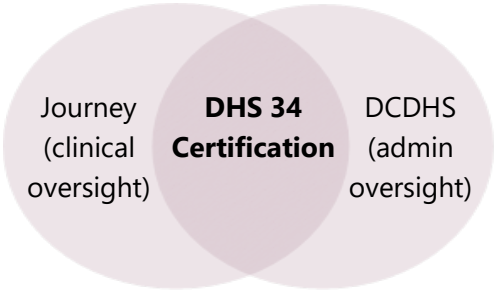
Dane Crisis Provider Network
DHS 34 and Medicaid Billing Handbook

Dane County Department of Human Services
Behavioral Health Division

Contents

Introduction

In Wisconsin, each County is required to provide Emergency Mental Health (crisis) Services as described in DHS 34 regulation and consistent with Wis. Stat. Ch. 51 and other applicable statutes and regulations. Dane County's DHS 34 certification is jointly held by the Dane County Department of Human Services ("DCDHS") and Journey Mental Health Center ("Journey"). DCDHS provides administrative leadership and oversight of programs that provide services under DHS 34, while Journey provides clinical leadership and oversight.



While DCDHS and Journey are at the core of our local crisis system of care, crisis services are provided by a collective of agencies that contract with DCDHS. Together these agencies form the **Dane Crisis Provider Network ("DCPN")**. The services provided by DCPN agencies create a continuum of support for people experiencing a crisis. The four (4) service types offered in our crisis continuum, and the program(s) that provide each, are listed below:

Crisis Hotline

- Crisis Unit (Journey)

Crisis Response

- Crisis Unit (Journey)
- CARES (Journey)
- Law Enforcement-Embedded Crisis Workers (Journey)
- YouthConnect (DCDHS)

Crisis Case Management (Linkage and Follow-Up)

- Anesis Crisis Case Management (Anesis)
- Crisis Stabilization (Journey)
- Enso Crisis Case Management (Tellurian)
- Keystone Crisis Case Management (Journey)
- Off the Square Club (Lutheran Social Services)
- Resource Bridge (Journey)
- Safe Haven (Porchlight)
- SOAR Crisis Case Management (SOAR)
- YouthConnect (DCDHS)

Residential Stabilization

- Dane County Care Center (Tellurian)
- Transitional Housing Program (Tellurian)
- Group Homes, Adult Family Homes, Treatment Foster Care (multiple)

The DCPN strives to deliver crisis care in a way that is accessible, acceptable, appropriate, and accountable, and to create seamless transitions between services in the continuum.

Accessible

People know how to ask for help, and services are easy to understand and navigate. Services are available in a timely manner and with minimal barriers.

Acceptable

Programs deliver care that feels like care. People are willing to ask for help and engage with services because they feel supported and treated with dignity.

Appropriate

The right help is offered at the right time. Services effectively target and address individual needs in the least restrictive manner and environment possible.

Accountable

Each program reliably fulfills is role in the continuum and follows through on its commitments to people in crisis, other programs, and the broader community.

Eligibility for Crisis Services

A **crisis** is a "situation caused by an individual's apparent mental disorder which results in a high level of stress or anxiety for an individual, persons providing care for the individual, and/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" (DHS 34.02(5)).

In general, initiating crisis services is indicated (and may be billed to Medicaid) when there is documentation that:

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

Criteria for determining whether it is appropriate to continue delivering crisis services after an initial contact and intervention are identified in ForwardHealth Topic #6759 and listed below. While this guidance applies specifically to (residential) Crisis Stabilization services, it is useful in identifying the appropriateness of continued service delivery in the Crisis Case Management (Linkage and Follow-Up) context as well. The identified factors that support continued delivery of crisis services include:

1. Continued risk of self-harm
2. Continued risk of harm to others
3. Impaired functioning due to symptoms of a mood and/or thought disorder
4. Recent failure of less restrictive options (independent living, CSP, group living)
5. Lack of available/effective supports (including family) to maintain functioning and safety (e.g., "If supports are withdrawn, the person would be at high risk for relapse, which would lead to more restrictive placement")
6. Need for intensive monitoring of symptoms and/or response to recent med change
7. Recent history of the above that supports the belief that if supports are withdrawn, the risk for more restrictive setting would be imminent

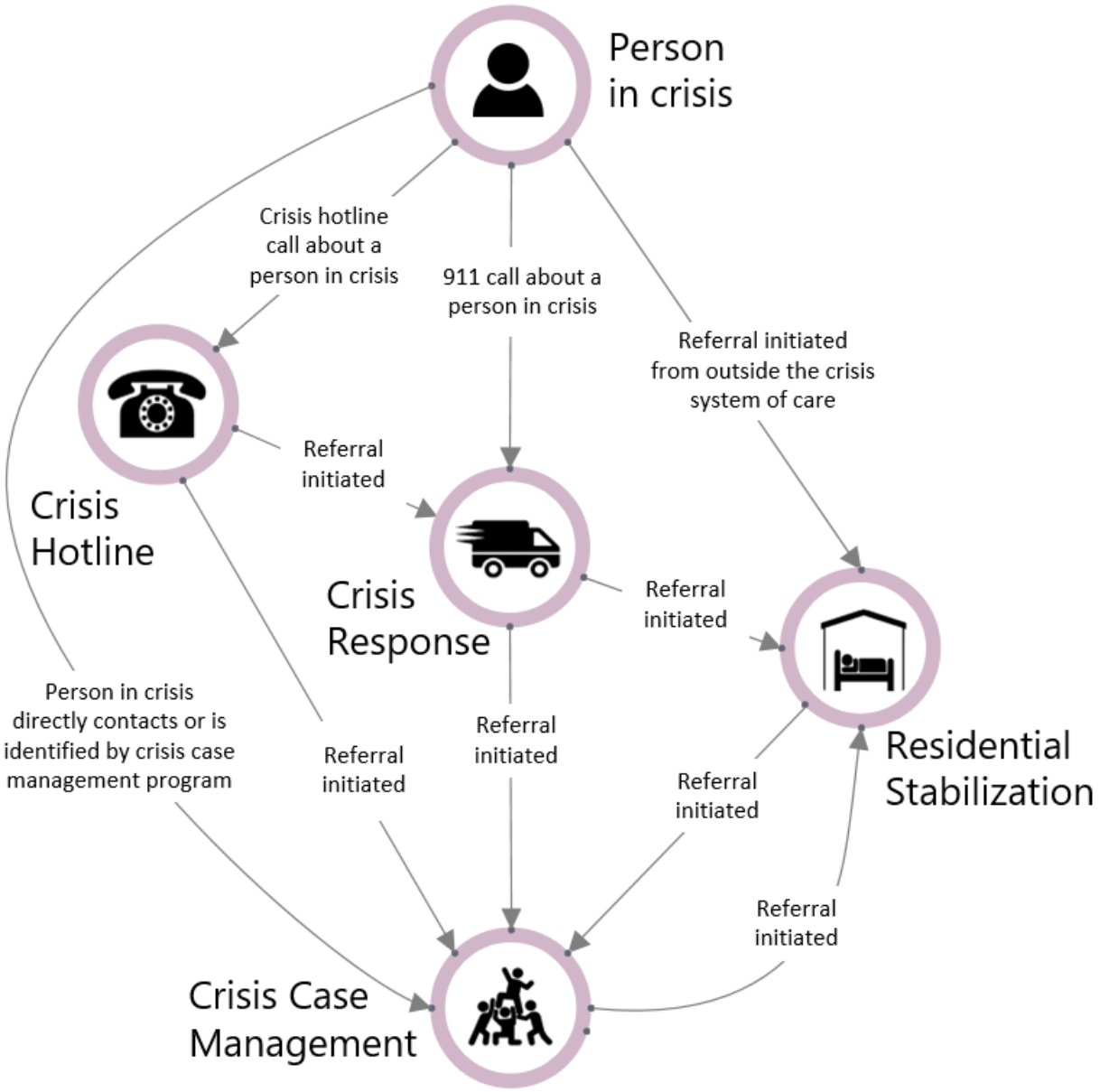
Each crisis program is responsible for ensuring that prospective clients meet these and any additional eligibility criteria established in their contract with DCDHS (for example, many Crisis Case Management and Residential Stabilization programs require clients to meet Dane County residency criteria).

Handbook Scope and Limitations

The purpose of the handbook is to communicate important information about the Dane County crisis system of care and how to participate as a member of the DCPN. It is intended to explain Dane-specific processes and practices, and summarize and clarify important guidance from sources such as DHS 34 and the ForwardHealth Crisis Intervention Online Handbook. It is not intended as a comprehensive summary of all requirements that may apply to a particular program or staff member.

Collaboration among Crisis Programs

This diagram is a visual representation of how a person in crisis might experience the crisis continuum. Individuals may self-identify their need for support, or may be referred by someone else, such as a loved one, a case manager, emergency room staff, or a concerned member of the public. Once identified by the crisis services system, a person may be referred among crisis service programs to help meet their needs.



It is important to note that individuals in crisis also interact with programs and services not pictured here, including 988, law enforcement, ongoing behavioral health teams (e.g. CCS, CSP), and the medical emergency response system (e.g. EMTs, emergency rooms, etc.).

Referral and Follow-Up

Effective collaboration and coordination among crisis programs is essential. For example, when there is initial contact with an individual in crisis, an important component of that service will often be to help the person connect with additional crisis services for follow-up. This may include coordinating with the person's ongoing care team if they have one, referring them to the Dane County Care Center (Tellurian) if they are at risk of hospitalization, and/or referring them to one or more crisis case management programs for support, symptom monitoring, and assistance with connecting or reconnecting with ongoing care.

Referrals should include a warm handoff whenever possible, and information should be shared among crisis programs working with an individual. Multiple crisis programs may support a client concurrently as long as this is clinically indicated and reflected on an active response plan.

Coordination with Journey

There are special considerations for coordination with Journey as the clinical hub for the DCPN.

Journey Crisis Unit ("Crisis Proper")

The Crisis Unit provides crisis hotline and response services, and is responsible for assessing whether involuntary services are required. All crisis programs are expected to promptly contact the Journey Crisis Unit at (608) 280-2600 if any of the following are true:

- The program believes a client they are working with currently poses or is likely to pose a risk of harm to self or others
- The program believes a client they are working with is likely to experience law enforcement contact as the result of their crisis
- The program believes the Crisis Unit is likely to be contacted by or about a client they are working with, and has information that would assist the Crisis Unit in responding

Such information-sharing is intended to assist the Journey Crisis Unit in providing effective and appropriate responses. The Crisis Unit is also expected to share relevant information with crisis program(s) known to be actively working with a client.

Journey Crisis Stabilization

The Crisis Stabilization team provides Crisis Case Management (Linkage and Follow-Up) services and is responsible for monitoring individuals who are under Wis. Stat. Ch. 51 commitment. The Crisis Stabilization team also provides clinical support and oversight to DCPN agencies, including management of Response Plans and Crisis Plans.

