Chapter HFS 61
COMMUNITY MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND ALCOHOLISM AND OTHER DRUG ABUSE SERVICES

Note: Chapter HSS 61 was renumbered chapter HFS 61 under s. 13.93 (2m) (b) 1., Stats., Register, August, 1996, No. 488.

Subchapter I —General Provisions

HFS 61.01 Introduction. These are standards for a minimum level of services. They are intended to establish a basis to assure adequate services provided by 51.42/51.437 boards and services provided by agencies under contract with the boards.

History: Cr. Register, January, 1980, No. 289, eff. 2–1–80.

HFS 61.02 General definitions. The following definitions apply to all standards for community mental health, developmental disabilities, and alcoholism and other drug abuse services.

(1) "Board" means a board of directors established under ss. 51.42/51.437, or 46.23, Stats.

(2) "Consultation" means providing assistance to a wide variety of local agencies and individuals. It includes indirect case consultation: the responding to specific requests of consultees to help resolve an individual case management problem or to improve the work function of the consultee. It includes problem related consultation: the providing of assistance to other human service agencies for educational purposes rather than individual case resolution. Consultation includes administrative and program consultation: the providing of assistance to local programs and government agencies in incorporating specific mental health, developmental disabilities and alcohol and other drug abuse principles into their programs.

(3) "Department" means the department of health and family services.

(4) "Education" means the provision of planned, structured learning experiences about a disability, its prevention, and work skills in the field. Education programs should be specifically designed to increase knowledge and to change attitudes and behavior. It includes public education and continuing education.

(a) Public education is the provision of planned learning experiences for specific lay or consumer groups and the general public. The learning experiences may be characterized by careful organization that includes development of appropriate goals and objectives. Public education may be accomplished through using generally accepted educational methods and materials.

(b) Continuing education is individual or group learning activities designed to meet the unique needs of board members, agency staffs, and providers in the community–based human service system. Learning activities may also be directed towards the educational goals of related care providers such as health care, social service, public school and law enforcement personnel. The purpose may be to develop personal or occupational potential by

acquiring new skills and knowledge as well as heightened sensitivity to human service needs.

(5) "Employe or position, full–time," means as defined by the employing board or agency.

(6) "Public information" means information for public consumption provided through the use of mass media methods about services, programs, and the nature of the disability for which the services and programs are provided. It consists of such activities as writing news releases, news letters, brochures, speaking to civic groups or other assemblies, and use of local radio and television programs. Public information programs should be specifically planned and designed to inform.

History: Cr. Register, January, 1980, No. 289, eff. 2–1–80; emerg. r. and recr. (7), eff. 3–9–89; r. and recr. (7), Register, May, 1989, No. 401, eff. 6–1–89; **correction in (3) made under s. 13.93 (2m) (b) 6., Stats., Register, August, 1996, No. 488.**

HFS 61.021 Program element definitions. (1) "Day treatment" means case management, counseling, medical care and therapy provided on a routine basis in a nonresidential setting for a scheduled portion of a 24 hour day to alleviate alcohol and drug problems, but does not include aftercare defined under s. HFS 61.51 (1).

(2) "Emergency care I" means all outpatient emergencies including socio–emotional crises, attempted suicides, family crises, etc. Included is the provision of examination, in accordance with s. 51.45 (11) (c), Stats., and if needed, transportation to an emergency room of a general hospital for medical treatment.

(3) "Emergency care II" means 24 hour emergency services provided on a voluntary basis or under detention, protective custody, and confinement. Services include crisis intervention, acute or sub–acute detoxification, and services for mental health emergencies. Clients are to be assessed, monitored, and stabilized until the emergency situation is abated. Included is the provision of examination, in accordance with s. 51.42 (11) (c), Stats., and transportation, if needed, to an emergency room of a general hospital for medical treatment.

(4) "Extended care" means a treatment oriented living facility service where supervision, training, and personal care are available and access to programs and medical care is ensured during a 24 hour day. Extended care programs emphasize self care, social skills training, treatment, and recreation for dependent persons with mental disabilities and in need of extended care.

(5) "Inpatient" means a medically oriented residential service which provides continuous medical services on a 24 hour basis to enable an individual with problems related to mental illness, alcohol and other drug abuse to function without 24 hour medical support services.

