	Axis	Description
I (R/O)	Oppositional Defiant Disorder	III	asthma
I (Primar	Attention Deficit Dis, combined typ	IV	divorce of parents
II	Communication Disorder NOS	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 ....

# Entering Progress Notes on Synthesis Crisis Providers

Rev: 4/07

## STEPS TO THE PROCESS

- 1) Entering the Note
- 2) Finalizing the Note
- 3) Supervisory Approval
- 4) Printing Notes

## STEP 1: Entering the Note

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

Select	Last Name	First Name	DOB	Program
	Anderson	Ola	2/5/1988	Wraparound
	Anderson	Theresa	1/1/1991	Wraparound
	Hogan	Aggie	1/1/1982	Wraparound
	Jansky	Jennifer	4/20/1995	Wraparound
	Jones	John	2/2/1988	Wraparound

Select the Client Name.

To look up a client name - type part of the last name in the Search box and click "Search." Click on the envelope to open that client.

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

Finalize Notes   Add Note  
Print Notes   Print POC   Print Crisis Plan

Click on **Add Note**.

## Data Entry Screen for Provider Notes:

**Provider Notes** [Check Spelling] [Insert] [Cancel]

Hours reported for the current calendar month: 0

**Date of Contact:** (mm/dd/yyyy) [ ]

**Recipient:** [ ]

**Start Time:** [ ]:[ ] [AM] [PM]

**End Time:** [ ]:[ ] [AM] [PM]

**Service Type:** Multiple Types Permitted

- Crisis Stabilization
- Crisis Supervision
- Client Contact
- Collateral Contact
- Meetings
- No Show
- Recordkeeping
- Release of Info

**Billing Type**

Medicaid Billable [0]

Non-Medicaid Billable [0]

**Total Hours** (should not exceed 8) [0]

Face-to-Face Time [0]

\* Enter numbers and decimal points; no text.

\*\* Use the minutes to hours conversion below.

0-6 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 does NOT require these fields to be entered. Your AGENCY, however, may require that.

**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 (Client, Collateral, Travel, etc.). You can select multiple types for one note.

- **Client Contact:** ANY type of contact with the identified client alone or with collaterals. Include travel time and recordkeeping time for the contact.
- **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 client was a part of the contact, use the "Client Contact" code. Include travel time and recordkeeping time for the contact.
- **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 client was not available when the provider arrived at the place of contact.
- **Recordkeeping:** Use this code for every entry to acknowledge that part of the time being billed is applicable to the time spent writing the note.

- **Release of Information:** Use this code when written material is released from a client record and/or for disclosure of protected health information. The Release fo 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."
- **Travel:** Use this code in conjunction with other applicable codes when you are billing for travel time.
- **Other:** Use this code if service time you are documenting cannot be identified as any other service type (i.e., writing/preparing a progress summary report for the court or preparing written crisis stabilization related letters/documents to be given to the client/family).

**Service Hour Reporting:**

**Medicaid Billable:** Generally, all of your contact time will be reflected in this box. Exceptions are below.

**Non-Medicaid Billable:**

- 1) No Shows
- 2) ANY time reported while the youth is in Detention or Jail

You can report BOTH types of billing hours on one note. Synthesis will calculate the total hours.

**Face-to-Face Time:** Of the total time reported for the note, indicate how much of that time was face-to-face with the identified service recipient

**Provider Note Text**

See Section II, K of Policy #036, Crisis Stablization/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"

## STEP 2: Finalizing the Note

Notes must be finalized (which becomes your signature). After you finalize a note - it is no longer editable by you. (NOTE: Supervisors will later Reject or Approve each entry; if an entry is Rejected, the note will become editable again.) Notes can be finalized individually, or in a batch for a client.

To finalize an individual note, simply click the "Finalize" button on the Progress Note screen.

Finalizing a batch of notes for a client is done from the initial display screen shown after you select a client name.