While each program's clinical supervisor should be the first point of contact for clinical and documentation questions, Crisis Stabilization can provide (non-urgent) supplemental support when needed. The team can be reached at (608) 280-2624 or linkage.followup@journeymhc.org.

Documentation

In accordance with DHS 34.24, programs that deliver crisis services are required to maintain accurate records of the services provided to clients. These records must be kept in a safe and secure manner consistent with standard professional practices for the maintenance of mental health records. Records should be arranged in a format which provides for consistent recordkeeping within the program and which facilitates accurate and efficient record retrieval. The use of an electronic health record (EHR) is encouraged but not required.

All staff are required to keep and maintain true and accurate records that reflect all services provided to clients. Remember that time spent on travel and documentation should be included and billed for. Activities that are not billable are identified in ForwardHealth Topic #6802.

Who to Ask: *General questions regarding documentation may be directed to your program's clinical supervisor or the Journey Crisis Stabilization team at (608) 280-2624 or linkage.followup@journeymhc.org. Send questions about Response Plans or Crisis Plans specifically to crisis.response.plan@journeymhc.org.*

Response Plans

According to DHS 34.23(1), to be eligible for crisis services, a person must be in a mental health crisis or be in a situation which is likely to develop into a crisis if supports are not provided. If a person is determined to be in need of crisis services, a **Response Plan** must be initiated.

A Response Plan has two main functions:

1. Summarizes key information regarding the person, the nature of their crisis, and the services and supports to be applied to help them, serving as a reference for crisis responders and others providing care to the person.
2. Authorizes services to be billed to the MA crisis benefit.

A Note About Language: *BH programs create various documents to guide client care, with names like "recovery plan", "care plan", "safety plan", and "individual service plan". However, Response Plans and Crisis Plans are specific documents described by local regulations (DHS 34 and ForwardHealth). Using this common language will help us be on the same page as a crisis system!*

An individual receiving crisis services from one or more DCPN programs will have a single Response Plan associated with that episode of crisis care. These centralized Response Plans are maintained in SmartCare, Journey's EHR, and are approved by designated Journey staff.

The specific process for creating and updating client Response Plans differs by program type. Detailed workflows and FAQs about Response Plans can be found in Appendix B.

Service Notes

As soon as possible after any crisis service is provided, staff must document the service by recording the following information:

1. The time, place, duration, and nature of the service and who initiated contact. The content of the service note must substantiate the amount of time billed.
2. The staff person(s) involved and any other person(s) present or involved.
3. The services provided and the outcomes achieved.
4. Information relevant to the client's ongoing level and quality of functioning.
5. Any referrals made.

Service Note Structure

One common format for service notes is the "DAP" format. While DAP-style notes are not required, they can help guide staff members in capturing all the necessary information: *data* about the interaction and service, the service provider's *assessment* of the client, and the *plan* moving forward.

D: Data

- Time, place, duration, and nature of service
- Client presentation/appearance, mental status
- Client reports
- Services provided

A: Assessment

- Progress toward treatment goals
- Client responses to services
- Evaluation of risk

P: Plan

- Anticipated next meeting or service
- Steps to be taken by the client
- Steps to be taken by the staff member
- Planned consultation or other third-party contact

DHS 34 Crisis Plans

Only a small subset of clients who receive crisis services will have a **Crisis Plan** as described in DHS 34.23(7). DHS 34 Crisis Plans are to be developed for clients at high risk of recurrent crises.

In Dane County, Crisis Plans are developed for anyone under a Ch. 51 civil commitment or settlement agreement, anyone who is placed in a residential stabilization program (other than on a short-term basis for hospital diversion), and others who are identified as being at high risk of recurrent crises, which may include people who often present to emergency departments with psychiatric needs, who have chronic suicidal thoughts, who display a pattern of suicidal or homicidal threats or acts, and/or who experience an increase in symptoms that results in repeated contact with crisis programs.

One way to think about the difference between a Response Plan and a Crisis Plan is that Response Plans emphasizes *response* – what services will be applied immediately to help resolve the present crisis, while Crisis Plans emphasizes *plan* – preparation for a future crisis.

RESPONSE plan
crisis _PLAN_

Crisis Plans are collaborative documents developed with the Journey Crisis Stabilization team, the client, the client's parent(s) or guardian(s) (if applicable), their case manager, if any, and any other people or programs providing treatment and support for the person. Crisis Plans identify the interventions most likely to be effective in helping the person resolve or manage a crisis, given the client's unique strengths and needs and the supports available. They are intended to provide guidance for anyone responding to and supporting the person during a crisis, such as crisis programs, law enforcement, community supports, the medical system, and family.

In most cases, Journey staff will initiate the process of scheduling a meeting to create a new Crisis Plan. Detailed workflows and FAQs that address the roles of different program types in developing and updating Crisis Plans can be found in Appendix B.

Quality Assurance

Each program's clinical supervisor is responsible for ongoing quality assurance of crisis services and related documentation. In addition, DCDHS and/or Journey staff may review any and all documentation related to crisis services to ensure services and billing claims meet all criteria outlined in this handbook and other relevant guidance.

If documentation does not meet the required standard, claims may be denied, and as a result would not be reimbursed or could be recouped. Payment may also be withheld for non-compliance with quality assurance activities or non-compliance with quality assurance standards.

Upon request for submission of documentation by DCDHS or Journey, programs have five (5) business days to produce any and all materials requested. In the event of an audit by DHS, programs will need to produce documentation on the timeline expected by DHS.

Billing Medicaid for Crisis Services

Crisis services delivered to eligible Wisconsin Medicaid members are covered under the ForwardHealth "Crisis Intervention" benefit, and DCPN agencies are expected to bill Medicaid for services whenever possible. Agencies provide billing information to DCDHS and DCDHS submits claims to the Wisconsin Department of Health Services (DHS).

Wisconsin DHS's ForwardHealth Crisis Intervention Online Handbook is the most comprehensive and up-to-date resource on billing Medicaid for crisis services.

Client Eligibility for Medicaid-Covered Crisis Services

ForwardHealth Topic #6761 describes eligibility criteria for billing Medicaid for crisis services. Crisis services may be initiated and billed to Medicaid when there is documentation that:

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

This documentation is accomplished through the creation of a response plan that establishes the medical necessity of crisis services and recommends the specific services to be delivered to the individual (see the response plan section of this handbook for more details).

Who to Ask: *Questions regarding client eligibility should be directed to your clinical supervisor or the Journey Crisis Stabilization team at (608) 280-2624 or linkage.followup@journeymhc.org.*

Client Registration and Linkage

Programs will automatically be able to enter billing claims for all clients that have been previously served by their agency. If a client has never been served by a program's agency they will not be visible in the billing portal and a linkage request must be submitted.

To request a client be linked to your program, email crisisbillingsupport@danecounty.gov with a completed Client Registration Form ("600 Form"). This form can be found here: https://providers.dcdhs.com/Reporting-Requirements/Client-Registration-Form.

Who to Ask: *Questions regarding client registration and linkage should be directed to crisisbillingsupport@danecounty.gov.*

Once registration and linkage has been completed, billing claims for services delivered to that client may be entered through the crisis billing portal.

Submission of Claims

> ***Who to Ask:*** *Questions regarding the billing portal or submitting claims should be directed to crisisbillingsupport@danecounty.gov.*

Billing claims can be entered into the DCDHS crisis billing portal by agency staff with portal access. Rostered service providers who need portal access to enter their own billing claims are granted access as part of the rostering process. Access to the portal for staff members who are not service providers but who are in support roles may be requested by emailing the staff member's full name, agency, and email address to crisisbillingsupport@danecounty.gov. Information about the portal, a link to the portal itself, and instructional materials on entering claims can be found on the DCPN website at https://providers.dcdhs.com/DCPN.

Billing claims should be submitted weekly, and *must* be submitted no later than the 7th day of the month after the date of service. DCDHS will submit program claims to ForwardHealth monthly. Once Forward Health has processed the claims and produced a remittance report, DCDHS will share the remittance details with contracted programs for review.

Place of service

All Medicaid claims must have a **place of service** (POS) code entered for the service provided. The POS codes used for crisis claims are identified in ForwardHealth Topic #6798. The POS code for each claim should reflect where the service was rendered (in other words, the location of the *service provider* at the time of the service. If a service provider delivers services to a client in multiple places on a single day, the selected POS should be the location where the most time was spent. Definitions for each POS code are established by CMS and can be found here: https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets.

Telehealth

In general, the place of service will be the physical location of the service provider at the time they provided the service. However, if a service is delivered via telehealth, a telehealth POS code must be selected. All telehealth services must adhere to guidance established in ForwardHealth Topic #510, including that:

- The client must consent to the use of telehealth
- The connection must be good enough that the service can be delivered with the same quality as it would be in person
- Audio-video communication (rather than audio-only communication) must be used whenever possible.

When entering claims with a telehealth POS there is a place to indicate whether the service was delivered using audio-visual communication or audio-only communication.

Procedure Codes (Service Types)

All Medicaid claims have a corresponding **procedure code** (HCPCS code). Each Dane County crisis program is able to deliver a specific type of service, and when claims are entered into the billing portal for that program, the appropriate procedure code is automatically applied.

While agency staff do not need to manually select the procedure code when entering billing claims, it is beneficial to understand what the different procedure codes are and how they are related to the various crisis services available in the Dane continuum of care. These procedure codes are also listed in ForwardHealth Topic #6763.

More about delivering and billing for each type of service can be found in the "special considerations" section of this handbook dedicated to each service type.

H0030 - Local Crisis Intervention Line

- Billed by the Crisis Hotline program
- Claimed on a per-call basis, up to one call per day per member

H2011 - Crisis Response

- Billed by Crisis Response programs
- Hourly reimbursement in 15-minute increments

T1016 - Linkage and Follow-Up

- Billed by Crisis Case Management programs
- Hourly reimbursement in 15-minute increments

S9484 and S9485 - Crisis Stabilization

- Billed by Residential Stabilization programs
- S9484 is used for hourly reimbursement in 1-hour increments
- S9485 is used for per-diem reimbursement

Special Considerations: Crisis Hotline

A crisis hotline is a local telephone number that individuals in crisis (or people calling on their behalf) can contact for professional support. A crisis hotline is available 24 hours per day, every day of the year. The ForwardHealth service type for this service is **Local Crisis Intervention Line**, and the procedure code used is H0030, which can be billed once per day per Medicaid member. Dane County's local crisis hotline is operated by the Journey Crisis Unit.