(a) Children or adolescents shall not be placed in adult inpatient services for extended periods of time. Placement of an individual under 18 years of age in an adult program shall be for evaluation purposes only and shall not exceed 21 total days within a 3 month time span.

(b) Inpatient treatment of individuals under 18 years of age shall be provided in specialized inpatient programs which comply with standards specified in s. HFS 61.79.

(6) "Intervention" means activities designed to identify individuals in need of mental hygiene services, including initial assessment, to judge the presence of problems, such as mental illness, developmental disabilities, alcohol or other drug abuse. Intervention begins with assessment and includes information and referral services, drop–in service and public information service. Activities which may initiate persons into the service, such as, rendering a judgment about the appropriate source of help, referral and arranging services.

(7) "Outpatient" means a non–residential program for persons with problems relating to mental illness, developmental disabilities, alcohol or other drug abuse to ameliorate or remove a disability and restore more effective functioning and to prevent regression from present level of functioning. Outpatient service may be a single contact or a schedule of visits. Outpatient program may include, but is not limited to, evaluation, diagnosis, medical services, counseling and aftercare.

(8) "Prevention" means activities directed toward the general population, or segments of the population, which is designed to increase the level of knowledge about the nature and causes of disabilities, change attitudes and take medical and environmental steps for the purpose of aiding persons before their problems develop into disabilities needing further services. Prevention activities include education services and consultation services.

(9) "Protective services" means services directed toward preventing or remedying neglect, abuse, or exploitation of children and adults who are unable to protect their own interests.

(10) "Research and evaluation" means the studying of causes, treatments and alleviations of problems as well as the formal application of techniques to measure the effectiveness of programs through the use of recognized statistical designs and evaluation procedures.

(11) "Sheltered employment" means non–competitive employment in a workshop, at home, or in a regular work environment for persons with a physical or mental handicap. A handicapped person is defined as any person who, by reason of physical or mental defect or alcohol or drug abuse, is or may be expected to be totally or partially incapacitated for remunerative occupation.

(12) "Special living arrangements" means special services in foster family homes, foster care institutions, halfway houses, respite care, community based residential facilities, and other special living arrangements.

(13) "Systems management" means activities, both internal and external to programs, to effect efficient operation of the service delivery system.

(a) Internal program management includes administration, objective setting, planning, resource acquisition and allocation and monitoring of staff.

(b) External activities include interagency coordination, consultation, and comprehensive planning for the purpose of providing an integrated continuum of services to those needing such a system of services.

(14) "Training" means education activities for staff of program which serve or could potentially serve individuals with problems related to mental illness, developmental disabilities, alcohol and other drug abuse, concerning the nature, causes, and treatment of these disabilities for the purpose of better serving clients.

History: **Renum. from HSS 61.02 (7) to (20) under s. 13.93 (2m) (b) 1., Stats., Register, August, 1996, No. 488, eff. 9–1–96.**

HFS 61.022 Disability related definitions. (1) "Alcoholic" means a person who habitually lacks self–control as to the use of alcoholic beverages, or uses such beverages to the extent that health is substantially impaired or endangered or social or economic functioning is substantially disrupted.

(2) "Autism" means a severe disorder of communication and behavior manifested during the early stages of life. The autistic child appears to suffer primarily from a pervasive impairment of cognitive or perceptual functioning, or both, the consequences of which may be manifested by limited ability to understand, communicate, learn, and participate in social relationships.

(3) "Cerebral palsy" means a term applied to a group of permanently disabling symptoms resulting from damage to the developing brain that may occur before, during, or after birth; and that results in loss or impairment of control over voluntary muscles.

(4) "Detoxification receiving center in alcohol and other drug abuse programs" means a short term facility with limited medical supervision but which has written agreements with a hospital to provide emergency medical care.

occupational therapy assistant or a graduate of the division of mental hygiene's Activity Therapy Assistant Course. Where other health care services are located in the same or continuous property, one full–time occupational therapist may serve the other health care service as well as the inpatient mental health services. The mental health inpatient service shall maintain a ratio of 1.6 hours of activity therapy staff time per patient per week. A registered music therapist or art therapist may fill the requirement for activity therapy positions after one registered occupational therapist has been employed. Where work therapy is utilized, each service shall designate the registered occupational therapist, unless the service has employed a vocational rehabilitation counselor. In this circumstance the vocational rehabilitation counselor shall be in charge of industrial therapy.