Provider Notes		Finalize Notes	Add Note
	Print Notes	Print POC	Print Crisis Plan
Select	Note Information	Status	
	<a href="#">4/7/2007 - Aggie Hale: Writer travelled to client's home and met with client and mother .....</a>	Finalized	
<input type="checkbox"/>	<a href="#">4/5/2007 - Pamela Alioto: content of note ...</a>	Draft	
	<a href="#">4/1/2007 - Aggie Hale: Attended child and family team meeting ...</a>	Finalized	

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

**For the Crisis Worker - this is the final step in the process unless your Supervisor rejects your note. If you have a Progress Note rejected by your supervisor, you will receive a login message informing you of that Rejection, which will contain a link to the Progress Note that needs to be edited. You will be able to edit that note, and will need to "re-finalize" it 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](#)

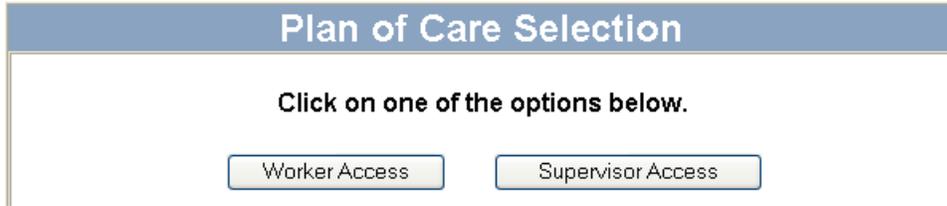
After "Click to View," a list of any rejected notes will appear. Click on client name to link to note.

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 client (as described above for the workers), or you can do a group of supervisees and all of their clients for a specific time frame.

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

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



The screenshot shows a window titled "Plan of Care Selection". Below the title bar, there is a central instruction: "Click on one of the options below." Below this instruction are two buttons: "Worker Access" on the left and "Supervisor Access" on the right.

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, 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 by anyone, and are ready for billing.



The screenshot shows a window titled "Approve Notes by Worker". At the top right of the window are three buttons: "Approve", "Reject", and "Cancel". Below the title bar, there is a central instruction: "Select a date range to approve/reject." Below this instruction are two input fields: "Starting Date:" followed by a text box, and "Ending Date:" followed by a text box. Below these fields is a blue header bar with the text "SELECT WORKERS TO APPROVE/REJECT". Underneath this bar, there is a section titled "Crisis Providers" with three checkboxes and names:  Pamela Alioto [*palioto*],  KAREN ABLE [*kable*], and  PHILLIP SMITH [*psmith*].

# STEP 4: Printing Notes

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

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

Select Provider Notes

Select	Last Name	First Name	DOB	Program
	Anderson	Ola	2/5/1988	Wraparound
	Anderson	Theresa	1/1/1991	Wraparound
	Hogan	Aggie	1/1/1982	Wraparound
	Jansky	Jennifer	4/20/1995	Wraparound
	Jones	John	2/2/1988	Wraparound

Select the Client Name.  
To look up a client name - type part of the last name in the Search box and click "Search." Click on the envelope to open that client.

Click on "Print Notes"

Select	Note Information	Status
<input type="checkbox"/>	4/5/2007 - Pamela Alioto: content of note ...	Draft

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

Provider Notes

**Print Provider Notes**

Starting Date:

Ending Date:

Print All Provider Notes

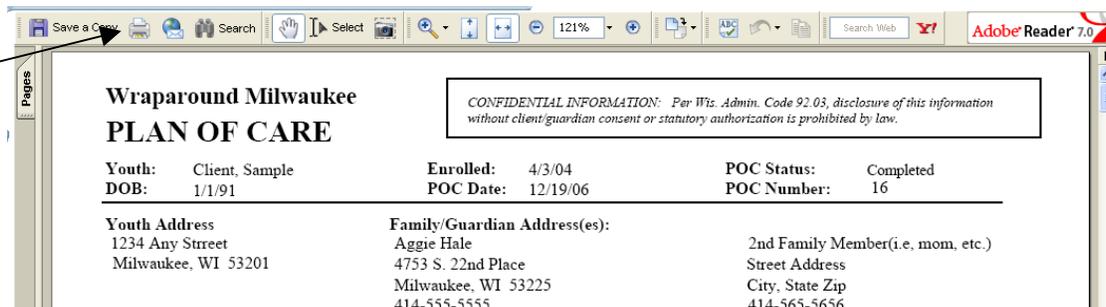
# Printing Plans of Care (POCs) and Crisis Plans

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



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.



# TRANSPORTATION CONSENT FORM

YOUTH/CLIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_  
(Print)

\_\_\_\_\_  
(Provider's Name) OF \_\_\_\_\_  
(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.**