Telephonic Triage

When an individual in crisis or someone acting on their behalf (a referent) contacts the crisis hotline, phone workers must engage in **telephonic triage** by doing a preliminary assessment to determine the nature of the call and the need for further evaluation, an immediate in-person response, and/or referrals to other services. Telephonic triage is not billable. More information and guidance regarding telephonic triage can be found in ForwardHealth Update number 2023-06 (available at https://www.forwardhealth.wi.gov/kw/pdf/2023-06.pdf)

If the phone worker identifies that the person the call is about is in crisis and requires further crisis services, a Local Crisis Intervention Line (H0030) service can be provided if one has not already occurred that day. This requires the creation of a response plan, unless there is already an active plan on file that recommends using the Local Crisis Intervention Line.

Transitioning to Other Service Types

If a H0030 service has already been provided to the client that day and/or if another type of crisis service (such as an in-person crisis response or follow-up services with a crisis case manager) is identified as most appropriate, the telephone worker may facilitate initiation of services other than H0030, provided that there is an active response plan on file that recommends them. If such a response plan does not exist, one must be created, or an existing plan must be updated to include the services to be delivered.

Place of Service

A telehealth place of service must be used for all H0030 claims. There are two telehealth POS codes:

- 02: Telehealth provided other than in patient's home (to be used when the client is in a location *other* than their home when the service is provided)
- 10: Telehealth provided in patient's home (to be used when the client is in their home when the service is provided)

Special Considerations: Crisis Response

Crisis response is a rapid response to an individual experiencing a behavioral health crisis, regardless of their location. It is intended as an in-person service delivered by going to the individual, but can also be delivered on a walk-in basis. If appropriate, crisis response may be delivered via telehealth according to telehealth guidelines. The ForwardHealth service type for this service is **Crisis Response**, and the procedure code used is H2011.

Mobile Crisis Teaming

A crisis response may be delivered by a team of responders working together. As described in ForwardHealth Topic #22777, when all of the following are true, a crisis response is officially considered a **teamed response**:

- All team members must be rostered crisis service providers
- At least one team member must be a professional with the qualifications described in DHS 34.22(3)(b)3, and there must be at least one additional Medicaid provider
- At least one team member must provide services in person (additional team members may provide services in person or via telehealth)

When a Crisis Response (H2011) claim is entered in to the crisis billing portal, there is a place to indicate whether it meets the definition of a teamed response.

Coordination and Referral

An important component of crisis response is helping the person in crisis access appropriate follow-up services to maximize their stability in the community. This may include making contact with the person's ongoing care team if they have one, referring them to Dane County's residential hospital diversion facility (the Dane County Care Center operated by Tellurian), and/or referring them to one or more crisis case management programs for support, symptom monitoring, and assistance with connecting or reconnecting with ongoing care.

Response plans developed in the course of crisis response must identify recommended crisis services and should be shared with these programs so that care can be coordinated between providers. Individuals in crisis may receive services from multiple crisis programs at once as clinically indicated. All services must be reflected on an active response plan.

Use of Telehealth for Crisis Response

Crisis response services are intended to be delivered in person, and in-person response is recommended whenever possible and appropriate. However, crisis response may be provided via telehealth, following guidelines established by ForwardHealth (see Topic #510 and the Place of Service section of this handbook for more information). For telehealth to be permissible, it must be "functionally equivalent" to an in-person service.

Special Considerations: Crisis Case Management

Crisis case management refers to crisis support services provided outside of a residential context that focus on helping a person in crisis regain stability and connect to supports that will help them remain safe and stable in the community. The ForwardHealth service type for this service is **Linkage and Follow-up**, and the procedure code used is T1016.

Crisis Case Management Services

The linkage and follow-up services delivered by crisis case management programs are described in ForwardHealth Topic #6804. Examples of these services include:

- Determining whether new or additional ongoing connections are needed, and helping to form these linkages
- Providing follow-up contacts until the client has begun to receive assistance from an ongoing service provider, unless they do not consent to further services
- Coordinating with the client's ongoing mental health service providers, if any
- Enhancing individual and family coping skills
- Developing a new crisis plan under DHS 34.23(7) or revising an existing plan

Concurrent Crisis Case Management Services

DCPN crisis case management programs vary in intensity, service setting, and target population. Individuals in crisis may receive services from multiple crisis programs, including multiple crisis case management programs, at once as clinically indicated. All services must be reflected on an active response plan.

Use of Telehealth for Crisis Case Management

Crisis case management includes services delivered directly to a client, as well as contacts with 3rd parties to gather information, coordinate care, etc. A telehealth place of service is to be used when services are delivered directly to a client in a manner consistent with telehealth guidelines (ForwardHealth Topic #510 and the Place of Service section of this handbook). The place of service used for all other services, including telephonic or audio-visual communication with 3rd parties, should reflect the location of the service provider at the time of the service.

Response Plans and Crisis Plans

Specific guidance for Crisis Case Management (Linkage and Follow-Up) programs with regards to Response Plans and Crisis Plans can be found in Appendix B. There is both a workflow that shows the steps that need to be taken to establish/update plans, as well as a FAQ document specific to this service type.

Special Considerations: Residential Stabilization

Residential stabilization services are services delivered in a residential setting to a person in crisis who has such services identified in their response plan and/or crisis plan. The ForwardHealth service type for this service is **Crisis Stabilization**, and the procedure code used is either S9484 (for hourly) or S9485 (for per diem).

Eligibility and Determination of Need

As described in ForwardHealth Topic #6805, residential stabilization services are only covered by Medicaid when necessary for one or both of the following:

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

Additional clinical criteria for continued residential stabilization are established in ForwardHealth Topic #6759 and listed below. Each residential stabilization program and its clinical supervisor to document "determination of need" (in other words, the factors that support a person continuing to receive residential stabilization services) at least weekly.

Eligibility requires at least one of the following:

1. Continued risk of self-harm
2. Continued risk of harm to others
3. Impaired functioning due to symptoms of a mood and/or thought disorder
4. Recent failure of less restrictive options (independent living, CSP, group living)
5. Lack of available/effective supports (including family) to maintain functioning and safety (e.g., "If supports are withdrawn, the person would be at high risk for relapse, which would lead to more restrictive placement")
6. Need for intensive monitoring of symptoms and/or response to recent med change
7. Recent history of the above that supports the belief that if supports are withdrawn, the risk for more restrictive setting would be imminent

Service Notes for Per Diem Residential Stabilization Programs

Documentation for per diem programs (those that bill under S8495) must specifically indicate whether the client was present on the date of the note. Billing cannot be submitted for dates on which a client is not present.

Service Provision by Multiple Staff

Wisconsin Medicaid will cover more than one program staff member providing crisis services to a client simultaneously if this ensures the client's or others' safety (e.g., if the client is threatening to hurt others). Program staff are required to clearly identify the number of staff involved when billing for more than one staff person at the same time and the rationale for using multiple staff in their documentation each time this occurs.

Wisconsin Medicaid also covers services delivered by outside professional staff who come into a residential stabilization facility for a limited time to provide services to a resident, if these services are not duplicative. In some cases, such services must be related to discharge planning to be billable.

Resident Records

In addition to meeting the general requirements for records and documents found elsewhere in this handbook, residential service providers must meet all of the following standards:

1. The agency must maintain a record for each resident that includes all of the following:
    a. The resident's name and date of birth.
    b. If the resident has a guardian or activated Power of Attorney (POA), the name, address, and phone number, and email address of those individuals.
    c. Any other people identified by the resident as a support.
    d. The name, address and phone number of the resident's primary care provider and all other individuals who shall be to be notified in the event of an emergency.
    e. If applicable, the name, address and phone number of the placing agency, case management agency, and case manager.
    f. If applicable, the most current agreement for services between the resident, the placement provider, and the County.
    g. Medical insurance information including (as applicable) Medicaid and Medicare numbers, private insurance, and the name of the pharmacy that the resident uses.
    h. All available medical reports received during the past two (2) calendar years at any primary care professional, dentist, or other professional health care provider visit during the period the resident has been placed.
    i. The resident's current Individual Service Plan.
    j. Documentation that the resident and the resident's guardian, if any, have been properly notified of the residential program's rules and expectations, client rights, and the grievance procedure, and copies have been provided to the parties.

2. Resident records shall be maintained in a secure location within the home to prevent unauthorized access. The records of residents shall be confidential in accordance with all applicable state and federal laws, regulations and program requirements. Access to records of a resident's HIV test results shall be controlled by s. 252.15, Stats. Access to other resident records shall be restricted to the following: the resident, the resident's guardian, authorized representatives of the department, other persons or agencies with the informed written consent of the resident or resident's guardian, if applicable, persons or agencies authorized by s. 51.30, Stats., ss. 146.81 to 146.83, Stats., or 42 CFR Part 2, and persons or agencies authorized by other applicable law.
3. Section 51.30 (4) (b) 5. and 15., Stats., permits sharing of limited information in certain circumstances between the department and a county department established under s. 46.215, 46.22, 46.23, 51.42 or 51.437, Stats.
4. Copies of a resident's record shall be made available on request to the resident, the resident's guardian or a designated representative of the resident as soon as reasonably practicable if authorized in writing by the resident, at a cost no greater than the cost of reproduction.

Response Plans and Crisis Plans

Specific guidance for Residential Stabilization programs with regards to Response Plans and Crisis Plans can be found in Appendix B. There is both a workflow that shows the steps that need to be taken to establish/update plans, as well as a FAQ document specific to this service type. There are separate workflow and FAQ documents for the Dane County Care Center (DCCC).

Staff Conduct

Staff members of DCPN agencies must adhere to the following guidelines regarding the provision of crisis services. Staff members are also responsible for adhering to all professional standards and agency policies that apply to them.

1. Staff shall not provide any crisis service that they are not professionally qualified to provide and for which they lack necessary licensure or certification.
2. Staff shall not violate any law in any jurisdiction related to providing crisis services.
3. Staff shall not misrepresent their education, professional credentials, or experience.
4. Staff shall not engage in false or fraudulent billing practices.
5. Staff shall not make false or misleading statements during the provision or documentation of crisis services.
6. Staff shall not discriminate on the basis of age, race, ethnicity, religion, color, gender, disability, marital status, sexual orientation, national origin, cultural differences, ancestry, physical appearance, arrest/conviction record, military participation, political beliefs, or any other protected class with regard to service provided or denied.
7. Staff shall not provide or attempt to provide crisis services while impaired due to the use of alcohol or other drugs, or as a result of an illness impacting their ability to safely carry out their crisis functions.
8. Staff shall not violate confidentiality or HIPAA.
9. Staff shall not engage in any mistreatment of crisis clients including physical, verbal, sexual, financial, or emotional abuse.
10. Staff shall not engage in sexual contact or sexual/seductive conduct with a crisis client or member of the crisis client's immediate family.
11. Staff shall avoid dual relationships or relationships that create a conflict of interest. Whenever possible, staff members shall not provide crisis services to close friends or relatives, employees, employers, supervisors, supervisees, or any other person with whom the staff member shares a close ongoing relationship.
12. Staff shall not operate a residential facility or a motor vehicle on crisis business without legally required licensure/certification and insurance.
13. Staff shall not engage in financial transactions with crisis clients including lending, borrowing, or taking possession of client funds unless expressly authorized to do so.
14. Staff shall not exchange anything of value with or offer gifts that have a retail value of more than $15 individually or a total of $75 per year per client to a crisis client. Gifts of cash or cash equivalents are always prohibited.