(d) *Social services.* Each service shall employ one full–time social worker and provide for a minimum of .8 hour a week social work time per patient under care. Social workers must have a master's degree from an accredited school of social work or a bachelor's degree in social work, or social science. The first social worker hired must have a master's degree in social work.

(e) *Psychological services.* Each service shall employ or contract for the services of a clinical psychologist licensed in the state of Wisconsin to provide psychological testing, counseling and other psychological services. A minimum ratio of .8 hour per week psychology time per patient under care shall be provided.

(f) *Exceptions.* A special exception to any of the foregoing personnel requirements may be granted in unusual circumstances, if a service develops an alternative proposal, satisfactory to the department, to provide an innovative approach to patient care, which provides levels of services equivalent to those required in these standards. An exception may also be granted to a proposal which substitutes personnel with qualifications equal to those listed above.

(2) PROGRAM CONTENT. (a) *Therapeutic milieu.* 1. General consideration. An important factor in a mental health treatment program in an inpatient service is a therapeutic atmosphere. Although intangible, the presence or lack of this atmosphere is pervasive and immediately apparent. It is important that all staff members treat each patient with respect, providing all freedoms his or her condition permits and allowing the patient to retain a sense of individuality, freedom of choice and independence. Patients shall be encouraged to behave appropriately and in a socially acceptable way. Patients shall be permitted to dress in individually selected street clothing and retain sentimentally important personal possessions as clinically indicated. They shall be permitted to write letters, subject to restrictions only as clinically indicated. Home–like living quarters with drapes, pictures and furnishings shall be provided, and normal needs for privacy and feelings of modesty respected. Conversely, severe restriction of freedom of movement by prison–like practices; implicit or explicit expectations of dangerous, unpredictable behavior; use of punishment, especially seclusion and restraint, in the guise of therapy; exploitation of patient labor; use of spoons only as eating utensils and the like, shall not be permitted.

2. Staff functions. To maximize the therapeutic effect of hospitalization, all aspects of mental health inpatient care must be integrated into a continuous treatment program. The activities of all staff— psychiatrists, physicians, psychologists, social workers, activity therapists, nurses, aids, chaplains and others—must be coordinated in a concerted treatment effort, utilizing the special skills and roles of each in a complementary manner to effect a total therapeutic purpose. The services of volunteers must be used in the same way. The specific treatment responsibilities of psychiatrists, psychologists, social workers and activity therapists are generally well understood, but the contributions of volunteers and other staff, such as chaplains and food service workers, also have important implications for patients' welfare. Their work must be carried out in a manner which furthers the total treatment program. Nursing staff shall be full partners in therapeutic team and, as a significant portion of their nursing responsibilities, shall participate in activities such as group therapy, supportive counseling, and socializing experience for patients. Mental health aides are valuable contributors to the therapeutic milieu. As staff members who are constantly in close contact with patients, their activities are to be geared carefully to provide patients with emotional support and respite from inquiry into their difficulties, promote their independence, and provide them with companionship and assistance in personal care and grooming, recreational activities, social behavior, care of property and day to day living.

(b) *Evaluation.* Every newly received patient shall be evaluated by the professional staff within 48 hours after admission. This evaluation shall include psychiatric examination, the initiation of family contact and social history taking, and psychological examination when indicated. A plan of treatment and/or disposition shall be formulated and periodically reviewed. Progress notes on all cases shall be written frequently and regularly as the patient's condition requires, but in no instance less than once a week.

(c) *Clinical records.* The mental health inpatient service shall maintain a current treatment plan and clinical record on each patient admitted to the service.

(d) *Drug and somatic therapy.* Every patient deemed an appropriate candidate shall receive treatment with modern drugs and somatic measures in accordance with existent laws, established medical practice, and therapeutic indications as determined by current knowledge.

(e) *Group therapy.* Each mental health inpatient service is encouraged to develop group therapy programs, including remotivation groups where appropriate. Nursing and aid staff should be trained in these therapy techniques.