Client Rights and Grievance Resolution Policy

Notification of Rights

Clients receiving crisis services have rights under Wis. Stat. 51.61(1) and DHS 94, as well as other applicable statutes and regulation. Each DCPN agency and program must:

- Have an established process for explaining client rights to new clients that adheres to requirements in DHS 94.04.
- Post the Wisconsin DHS client rights poster in a highly visible area in each client area.
- Provide each client with a written copy of their rights. This can be satisfied by providing a *Client Rights and the Grievance Procedure* pamphlet published by Wisconsin DHS.

To access printable copies of client rights pamphlets and for information about requesting free client rights posters, visit the DHS Client Rights Pamphlets and Posters webpage at https://www.dhs.wisconsin.gov/clientrights/formspubsposters.htm.

Client Rights

The rights of clients being served by crisis programs are summarized on the DHS client rights webpage (https://www.dhs.wisconsin.gov/clientrights/intro.htm), and below. Every person receiving services has a right to:

1. Treatment rights
    a. Receive prompt and adequate treatment.
    b. Participate in their treatment planning.
    c. Be informed of their treatment and care.
    d. Refuse treatment and medications unless court-ordered.
    e. Be free from unnecessary or excessive medications.
2. Record privacy and access
    a. Challenge the accuracy, completeness, timeliness, and relevance of record entries.
    b. Have their information kept confidential.
    c. Not have their records released without consent (there are exceptions to this).
    d. View their own records.
    e. View medicine and treatment records (there are exceptions to this).

    More information regarding treatment record confidentiality can be found here.
3. Communication rights
    a. Have reasonable access to a telephone.
    b. See (or refuse to see) visitors daily. *
    c. Send or receive mail.
    d. Contact public officials, lawyers or patient advocates.

4. Personal rights
    a. Have the least restrictive environment (there are exceptions to this).
    b. Not be secluded or restrained (there are exceptions to this).
    c. Wear their own clothing and use their own possessions. *
    d. Have regular and frequent exercise opportunities.
    e. Have regular and frequent access to the outdoors.
    f. Have staff make reasonable (non-arbitrary) decisions about them.
    g. Refuse to work – except for personal housekeeping tasks.
    h. Be paid for work they agree to do that is of financial benefit to the facility.
5. Privacy rights
    a. Not be filmed or taped without consent.
    b. Have privacy in toileting and bathing. *
    c. Have a reasonable amount of secure storage space for personal possessions. *
6. Miscellaneous rights
    a. Be treated with dignity and respect by all staff.
    b. Be informed of their rights.
    c. Be informed of any costs of their care.
    d. Refuse electro-convulsive therapy (ECT).
    e. Refuse drastic treatment measures.
    f. File grievances about violations of rights.
    g. Be free from any retribution for filing grievances.

Client rights marked with an asterisk may be limited or denied by some programs under certain circumstances. If a program feels there is a clinical need to limit or deny a right that may be limited or denied, it should complete the DHS Form F-26100 and send it to its certifying agency.

Who to Ask: *Questions regarding client rights should be directed to your contract manager.*

Assistance with Grievance Procedure and Exercise of Rights

Clients have the right to advocacy throughout the grievance process. Agencies and DCDHS must assist clients as needed and cooperate with organizations and individuals providing such assistance, including a client's case manager, the Wisconsin Coalition for Advocacy, Disability Rights Wisconsin, client rights staff, and any other organization or person providing advocacy. No person may be required to waive any rights as a condition of receiving services.

Any form of coercion to discourage or prevent a client or a client's guardian or designated representative from exercising any rights is prohibited. Any form of retaliation against a client or a client's guardian or designated representative for exercising rights, or against a service provider who provides assistance or advocacy, is prohibited.

Grievance Resolution Process

Key things to know about the grievance process include the following:

- A parent, guardian, or other person acting on a client's behalf may file a grievance.
- Clients cannot be threatened or penalized in any way for filing a grievance.
- Programs must inform clients of their rights and how to use the grievance process.
- Clients may, at the end of the grievance process, or at any time during it, choose to take the matter to court.
- Grievances must be filed within 45 days of becoming aware of the problem, but an extension can be granted for good cause.

Grievance Process Step 1 – (Optional) Informal Discussion/Resolution

Rather than file a formal grievance, a client may request an informal discussion of his/her complaint with the staff and/or manager of the program with which the client has the complaint.

Clients should be encouraged to share their complaints, disagreements or concerns directly with program staff, or the supervisor or manager who oversees the program. The client may also directly contact the agency's client rights officer (or the DCDHS client rights specialist if an agency does not have their own), to discuss options for resolution or seek assistance with a potential complaint/grievance.

Grievance Process Step 2 – Program Level Review

Within 45 days of the incident, a grievance either verbal or in writing, may be filed with the agency by submitting it to the agency's client rights officer, the program manager, or any staff member. Grievances against crisis programs and staff are processed through each agency's grievance process.

If an agency does not have its own grievance process and client rights officer, a grievance may be filed by contacting the DCDHS Behavioral Health client rights specialist using the contact information below:

BHintake@danecounty.gov
1202 Northport Dr
Madison, WI 53704
608-242-2600

After receiving a grievance, a client rights officer at the agency (or DCDHS) will meet directly with the client and may interview the client, staff and/or others involved and review the client's clinical treatment record. At any time during a formal level review, the client may decide to use or return to the informal resolution process.

Unless the grievance is resolved informally, or an extension was agreed upon, the client and those who assisted the client in filing the grievance, and the program manager, will receive a report from the client rights officer with findings and recommendations within 30 days. If the grievance is determined to be founded, the report must describe the specific actions recommended by the client rights officer. If all parties agree with the recommendations for resolution those recommendations should be put into effect.

If there is a disagreement over the report, more discussion may be had to come up with a mutually agreed upon plan for resolution of the grievance. If, through further discussion, their still remains disagreement with the resolution, the program manager must prepare a written decision describing the matters which remain in dispute and stating the findings and determinations and recommendations which form the official position of the program. The program manager's report must include a notice and explain how, where and by whom a request for administrative review of the decision may be filed including the time limits for requesting administrative review. The report must be given personally or sent via first class mail to the client and anyone else who received a copy of the client rights staff person's report.

Grievance Process Step 3 – Administrative Review by Dane County

Within 14 days of the date the grievant receives the written decision from the program manager, a person may file a request for an administrative review by the Dane County Administrator. A request for Dane County Administrator review of a program manager's decision shall include the basis for the grievant' s objection and may include a proposed alternative resolution. The County Administrator, or their designee, will review a copy of the original grievance, the report of the client rights officer, the written decision, and the request for review to the County Administrator, or their designee. The County Administrator, or their designee, may make further inquiry into the allegations which may include: personal interviews, telephone calls and inspection of documentation of facilities relevant to the grievance.

After completion of the review, the County Administrator will prepare a written report and determine if the grievance was founded or unfounded. If the County review is conducted by the County Administrator's designee, the designee must submit a draft report to the County Administrator who must issue the written decision in the matter. Distribution of the County Administrator's decision shall go to the client and/or grievant, program manager, client rights officer, parent/guardian of client, as required, and all staff who received a copy of the program manager's decision. The County Administrator's decision shall include a notice to the client and the program manager which explains how and where a state level review of the decision can be requested and the time limits for the further review to the state. A state level review must be requested by any party within 14 days from the date the party receives the County Administrator's administrative review.

Grievance Process Step 4 – Review of County Decision by the State of Wisconsin

Within 14 days of the Dane County Administrator's administrative decision, a person may file a request for review by the State Grievance Examiner:

State of Wisconsin Grievance Examiner
Wisconsin Department of Health Services
Client Rights Office
PO Box 7851
Madison, WI 53707-7851

The Grievance Examiner will review the County Administrator's decision, gather additional information as necessary, and issue a decision within 30 days of receiving the request for review.

Grievance Process Step 5 – Final State Review

The Grievance Examiner's decision will describe the process and time limits for requesting final state review. A final state review decision must be made within 30 days of receiving the request for final state review.

Note: The timeframes stated above can be extended by agreement of all parties and are shorter if one or more people are at significant risk of physical or emotional harm due to the circumstances identified in the grievance

Crisis Program Staff Requirements and Rostering

Staff Role Types

DCPN agencies utilize a variety of people working in different roles to deliver crisis programs. Any person working in a crisis program under an agency's direction or control (including employees, interns, contractors, and volunteers) are subject to certain requirements. Generally speaking, roles can be divided into two categories according to whether they are involved in delivering crisis services to clients: *service providers* and *support roles*.

Service Providers

Any individual working on behalf of an agency who directly provides crisis services to clients must be rostered as a **service provider** with DCDHS. The rostering process is described below in detail and includes a Caregiver Background Check (CBC).

Most rostered service providers will have Medicaid services billed under their name, though some may not (for example, some staff working in residential stabilization programs that bill per diem). If an individual service provider will enter their own billing claims into the DCDHS Crisis Billing Portal, portal access may be requested for that person during rostering.

Program Support Roles

A variety of other roles *that do not provide direct crisis services* may also be involved in operating a crisis program. The requirements for a person in such a will role depend upon whether they will have regular, direct client contact and whether they will enter crisis billing claims.

If the support role involves…	**Regular, direct client contact**	**Entering billing claims**
Then it requires…	Caregiver Background Check (CBC)	DCDHS Crisis Billing Portal access
Examples include…	Foodservice worker who serves food to clients; volunteer who leads a knitting group	Billing specialist; administrative support
Notes	These CBCs do not need to be submitted to DCDHS, but must be kept on file with the agency	Access to the DCDHS Crisis Billing Portal may be requested by sending an email with the staff member's full name, agency, and email address to crisisbillingsupport@danecounty.gov

Rostering Crisis Service Providers

Staff members who will provide crisis services must be rostered as crisis service providers with DCDHS. Rostering involves providing information and documentation that demonstrates compliance with DHS 34 requirements. If a service provider works for multiple agencies, they must be rostered separately by each agency.

Rostering a New Staff Member as a Service Provider

To roster a new staff member as a crisis service provider with an agency, a representative of the agency must fill out a web-based form created by DCDHS. A link to this form can be found at https://providers.dcdhs.com/DCPN. The form collects all pieces of information and documentation needed to initially register a staff member as a crisis service provider and establish compliance with DHS 34 requirements.