(f) *Activity therapy.* The occupational therapist shall organize and maintain an activity therapy program on a year–round full time basis. This treatment and rehabilitation program shall be reality oriented and community focused. The program shall be carried on both in the facility and in the community. The activity therapy department shall also provide a program of recreational activities to meet the social, diversional and general developmental needs of all patients. A recreational therapist may be employed for this purpose. Activity therapy should be part of each patient's treatment plan and should be individually determined according to needs and limitations. The record of the patient's progress in activity therapy should be recorded weekly and kept with the patient's clinical record.

(g) *Industrial therapy.* Industrial therapy assignments shall be based on the therapeutic needs of the patient rather than the needs of the inpatient service. Industrial therapy shall be provided only upon written order of the psychiatrist. The written order shall become part of the patient's clinical record. The industrial therapy assignment of patients shall be reviewed by the treatment staff weekly. The review shall be written and included in the patient's clinical record. Continued use of industrial therapy will require a new order from the psychiatrist weekly.

(h) *Religious services.* 1. Adequate religious services must be provided to assure every patient the right to pursue the religious activities of his or her faith.

2. Each service shall provide regularly scheduled visits by clergy.

3. Each service may utilize the services of a clinical pastoral counselor as a member of the treatment team, provided he or she has had clinical training in a mental health setting.

(i) *Use of mechanical restraint and seclusion.* Mechanical restraint and seclusion are measures to be avoided if at all possible. In most cases control of behavior can be attained by the presence of a sympathetic and understanding person or appropriate use of tranquilizers and sedatives upon order of the psychiatrist. To eliminate unnecessary restraint and seclusion, the following rules shall be observed.

1. Except in an emergency, no patient shall be put in restraints or seclusion without a medical order. In an emergency the administrator of the service or designee may give the order. Such action shall be reviewed by a physician within 8 hours.

2. Patients in seclusion—restraints must be observed every 15 minutes and a record kept of observations.

(j) *Extramural relations.* Inpatient mental health services are one component of community based comprehensive mental health program provided or contracted by the unified boards under s. 51.42, Stats. As a component of the community based comprehensive program the inpatient service program must be integrated and coordinated with all services provided through the unified board. Evidence of integration and coordination shall be detailed in the unified board's plan. Professional staff should be used jointly by the inpatient and other services and clinical records shall be readily transferable between services.

1. Alternate care settings. Every effort shall be made to find and develop facilities for patients who require medical or social care or less than full time inpatient mental health treatment. Such facilities, known as alternate care settings, shall include but not be limited to group homes, foster homes, residential care facilities, nursing homes, halfway houses, partial hospitalization and day services. Special effort shall be made to place patients in family care settings whenever possible.

2. Vocational rehabilitation. The inpatient service shall establish an ongoing relationship with vocational rehabilitation counselors. Every effort shall be made to identify patients amenable to vocational rehabilitation and to refer them to the appropriate agency. Sheltered workshops shall be utilized to the fullest possible extent.

3. Family and community ties. Active effort shall be made to maintain the family and community ties of all patients. In many cases the inpatient service staff must take the initiative to develop and maintain family contact. Visiting of patients in the hospital and patient visits outside the hospital shall be as frequent and as long as circumstances permit. Maintaining community ties would include such activities as arranging for patients to do their own shopping, attending church, continuing employment, and participating in recreational activities within the community.

History: Cr. Register, December, 1973, No. 216, eff. 1–1–74; renum. from PW–MH 60.62, Register, September, 1982, No. 321, eff. 10–1–82; corrections made under s. 13.93 (2m) (b) 5., Stats., Register, June, 1995, No. 474.

HFS 61.72 Enforcement of inpatient program standards. **(1)** All community mental health inpatient services receiving state aid must meet the above standards. Departmental personnel familiar with all aspects of mental health treatment shall review each inpatient service at least annually in connection with state funding of county programs.

(2) State funding shall be discontinued to any inpatient service not maintaining an acceptable program in compliance with the above standards after the service has had reasonable notice and opportunity for hearing by the department as provided in ch. 227, Stats.

(3) The service will be deemed in compliance with these standards if its governing body can demonstrate progress toward meeting standards to the department; however, all services must be in full compliance with these standards within a maximum of 2 years of the issuance of these rules.