Detailed instructions explaining what is required and how to complete the form can also be found at https://providers.dcdhs.com/DCPN.

Who to Ask: *Questions regarding the rostering process should be directed to crisisbillingsupport@danecounty.gov.*

The information and documents collected on the Crisis Roster Registration Form include:

- The staff member's information (name, date of birth, start date)
- The staff member's professional level for purposes of billing the Medicaid crisis benefit
- The staff member's role and qualification type (from among the staff qualification categories established in DHS 34.21(3)(b))
- Documentation of a completed Caregiver Background Check
- Attestation that at least two reference checks/recommendations were obtained
- The staff member's résumé
- In some cases, proof of the staff member's degree or Certified Peer Specialist credential

Reporting Staff Changes

Agencies must inform DCDHS of changes to their crisis roster or the status of any of their service providers within two (2) business days by emailing crisisbillingsupport@danecounty.gov. Changes that must be reported include a change in a service provider's name, professional level, or employment status. On a quarterly basis, DCDHS sends agencies a listing of all their rostered staff members to verify that the information on file is accurate.

Interns

Clinical interns (paid or unpaid) must be rostered if they provide crisis services. Services delivered by interns are billable to Medicaid at the appropriate Professional Level.

Maintaining Active Roster Status

Once a staff member is rostered as a service provider, further documentation is periodically required to demonstrate ongoing compliance with DHS 34. All documentation required after the initial roster form is completed should be sent to crisisbillingsupport@danecounty.gov according to the schedule below:

Documentation Type	Frequency	Due Date
Orientation training log and supporting documentation	One-time	Within three (3) months of the staff member's start date as a service provider.
Any Caregiver Background Check (CBC) documents not initially submitted (e.g., out-of-state check or DD-214 documentation)	One-time	Within three (3) months of the staff member's start date as a service provider.
Clinical supervision log	Quarterly	No more than two (2) weeks after the end of each quarter of the calendar year, beginning with documentation for the same quarter as the staff member's start date as a service provider.
Ongoing training log and supporting documentation	Annually	No more than two (2) weeks after the end of each calendar year, beginning with the first full calendar year *after* the staff member's start date as a service provider (for example, for someone starting on any date in 2024, the first ongoing training log would be due at the end of 2025).
Repeat Caregiver Background Check (CBC)	Every four (4) years	No more than four (4) years following the date of the previous CBC result.

If an agency is more than three (3) months delinquent in providing documentation to support a service provider remaining active on the roster, DCDHS may suspend the ability to bill for services delivered by that staff member until documentation is received.

Professional Level

Service providers bill for crisis services under an established **professional level**. The professional level for each service provider is reported during the rostering process, and is then automatically applied to all billing claims for that service provider.

Who to Ask: *Questions regarding professional level should be directed to your contract manager*

The professional levels used for crisis billing are identified in ForwardHealth Topic #6777. ForwardHealth names but does not define these professional levels, so guidance from DCDHS on determining the professional level for each staff member delivering crisis services can be found below. Each staff member's professional level for crisis billing is the highest listed category that accurately describes them. Importantly, professional level is distinct from the qualification categories established in DHS 34.21(3)(b).

Professional Level	Definition / Qualifications
Psychiatrist	ABPN-certified psychiatrist
APNP	Licensed advanced practice nurse prescriber
Doctoral level	Doctoral degree in a relevant field*
Masters degree level	Master's degree in a relevant field*
Bachelors degree level	Bachelor's degree in a relevant field*
First Responder Level 2	Licensed/certified Paramedic or Paramedic with Critical Care Endorsement for Inter-Facility Transport
First Responder Level 1	Licensed/certified Emergency Medical Responder, EMT, Advanced EMT, or EMT-Intermediate
Certified Peer Specialist	Certified Peer Specialist
Paraprofessional	Skills and experience necessary to provide effective emergency mental health services

* Psychology, social work, human services, counseling, or another closely related discipline

If a staff member's professional level changes (for example due to obtaining a new degree or credential), the agency must inform DCDHS within two (2) business days. Professional level updates should be sent to crisisbillingsupport@danecounty.gov.

Caregiver Background Checks

DCDHS follows Wisconsin DHS's Caregiver Background Check (CBC) process. Instructions can be found at https://www.dhs.wisconsin.gov/misconduct/employee.htm.

CBC Record Components

A complete CBC record consists of *all three* of the following documents:

1. A Background Information Disclosure (BID) form filled out by the staff member.
2. A response from the Wisconsin Department of Justice (DOJ) consisting of either a "no record found" response or a criminal record transcript.
3. A response letter from the Wisconsin Department of Health Services (DHS) that reports the person's status, including any administrative finding or licensing restrictions.

To complete a CBC, the prospective staff member must provide their employer with a completed *F-82064 Background Information Disclosure* (BID) form. Agencies submit the BID to the Wisconsin Department of Justice (DOJ) online at https://recordcheck.doj.wi.gov/ or via mail. The DOJ runs the background check and sends the response documents to the agency.

For rostered staff members (service providers), CBC documents are provided to DCDHS as part of the rostering process. For staff members in support roles who will not be rostered but have regular, direct client contact, agencies do not need to submit CBC documents to DCDHS but must keep a current CBC on file

Who to Ask: *Questions regarding CBCs should be directed to your contract manager.*

CBC Timing and Frequency

A CBC must be completed prior to a staff member starting in any role where one is required, and must be repeated at least once every four (4) years, or at any time the agency has reason to believe that a new one should be obtained.

CBC Special Requirements

There are certain situations that may require additional background check documentation. For more information about special requirements see DHS's Wisconsin Caregiver Program Manual. Two of the most common special requirements are listed below:

- For staff members who lived outside the state of Wisconsin within the three (3) years preceding the background check, state background checks from all states where the staff member resided within the last three (3) years or an FBI Criminal Records Check (national fingerprint-based criminal history check) is required.
- For staff members who were discharged from the military within the three (3) years preceding the background check, military discharge papers (DD-214) are required.

CBC Findings

Agencies are responsible for examining CBC results and making employment decisions in accordance with the requirements and prohibitions in the law. DHS Publication P-00274 and the Wisconsin Caregiver Program Manual offer guidance regarding offenses that may prohibit an individual from working with clients. If a current staff member is convicted of a crime or has another action against them that could impact their ability to provide services, the agency must notify the DCDHS contract manager(s) of this within one (1) business day of finding out.

Training Requirements

All crisis service providers must meet orientation and ongoing training requirements, and each agency is responsible for the training of its own staff.

Orientation Training

Orientation training must be completed within three (3) months of a service provider's start date. For example, for a service provider who starts on November 1, 2023 must complete orientation training (and submit documentation of this) by February 1, 2024.

The amount of orientation training required depends upon a staff member's level of experience providing emergency mental health services when they start in their service provider position.

1. Less than 6 months of emergency mental health experience: 40 hours
2. 6 months or more of prior emergency mental health experience: 20 hours

During the rostering process, agencies identify whether the service provider being rostered requires 20 or 40 hours of orientation training based on their past experience. Agencies are responsible for determining what experience qualifies for the lower orientation training requirement, and where there is any doubt about the applicability of past experience, agencies should have staff complete the full 40 hours of orientation training.

Who to Ask:
Questions regarding training requirements should be directed to your contract manager.

University of Wisconsin Green Bay Behavioral Health Training Partnership (BHTP) offers a *Crisis Intervention Services Orientation* course as part of its Crisis Core Training Series. This free, self-paced online course covers topics required under DHS 34 and offers 17.5 training hours. Unless an exception has been granted by your contract manager, all new crisis service providers must complete this training. Instructions for signing up for BHTP courses, can be found in Appendix B of this handbook.

Orientation training should be documented using the Orientation Training Log template available at https://providers.dcdhs.com/DCPN.

Ongoing Training

Following orientation, each service provider is required to receive at least eight (8) hours of ongoing training per calendar year. To be counted, this training must be related to:

- Emergency mental health services
- Rules and procedures relevant to the operation of the program
- Compliance with applicable state and federal regulations
- Cultural competency in mental health services
- Current issues in client's rights and services.

DCPN webinars count toward ongoing crisis training requirements, and additional training opportunities will be shared by DCDHS as they are identified.

Staff who also provide other community mental health service types (e.g. CCS) may apply *relevant* training hours for those service types toward this requirement, but must submit documentation of training completion separately for each service type.

Ongoing training is calculated and documented annually on a calendar year basis, and must be completed in the first full calendar year following the service provider's start date. For example, a service provider who starts November 1, 2023 must complete ongoing training for 2024, and every year thereafter. Ongoing training documentation is due no more than two (2) weeks after the end of each calendar year.

Documentation of Training

Use the Orientation Training Log template and the Ongoing Training Log template available at https://providers.dcdhs.com/DCPN, to document training. Another form or way of documenting training may be used with permission of your contract manager, if it includes all of the following:

- Topic(s) covered in the training
- Date of training
- Method of training; e.g., live (synchronous) online training, pre-recorded (asynchronous) online training, workshop, in-person training
- Duration (amount of training time completed)
- Attestation of training completion by staff member and supervisor

Certificates of completion are required for all trainings that provide them, and should be submitted with the corresponding training log. All training documentation should be submitted together by emailing to crisisbillingsupport@danecounty.gov.

Clinical Supervision

Each program providing crisis services must identify a **clinical supervisor**. This individual is responsible for ensuring compliance with requirements outlined in DHS 34.21(7), providing day-to-day clinical oversight of crisis services delivered by the program, and providing DCDHS with documentation of clinical supervision for each staff member working in the program.

The clinical supervisor for each program must meet the qualifications of a clinical supervisor as identified under DHS 34.21(7)(f). Agencies must notify their DCDHS contract manager within one (1) week of a program having a change in who is providing clinical supervision.

Who to Ask: *Questions regarding clinical supervision requirements should be directed to your contract manager.*

A Clinical Supervision Log template is available at https://providers.dcdhs.com/DCPN, and its use is encouraged, but not required. Another form or way of documenting clinical supervision may be used, if it includes all of the following:

- Date of supervision
- Method of supervision (e.g. individual, group, side-by-side session)
- Duration (amount of supervision time completed)
- Attestation of supervision completion by staff member and supervisor

Documentation of clinical supervision delivered to each staff member who provides crisis services must be submitted on a quarterly basis, no more than two (2) weeks after the end of each quarter. If a staff member did not provide any crisis services during a given quarter, a document attesting to this should be submitted.

The number of hours of clinical supervision each service provider must receive depends upon their qualifications, as laid out in DHS 34.21(7)(d-e):

1. Service providers who have *not* had 3000 hours of supervised clinical experience, or who are not qualified under DHS 34.21(3)(b) 1 to 8, must receive a minimum of one hour of clinical supervision per week or for every 30 clock hours of face to face mental health services provided. The default should be one hour per week unless actual documentation of logged hours justifies less supervision.
2. Service providers who *have* completed 3000 hours of supervised clinical experience and who are qualified under DHS 34.21(3)(b) 1 to 8, must receive a minimum of one hour of peer clinical consultation per month or for every 120 clock hours of face to face mental health services provided. The default should be one hour per month unless actual documentation of logged hours can be proven to justify less consultation is required.