History: Cr. Register, December, 1973, No. 216, eff. 1–1–74; renum. from PW–MH 60.63, Register, September, 1982, No. 321, eff. 10–1–82.

HFS 61.73 Other community program standards – introduction. The following standards have been developed for community mental health programs receiving state aids, whether directly operated by counties or contracted from private providers. The standards are intended to insure that each mental health program will provide appropriate treatment to restore mentally disordered persons to an optimal level of functioning and, if possible, keep them in the community.

History: Cr. Register, March, 1977, No. 255, eff. 4–1–77; renum. from PW–MH 60.64, Register, September, 1982, No. 321, eff. 10–1–82.

HFS 61.74 Emergency care program. History: Cr. Register, March, 1977, No. 255, eff. 4–1–77; renum. from PW–MH 60.66, Register, September, 1982, No. 321, eff. 10–1–82; correction in (2) (b) made under s. 13.93 (2m) (b) 5., Stats., Register, June, 1995, No. 474; r. Register, September, 1996, No. 489, eff. 10–1–96.

HFS 61.75 Day treatment program. Day treatment is a basic element of the mental health program providing treatment while the patient is living in the community. Its services shall be closely integrated with other program elements to ensure easy accessibility, effective utilization and coordinated provision of services to a broad segment of the population. Day treatment provides treatment services for patients with mental or emotional disturbances, who spend only part of the 24 hour period in the services. Day treatment is conducted during day or evening hours.

(1) REQUIRED PERSONNEL. (a) Day treatment staff shall include various professionals composing a mental health team. They shall be directly involved in the evaluation of patients for admission to the service, determining plan of treatment and amount of time the patient participates in the service and in evaluating patients for changes in treatment or discharge.

(b) A qualified mental health professional shall be on duty whenever patients are present.

(c) A psychiatrist shall be present at least weekly on a scheduled basis and shall be available on call whenever the day treatment service is operating.

(d) A social worker shall participate in program planning and implementation.

(e) A psychologist shall be available for psychological services as indicated.

(f) A registered nurse and a registered activity therapist shall be on duty to participate in program planning and carry out the appropriate part of the individual treatment plan.

(g) Additional personnel may include licensed practical nurses, occupational therapy assistants, other therapists, psychiatric aides, mental health technicians or other paraprofessionals, educators, sociologists, and others, as applicable.

(h) Volunteers may be used in day treatment and programs are encouraged to use the services of volunteers.

(2) SERVICES. (a) A day treatment program shall provide services to meet the treatment needs of its patients on a long or short term basis as needed. The program shall include treatment modalities as indicated by the needs of the individual patient. Goals shall include improvement in interpersonal relationships, problem solving, development of adaptive behaviors and establishment of basic living skills.

(b) There shall be a written individual plan of treatment for each patient in the day treatment service. The plan of treatment shall be reviewed no less frequently than monthly.

(c) There shall be a written individual current record for each patient in the day treatment service. The record shall include individual goals and the treatment modalities used to achieve these goals.

History: Cr. Register, March, 1977, No. 255, eff. 4–1–77; renum. from PW–MH 60.67, Register, September, 1982, No. 321, eff. 10–1–82.

HFS 61.76 Rehabilitation program. The community mental health program shall be responsible for the provision of an organized rehabilitation service designed to reduce the residual effects of emotional disturbances and to facilitate the adjustment of the mentally ill, mentally handicapped and emotionally disturbed in the community through a variety of rehabilitation services. When possible, these services should be provided in conjunction with similar services for other disabilities.

(1) REQUIRED PERSONNEL. A person responsible for coordination of rehabilitation services shall be named and all staff shall

have qualifications appropriate to their functions. Each such person shall have the required educational degree for his or her profession and shall meet all requirements for registration or licensure for that position in the state of Wisconsin.

(2) PROGRAM OPERATION AND CONTENT. Because of the variety of programs and services which are rehabilitative in nature, individual program content is not enumerated. Such facilities as halfway houses, residential care facilities, foster and group homes shall meet all departmental and other applicable state codes. The department of health and social services shall evaluate each proposal for funding of rehabilitation services on the basis of individual merit, feasibility and consistency with the approved community plan required in s. 51.42, Stats. Applicants for aid under this section must fully describe the rehabilitation service designed to meet the particular needs of the residents of their county or counties, taking into consideration existing community resources and services.