Appendix A: Definitions

"Agency" means a social service organization that provides services funded by DCDHS. An agency may have one or multiple programs that provide Crisis services.

"Client" means a person receiving crisis services from a program.

"Clinical Supervision" means oversight by a qualified Clinical Supervisor to ensure crisis services provided by a program are delivered in a manner most likely to result in positive outcomes for the program's clients; the effectiveness and quality of services are improved over time; professional staff have the necessary training and experience needed to carry out their roles; and any credentialing or ongoing certification needs are met.

"Clinical Supervisor" means a mental health professional qualified under DHS 34.21(3)(b)1-8. Each program providing crisis services must identify a clinical supervisor to DCDHS.

"County Department" or "County" means Dane County Department of Human Services (DCDHS).

"Crisis" means a situation caused by an individual's apparent mental health symptoms 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.

"Crisis Plan" means a plan prepared under Wisconsin Administrative Code DHS 34.23(7) for an individual at high risk of experiencing a mental health crisis so that, if a crisis occurs, staff responding to the situation will have the information and resources they need to meet the person's individual service needs. In Dane County these are created in conjunction with the Journey Crisis Stabilization team.

"Crisis Response" means a rapid response to a member experiencing a behavioral health crisis, regardless of the member's location. The service is typically provided in person by going to the member in crisis (that is, mobile crisis) but may also be provided on a walk-in basis or via telehealth according to telehealth guidelines. Crisis response includes individual assessment and crisis resolution services rendered by a practitioner or team of practitioners rendering services simultaneously for a member in crisis.

"Crisis Stabilization" means short-term, intensive, community-based services and supports in a residential setting to avoid the need for inpatient hospitalization. Services may be provided on an hourly (S9484) or a per diem basis (S9485).

"Dane Crisis Provider Network" or "DCPN" means the group of agencies that provide crisis services to people in Dane County. DCDHS coordinates and oversees the DCPN.

"Linkage and Follow-Up" means implementation of follow-up activities from a response plan, including periodic follow-up contacts, coordination of additional services and supports, and enhancing coping skills until an ongoing services practitioner can begin or resume care.

"Local Crisis Intervention Line" means a behavioral health hotline service initiated when a member or an individual acting on behalf of the member contacts the county crisis line to seek professional local support for a member experiencing a behavioral health crisis. Crisis line services include screening to determine whether a crisis response is required and may include provision of basic information or de-escalation strategies.

"Place of Service" means the location from which a service provider delivered services. If telehealth was used to deliver services, a telehealth place of service code must be selected. Otherwise, the place of service should reflect the location of the service provider at the time of the service. For example, the POS would be "office" if a service provider was located at an agency office (or their home office) while delivering a service.

"Procedure Code" or "HCPCS Code" means the standard code established by ForwardHealth to describe the type of crisis service delivered to an individual.

"Program" means a program authorized by the county department to provide Crisis services. Multiple programs may be operated by a single agency.

"Program Administrator" The crisis program's clinical administrator has the overall responsibility for the operation of the program and for compliance of the program with DHS 34. Administrative oversight of Dane County Crisis services is provided by Dane County Department of Human Services. Clinical oversight of Dane County crisis services is provided by Journey ESU.

"Response Plan" means the plan of action developed by program staff under DHS 34.23(5)(a) to assist a person experiencing a mental health crisis. This plan establishes the services to be billed.

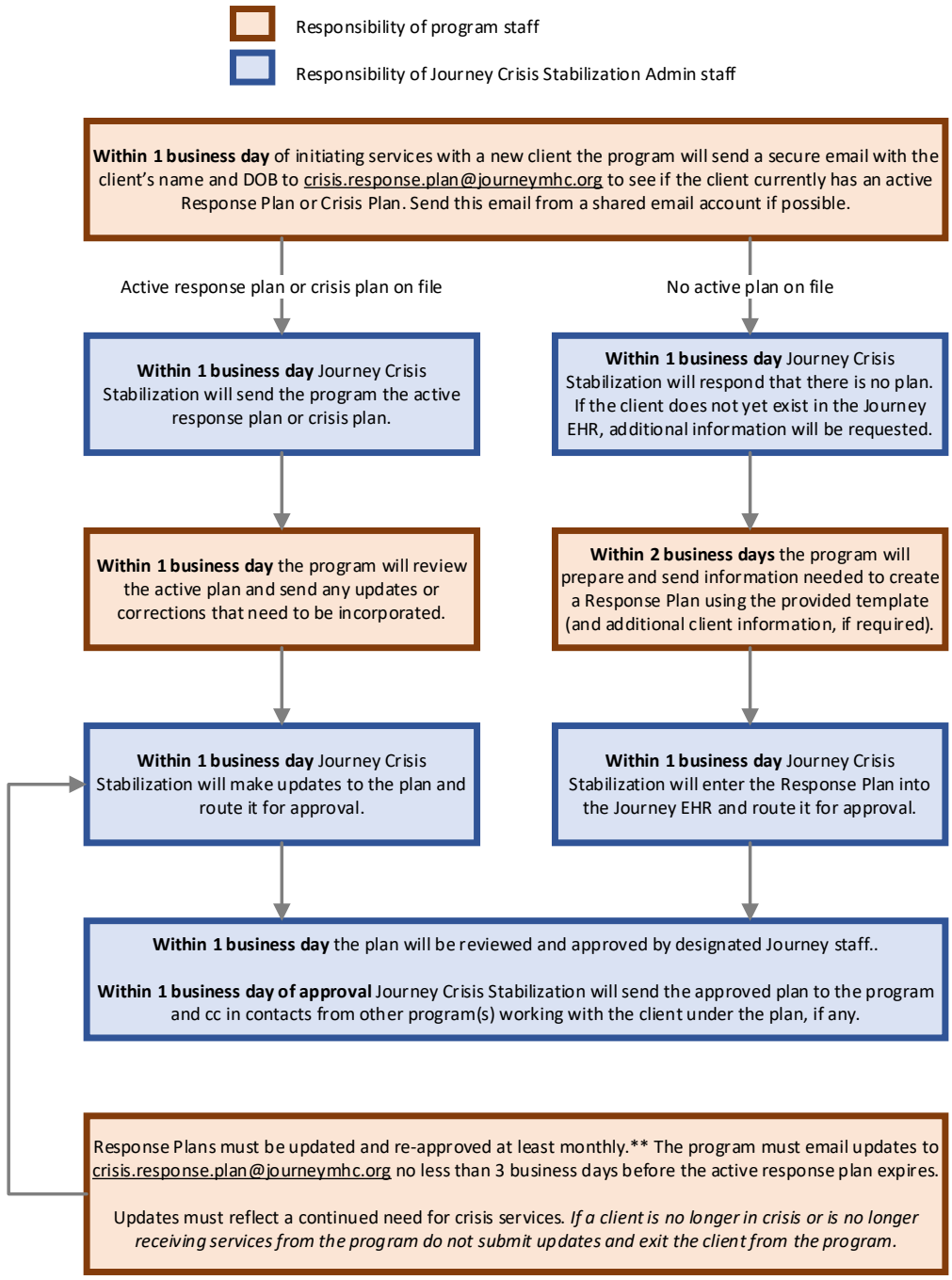
"Service Provider" means an individual working under the direction or control of an agency who provides crisis services to clients.

"Teamed Response" means a response by multiple providers when all of the following are true: 1) All team members must be rostered crisis service providers; 2) At least one team member must be a professional with the qualifications described in DHS 34.22(3)(b)3, and there must be at least one additional Medicaid provider; and 3) At least one team member must provide services in person (additional team members may provide services in person or via telehealth)

"Telephonic Triage" means the process of determining whether a call to the crisis hotline requires the delivery of crisis services.

Appendix B: Response Plan and Crisis Plan Workflows / FAQ

Workflow for Crisis Case Management (Linkage and Follow-Up T1016) Programs



* Journey programs will follow a modified workflow, reflecting direct access to and entry in the Journey EHR.

**If services are being delivered under an existing Crisis Plan, updates are required at least every 6 months. Journey Crisis Stabilization staff will initiate a process to update plans that are nearing expiration.

FAQ for Crisis Case Management (Linkage and Follow-Up T1016) Programs

How soon after services begin does a Response Plan or Crisis Plan need to be in place?
All crisis services must be delivered under an active Response Plan or Crisis Plan that is approved by designated Journey Mental Health Center staff no more than 14 days after services are initiated, and updated and re-approved on the required timeline (at least monthly for Response Plans, at least every 6 months for Crisis Plans). The workflows are designed to help ensure that these timelines are met.

Who is responsible for creating a client's Response Plan? What information goes into one?
Response Plans are developed based on information gathered through an initial contact with an individual in crisis. When a Journey-operated Crisis Response or Linkage and Follow-Up program has this initial contact they will enter a Response Plan directly into the Journey EHR. When a non-Journey Crisis Linkage and Follow-Up program has the initial contact, that program will share the information necessary to create a Response Plan with Journey Crisis Stab Admin staff, who will create the Response Plan in the Journey EHR. The information to be included in a Response Plan is described in DHS 34.23(3) and the provided Response Plan template will help facilitate easy entry of the information into the Journey EHR.

If a client already has an active Response Plan in place when a new Linkage and Follow-Up (T1016) program initiates services with them, what kind of update information should the program provide?
Depending on the nature of the initial contact that generated the Response Plan, the active plan may be more or less robust, which may mean that there is more or less additional information that would be of benefit. After reviewing the active plan, provide information necessary to update the plan with:

- any significant changes to or other key information about the client's circumstances, symptoms, or risks
- best contact information to use for collaboration between your program and others

Keep in mind that the intention is not for a Response Plan to be a running service note that documents every event that takes place while a client is in crisis. Rather, the Response Plan should serve as consolidated summary of the most important things for service providers to know, especially as it relates to keeping the person safe and helping them stabilize. Updates will be incorporated into the plan as appropriate and the updated version will be shared with the programs actively providing services.

Is it required for Linkage and Follow-Up (T1016) programs to do weekly documentation of the client's need for crisis services?

No. The requirement for weekly documentation of need is specific to Crisis Stabilization services (those billed under codes S9484 and S9485). Some programs that currently provide T1016 (Linkage and Follow-Up) services historically billed under the S9484 Hourly Crisis Stabilization billing code and therefore previously had to do this documented review, however this requirement does not apply to the T1016 billing code. While weekly documented review is not required for T1016, programs must continuously evaluate the ongoing need for crisis services and are expected to discontinue crisis services and billing when it is no longer appropriate.