History: Cr. Register, March, 1977, No. 255, eff. 4–1–77; renum. from PW–MH 60.68, Register, September, 1982, No. 321, eff. 10–1–82.

HFS 61.77 Consultation and education program. Prevention is as important to mental illness as it is to physical illness. Certain facts and relationships between mental illness and environmental factors, individual personal contacts, and human development stages can be the basis for sound primary prevention programs. Education programs designed to increase the understanding and acceptance of the mentally ill are especially vital as increased numbers of persons receive needed treatment in their own community. Such programs can help prevent the chronicity of recurrence of mental illness. They can bring persons to seek counsel or treatment earlier and help to remove what has been an unacceptable "label" for family, friends, and co–workers. Because consultation and education programs are required elements of community mental health programs, the activities must be as well defined, organized and provided for as those for other program elements. Mental health staff and time allocations must be made and structured consultation and education programs designed and carried out.

(1) CONSULTATION REQUIRED PERSONNEL. The mental health coordinator or designee shall be responsible for the consultation program. Mental health staff shall respond to individual consultation requests. In addition staff shall actively initiate consultation relationships with community service agency staff and human service personnel such as clergy, teachers, police officers and others.

(2) CONSULTATION SERVICE CONTENT. (a) No less than 20% of the total mental health program staff time, exclusive of clerical personnel and inpatient staff shall be devoted to consultation. The service shall include:

1. Case–related consultation.
2. Problem–related consultation.
3. Program and administrative consultation.

(b) There shall be a planned consultation program using individual staff skills to provide technical work–related assistance and to advise on mental health programs and principles. The following human service agencies and individuals shall have priority for the service:

1. Clergy
2. Courts
3. Inpatient services
4. Law enforcement agencies
5. Nursing/transitional homes
6. Physicians
7. Public health nurses
8. Schools
9. Social service agencies

(3) EDUCATION REQUIRED PERSONNEL. The qualified educator maintained by the community board shall be responsible for the mental health education program. Refer to this chapter. Mental health staff members shall cooperate and assist in designing and carrying out the mental health education program, providing their specialized knowledge on a regular, established basis to a variety of specified activities of the service. In cooperation with the education specialist maintained by the board, additional education staff may be employed on a full–time or part–time basis. Education services can also be contracted for through the same procedures followed for other service elements contracts.

(4) EDUCATION SERVICE CONTENT. No less than 10% of the total mental health program staff time exclusive of clerical personnel and inpatient staff shall be devoted to education. The service shall include:

(a) Public education.

(b) Continuing education.

1. Inservice training.
2. Staff development.

(5) EDUCATION PROGRAM. There shall be a planned program of public education designed primarily to prevent mental illness and to foster understanding and acceptance of the mentally ill. A variety of adult education methods shall be used including institutes, workshops, projects, classes and community development for human services agencies, individuals and for organized law groups and also the public information techniques for the general public. There shall be a planned program of continuing education using a variety of adult education methods and available educational offerings of universities, professional associations, etc. for agency staff and related care–giving staff.

History: Cr. Register, March, 1977, No. 255, eff. 4–1–77; renum. from PW–MH 60.69, Register, September, 1982, No. 321, eff. 10–1–82; correction made under s. 13.93 (2m) (b) 7., Stats., Register, June, 1995, No. 474.

HFS 61.78 Additional requirements for programs serving children and adolescents – introduction and personnel. (1) INTRODUCTION. The following standards have been developed for community mental health services for children and adolescents. Except for the substitution of minimal hourly requirements, these standards are intended to be in addition to ss. HFS 61.70 through 61.77 and are consistent with those stated in *Standards for Psychiatric Facilities Serving Children and Adolescents,* published by the American Psychiatric Association; and the Joint Commission on Accreditation of Hospitals. Planning psychiatric facilities and services for children and adolescents is difficult and complex. These standards are intended to insure a continuity of care notwithstanding the complexities involved. To accomplish this each service must:

(a) Consider the children and adolescents' development needs as well as the demands of the illness;

(b) Have cognizance of the vital meaning to children and adolescents that group and peer relationships provide;

(c) Recognize the central importance of cognitive issues and educational experiences;

(d) Recognize the children and adolescents' relative dependence on adults;

(e) Place some importance on the children and adolescents receiving repeated recognition for accomplishments;

(f) Provide an individualized treatment program by so structuring the environment to allow for optimal maturational, emotional and chronological growth.

(2) PERSONNEL REQUIREMENTS. The following personnel requirements are relevant only to children and adolescents' services and are applicable for each program. These requirements are in addition to the personnel qualifications listed in the General Provisions of Standards for Community Mental Health, Developmental Disabilities, and Alcoholism and Other Drug Abuse Services, ss. HFS 61.01 to 61.24.

(a) *Psychiatry.* Special effort shall be made to procure the services of a child psychiatrist who is licensed to practice medicine in the state of Wisconsin and is either board eligible or certified in child psychiatry by the American board of psychiatry and neurology. If a child psychiatrist is unobtainable, special effort shall be made to procure a psychiatrist who has had a minimum of 2 years clinical experience working with children and adolescents.

(b) *Nursing service.* 1. Registered nurses and licensed practical nurses. Special effort shall be made to procure the services of registered nurses and practical nurses who have had training in psychiatric nursing. A portion of this training shall have been with emotionally disturbed children and adolescents.

2. Aides, child care workers and other paraprofessionals. Each service shall make a special effort to recruit the aides, child care workers and paraprofessionals who have the following background.

a. College or university credit or non-credit courses related to child care.

b. Vocational courses planned for child development.

c. High school diploma and experience in children or adolescents' related activities.

(c) *Activity therapy.* Each program, excluding outpatient, shall provide at least one full-time activity therapist. In addition to having formal training in children and adolescents' growth and development, preference shall be given to those professionals who have had clinical training or professional experience with emotionally disturbed children and adolescents.

(d) *Social service.* The social worker shall have had 2 years experience working with children and adolescents.

(e) *Psychological service.* Each service shall employ or contract for the service of a clinical psychologist who shall have the appropriate experience in the area of children and adolescents. Providers of psychological services who do not meet these requirements shall be supervised by a qualified psychologist.

(f) *Educational service.* Each child and adolescent service shall have associated with that service at least one teacher either employed by the service or by a local educational agency.

(g) *In-service.* All personnel shall participate in a documented in-service education program at a minimum of 48 hours per year, relating to areas of mental health concepts of children and adolescents.

History: Cr. Register, March, 1977, No. 255, eff. 4–1–77; am. (2) (c), Register, March, 1979, No. 279, eff. 4–1–79; renum. from PW–MH 60.70 and am. (1) (intro.) and (2) (intro.), Register, September, 1982, No. 321, eff. 10–1–82.

HFS 61.79 Children and adolescent inpatient program. The following personnel requirements are minimum. There is no intention to restrict new programs to these minimal staffing patterns. Existing treatment programs which exceed these requirements may not be reduced without extensive and thorough review and a clear realization of what services would be lost by reduction.

(1) REQUIRED PERSONNEL. (a) *Psychiatry.* Each child and adolescent mental health inpatient service shall provide a minimum of 1.4 hours a week psychiatric treatment time per patient under care. Additional psychiatrists, as needed, shall be available for inpatient visits in order to carry out an adequate treatment program. For emergency purposes a psychiatrist will be on call 24 hours a day each day the facility is in operation. A psychiatrist shall be readily accessible by telephone and ideally, be able to reach the facility within one hour of being called.

(b) *Nursing service.* 1. The following schedule of licensed nursing coverage is minimal.

Day Shift	*Evening Shift*	*Night Shift* (see below)*
.64 hrs/pat/day	.64	.32
or		
4.48 hrs/pat/wk	4.48	2.24

* If child and adolescent service is part of an adult hospital with adjacent units, nursing service could be shared with other services on night shift Such nursing coverage should be documented in total nursing schedule for child and adolescent unit.