What should a program do if they think a client is no longer in a crisis / no longer meets criteria for crisis billing?

If program staff believe it is no longer appropriate to bill MA crisis for a client, the program should discontinue crisis billing and exit the client from the crisis program on 610 reporting, even if the program intends to continue to support the client in other ways (e.g., through another county program line that is not specific to providing crisis services). If unsure whether continued crisis billing is appropriate, consult your clinical supervisor, contract manager, and/or the Journey Crisis Stabilization team. Although eligibility should be evaluated continuously, the monthly Response Plan update process will provide a structure for routine formal review of whether a client meets criteria. If a client's Response Plan is nearing expiration and the client is no longer in crisis, rather than reaching out to the Journey Crisis Stabilization to update the Response Plan you should reach out to inform them that your program is discontinuing services.

For more information about criteria for crisis billing look to ForwardHealth topic #6761: crisis services may only be delivered if "the member is in a crisis or situation that may develop into a crisis if professional supports are not provided" and if "the provider can expect to reduce the need for institutional treatment or improve the member's level of functioning".

What should a program do if a client they have been providing crisis services to stops engaging / showing up?

The monthly Response Plan update process will provide a structure for identifying and "closing" clients who are not currently engaged. If a client's Response Plan is nearing expiration and the client not had recent contact with your program (or is not expected to have contact moving forward), rather than reaching out to the Journey Crisis Stabilization to update the Response Plan you should reach out to inform them that the client is no longer actively engaged.

If a Response Plan is not updated by a program because the client is not actively engaged this may result in the client's Response Plan lapsing if no other program is actively engaged with them, or in that program being "dropped" from the active plan. If you identify that a client is not actively involved with your program's services they should also be exited from the crisis program on 610 reporting. The client can always be reopened in the future if they reestablish contact and are in crisis.

If a client is being served under a Response Plan, who is responsible for making sure the plan is updated and reapproved at least monthly? How does the update process work?
A Response Plan expires 30 days after it was most recently approved. Non-Journey Crisis Linkage and Follow-Up (T1016) programs must provide Journey Crisis Stab Admin staff with updates no less than 3 business days before an active Response Plan is set to expire by emailing the information to crisis.response.plan@journeymhc.org. Updates must reflect and demonstrate a continued need for crisis services. If multiple crisis programs are actively supporting an individual, best practice is to collaborate with the other service providers to provide update information.

If a client has an active Crisis Plan in place when they initiate services with a Linkage and Follow-Up program, can the services be provided under that Plan? How do updates work?
If a client has an active Crisis Plan in place when they initiate services with a Crisis Linkage and Follow-Up (T1016) program, these services will generally be incorporated into the existing Crisis Plan as an update. Journey Crisis Stab Admin staff will update the Crisis Plan and connect the Linkage and Follow-Up program with the other members of the client's care team.

Journey Crisis Stab Admin staff track the expiration dates of active Crisis Plans and will help initiate and facilitate the Crisis Plan update/reapproval process. However, it is the responsibility of each program providing crisis services to ensure their service is authorized on an active plan. If a program has concerns about a client's Crisis Plan expiring, they should contact crisis.response.plan@journeymhc.org and/or their contract manager.

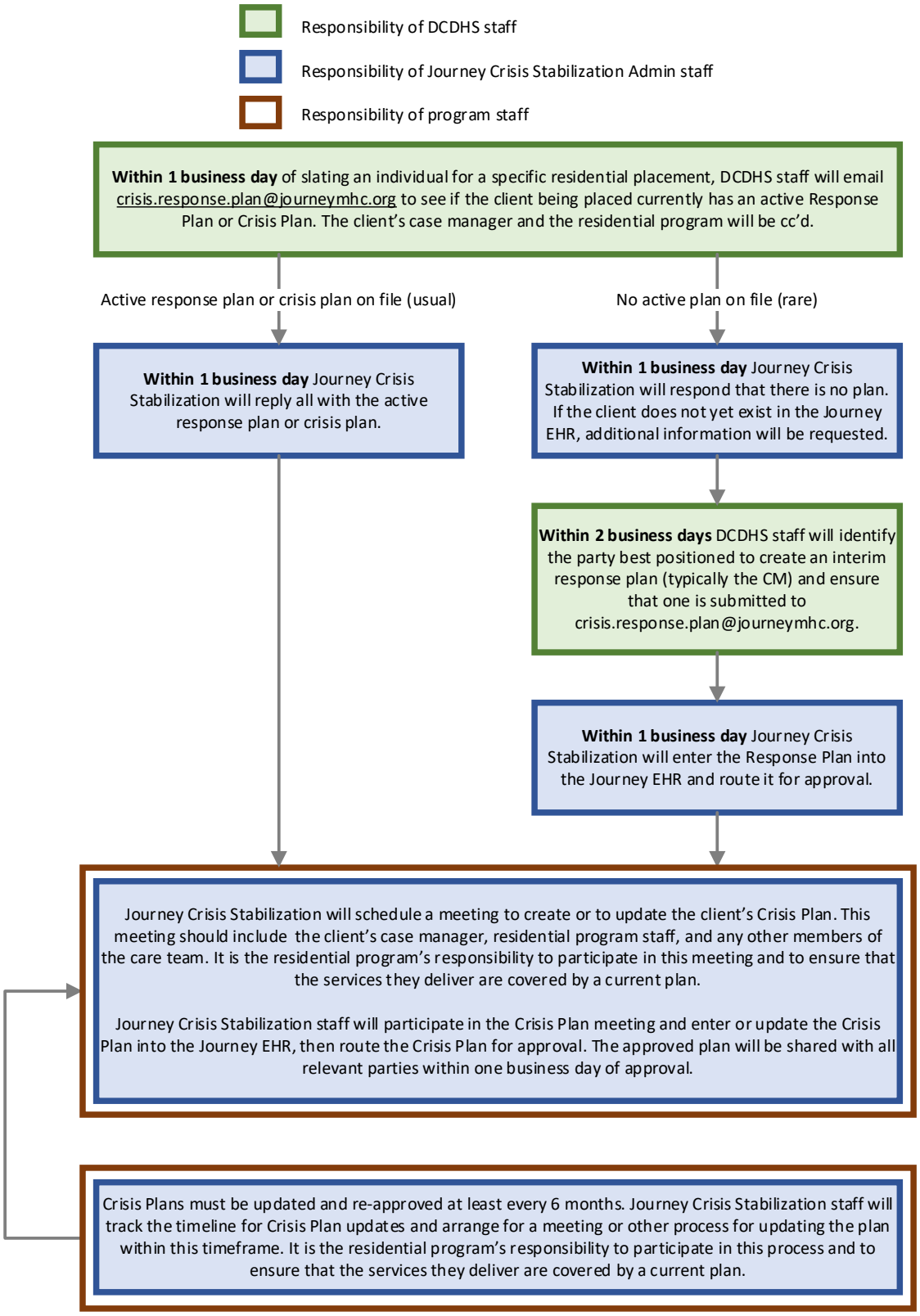
Is a Response Plan ever needed *in addition* to an active Crisis Plan?
If a client with an active Crisis Plan experiences a new episode of acute crisis requiring crisis response/intervention services (billed under the H2011 code), a Response Plan "layered on top of" the existing Crisis Plan may be created to describe and address the client's immediate needs.

Is it ever appropriate for a Linkage and Follow-Up program to propose that a Crisis Plan be created for a client who is currently being served under a Response Plan? If so, under what circumstances? What is the process?

While all individuals who receive crisis services will have a Response Plan created when services are initiated, only a small subset will have a Crisis Plan. Crisis Plans are intended as a more comprehensive, collaborative, and proactive tool for supporting individuals at high risk of recurrent crises. Individuals who are under a Ch. 51 civil commitment or who are in an ongoing crisis residential placement (e.g., group home, adult family home, or THP) will have a Crisis Plan created for them.

In some cases it may be beneficial to create a Crisis Plan for other individuals who have ongoing, recurrent, high-intensity needs for crisis services. If a client who does not already have a Crisis Plan is showing a pattern of ongoing and recurrent use of crisis services and if these service needs are likely continue, it may be appropriate to consult about creating a Crisis Plan for them. This is particularly true if the client is receiving high-intensity services from multiple crisis programs or if there is a large care team that could benefit from coordination. Generally speaking, if a program has been providing services under under a Response Plan for longer than 3 months and believes the client will continue to experience a high level of crisis service need for an extended period, it could be reasonable to consider creating a Crisis Plan. Programs can reach out to crisis.response.plan@journeymhc.org about creating a Crisis Plan for a client. Please note that in some cases the recommendation may be to continue to provide services under a Response Plan.

Workflow for Residential Stabilization (S9484 / S9485) Programs (other than DCCC)



FAQ for Residential Stabilization (S9484 / S9485) Programs (other than DCCC)

Does the creation of a Crisis Plan always have to involve a "Crisis Plan meeting"? Who attends? What is different for initial plan creation vs. updates?
Crisis Plans should be developed through a meeting involving the client, their case manager (if any), staff from the client's residential placement provider (if applicable), Journey Crisis Stabilization staff, any other supports or members of the client's care team. Although plan updates could happen without a meeting taking place, a meeting to review and update Crisis Plan at least every 6 months is a best practice.

Once a Crisis Plan has been created in the Journey EHR, how is it approved?
All plans are approved (signed digitally) by designated Journey staff.

How soon after moving into a residential placement must a Crisis Plan meeting occur?
There is no specific timeframe, however, all crisis services must be delivered under an active Response Plan or Crisis Plan. Assuming there is an active Response Plan in place at the time a client moves into a residential placement, the team should strive to convene to create a Crisis Plan before this active Response Plan expires. If that is not possible (e.g. if the current Response Plan expires at around the time the client moves in), the Response Plan can be updated to include the residential placement, and then a Crisis Plan meeting can be held before the *next* update/approval is due.

A Crisis Plan should be developed no more than 30 days after a client has moved into a residential placement, and ideally sooner. It is also acceptable to develop a Crisis Plan *prior* to move-in, if this is feasible.

If a client does not have an active Response Plan (or Crisis Plan) when they are slated to move into a residential placement, is an interim Response Plan always needed, or can a Crisis Plan be created directly?
It will be rare that a client without an active plan is slated to move into a residential placement. However, if it does happen, the residential provider and Journey Crisis Stabilization must ensure that there is an approved plan in place within 14 days of when crisis services begin. If it is possible to develop a Crisis Plan and have it approved within this timeframe, that is acceptable. If there is any question about whether this will be possible, a Response Plan should be prepared to "bridge" until a Crisis Plan is in place.

If a client already has an active Crisis Plan when they are slated for a residential placement, does a Crisis Plan meeting still need to be held?
Crisis Plans must be updated and reapproved at least every 6 months. However, substantial changes in the client's needs or situation warrant an update sooner. If a client with an existing Crisis Plan moves into a new residential placement, the Crisis Plan should be updated to reflect this. Best practice would be for a meeting to take place to review and update the existing plan, including the new residential provider.

If a client's Residential Crisis Stabilization services (S9484/5) are included on an active Crisis Plan, is it also required to do weekly documentation of the need for stabilization?
Yes. According to ForwardHealth guidance, the need for continued Crisis Stabilization services (those services billed under codes S9484 and S9485) must be documented at least weekly. Please see ForwardHealth topic #6759 for more information about the standard that must be met to continue billing for these services.

What should a program do if they think a client is no longer in a crisis / no longer meets criteria for crisis billing?
Crisis services can only be provided to individuals who meet criteria. For programs that provide Residential Crisis Stabilization (S9484/5), these criteria are described in ForwardHealth topic #6759. If you believe a client you are serving no longer meets these criteria, please speak with your contract manager or the person responsible for your placement agreement.

Who is responsible for making sure a client's Crisis Plan is updated and reapproved at least every 6 months? How does the update process work?
Journey Crisis Stab Admin staff track the expiration dates of active Crisis Plans and will help initiate and facilitate the Crisis Plan update/reapproval process. However, it is the responsibility of each program providing crisis services to ensure their service is authorized on an active plan. If a program has concerns about a client's Crisis Plan expiring, they should contact crisis.response.plan@journeymhc.org and/or their contract manager or the person responsible for the placement agreement.

Appendix C: Registration Instructions for BHTP Trainings

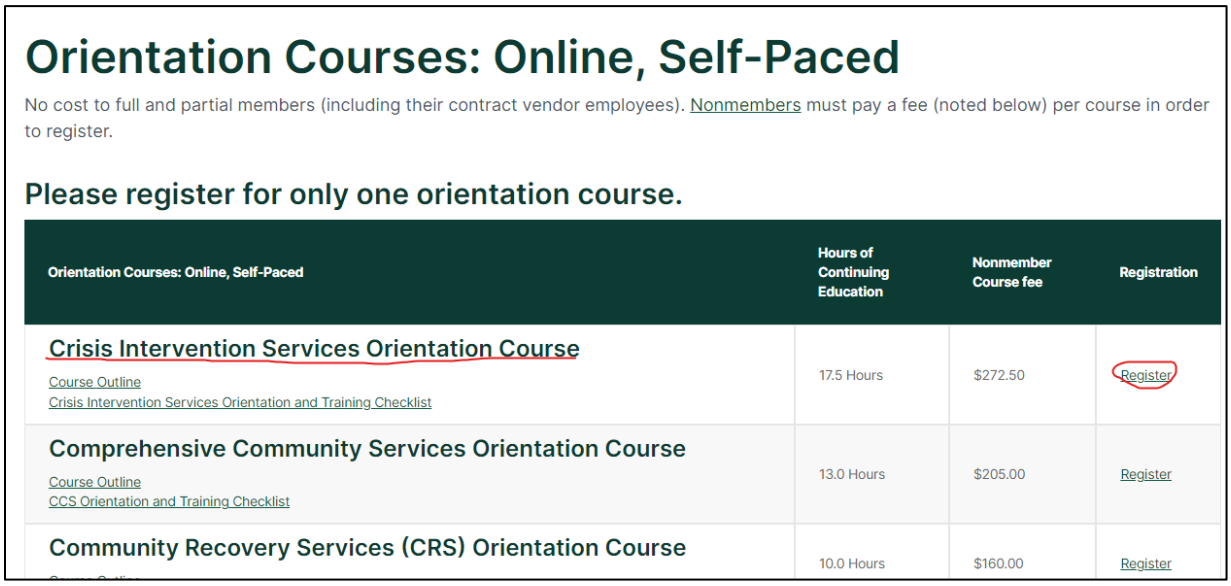
Step 1: Get Started

If you need to register for the first time, visit: https://www.uwgb.edu/behavioral-health-training-partnership/online-training/

If you have already signed up, you can login here: https://uws-ce.instructure.com/login/canvas

Step 2: Select Course and Register

Scroll down to find the course you wish to register for. For example, to register for the Crisis Intervention Services Orientation course, find the "Orientation Courses: Online, Self-Paced" section. Locate the course *Crisis Intervention Services Orientation Course* and click "Register."



Orientation Courses: Online, Self-Paced

No cost to full and partial members (including their contract vendor employees). Nonmembers must pay a fee (noted below) per course in order to register.

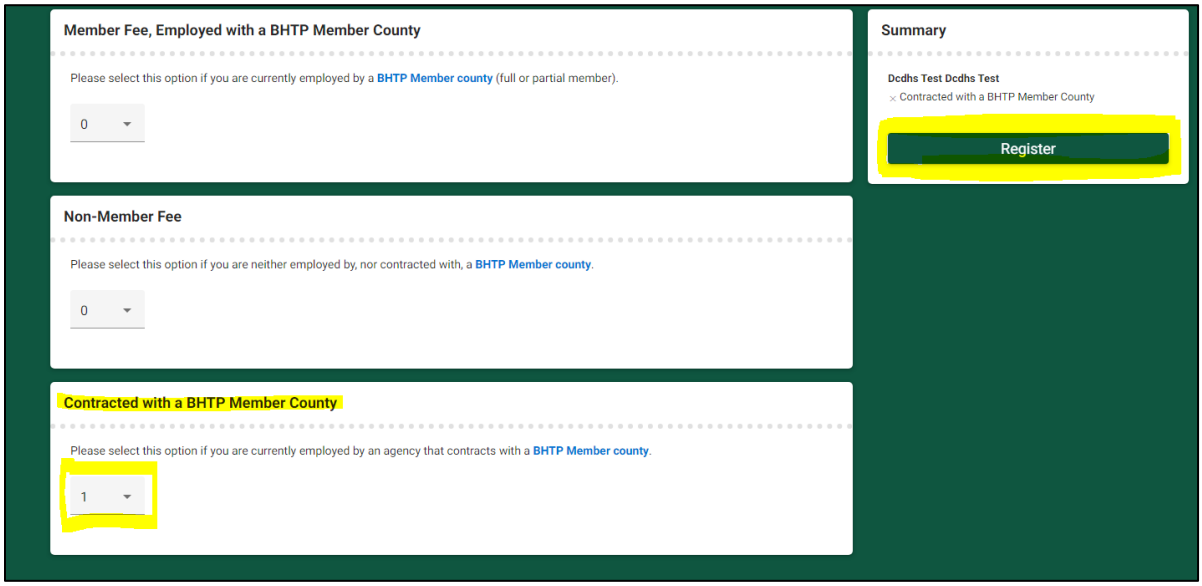
Please register for only one orientation course.

Orientation Courses: Online, Self-Paced	Hours of Continuing Education	Nonmember Course fee	Registration
Crisis Intervention Services Orientation Course Course Outline Crisis Intervention Services Orientation and Training Checklist	17.5 Hours	$272.50	Register
Comprehensive Community Services Orientation Course Course Outline CCS Orientation and Training Checklist	13.0 Hours	$205.00	Register
Community Recovery Services (CRS) Orientation Course	10.0 Hours	$160.00	Register

On the next page, click "Register" again.

Step 3: Select Member County

Select the option for "Contracted with a BHTP Member County" as shown below and enter the number of staff members who are being registered for the training, then click "Register".



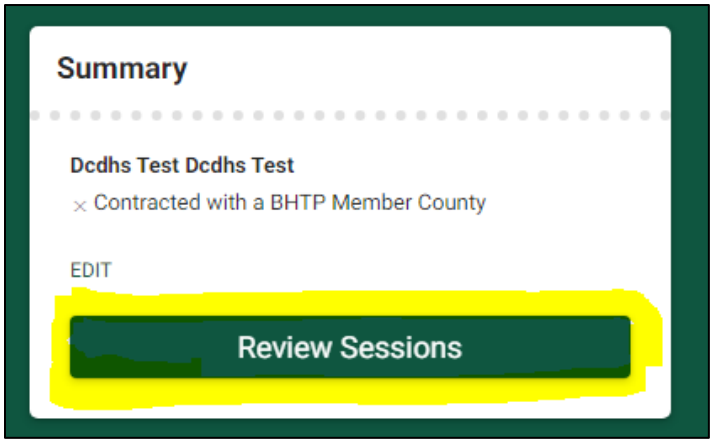
Step 4: Fill In Staff Member Information

On the following page, enter the name and contact email for the staff member(s) who will be participating in training,

Under "Please select the BHTP Member County that your agency contracts with" select Dane County. Enter the name and address of the agency the staff member works for. In the last two sections, enter the name and contact information for the staff member's supervisor or other person responsible for collecting documentation of training.

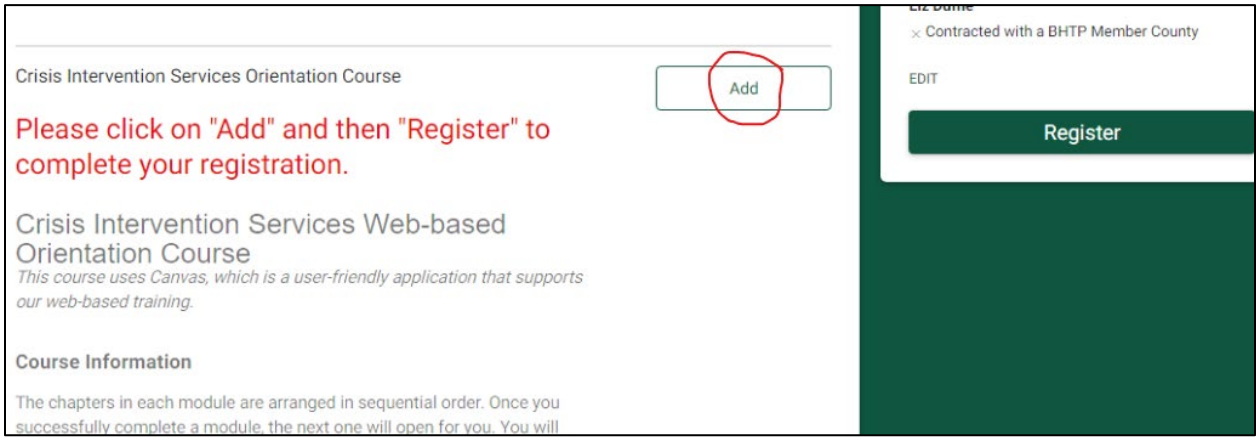
Step 5: Click Review Sessions

Scroll back to the top of the page and click on the "Review Sessions" option as shown below.



Step 6: Add the Training Course

On the following page, click the "Add" button to add the selected course, as shown below.



Step 7: Click Register

On the same page, after adding the course to your roster, click on the "Register" button as shown below.