2. Aides, child care workers and other paraprofessionals. Child care workers are primarily responsible for day-to-day living experiences of the children. They also carry out assigned aspects of the treatment program under the direction and supervision of designated treatment staff. Each service shall employ a sufficient number of aides, child care workers and paraprofessionals to provide the following minimal care:

Day Shift	*Evening Shift*	*Night Shift*
Children (0–12)		
.98 hrs/pat/day	1.28	.64
or		
6.86 hrs/pat/wk	8.96	4.48
Day Shift	*Evening Shift*	*Night Shift*
Adolescent (over 12)		
.80 hrs/pat/day	1.10	.40
or		
5.60 hrs/pat/wk	7.70	2.80

(c) *Activity therapy.* The inpatient service shall maintain a ratio of 1.6 hours of activity therapy staff time per patient per week. Additional therapists may be employed as needed. In addition sufficient free time for unstructured but supervised play or activity will be provided.

(d) *Social service.* Each service shall employ at least one full time social worker and provide for a minimum of 1.6 hours per week per patient under care.

(e) *Psychological service.* Each service must provide a minimum of one hour per week of psychology time for each patient under care.

(f) *Educational service.* Each mental health inpatient service for children and adolescents is responsible for providing or arranging for special educational programs to meet the needs of all patients being served in the facility. If the service provides its own school program, 4.8 hours per patient per week of teacher time is considered minimal care.

(g) *Vocational service.* If indicated by patient need each inpatient service shall make available a vocational program to each adolescent 14 years of age and older according to the individual patient's age, developmental level and clinical status. This program will be under the auspices of a vocational counselor and is to be carried out in conjunction with, and not in place of the school program. Vocational counseling and training shall be a minimum of 1.3 hours per patient per week, if the service operates its own school program and .8 hour per patient per week, if the facility uses public or other schools.

(h) *Speech and language therapy.* Each mental health inpatient service shall provide one hour per patient per week minimal care of speech and language therapist time for children and adolescents diagnosed as requiring such therapy.

(i) *Add–on factor.* To account for vacation time, sick leave or other absences to which employes may be entitled, the application of a "post shift"factor of 1.59 should be calculated for treatment posts staffed 7 days a week and 1.13 for those staffed 5 days a week. In addition, a 20% factor should be used to account for patient charting, planning and other non–face to face care which is required to maintain the program.

Example of calculation for a 10 bed unit:

Nursing–RNs (7 day week)		Psychiatry–Psychiatrists (5 day week)	
1.28 hrs per day per standard		1.4 hrs per week per standard	
X 10 patients (2 shifts)		X 10 patients	
12.8 hrs		14 hrs	
÷ 8 hrs per day per staff		D 40 hrs per week per staff	
1.6 staff posts		.35 staff posts	
X 20%	1.6	X 20%	.35
.32	J.32	.07	J.07
1.92	1.92	.42	.42
X 1.59 post shift factor for 365 day coverage		X 1.13 post shift factor	
3.05 positions		.4746 or .48 positions	

(2) PROGRAM OPERATION AND CONTENT. (a) *General consideration.* Children and adolescents shall be accepted for other than emergency inpatient treatment only if the child or adolescent requires treatment of a comprehensive and intensive nature and is likely to benefit from the program the inpatient facility has to offer or outpatient alternatives for treatment are not available. No child or adolescent shall be admitted to any inpatient facility more than 60 miles from home without permission of the department. Each inpatient service shall specify in writing its policies and procedures, including intake and admission procedures, current costs, the diagnostic, treatment and preventive services it offers and the manner in which these are regularly conducted. Intake and admission procedures must be designed and conducted to ensure as far as possible a feeling of trust on the part of the child and family. In preparation for admission, the diagnosis and evaluation as well as the development of the treatment plan shall take into consideration the age, life experience, life styles, individual needs and personality, clinical condition, special circumstances necessitating admission and special problems presented by the patient and family. Complete assessment shall include clinical consideration of each of the fundamental needs of the patient; physical, psychological, chronological and developmental level, family, education, social, environmental and recreational. In addition to establishing a diagnosis and carrying out treatment, each service must also make provision for the diagnosis and treatment of any concurrent or associated illness, injury, or handicap. When treatment is to be concluded, the responsible agency will plan with the child, parents and other significant persons or community agencies to ensure an environment that will encourage continuing growth and development.

(b) *Family participation.* Mental health inpatient service shall involve the family's participation. Information about the patient's home experiences will be obtained and the family shall be informed of the patient's problems, progress and experiences in the facility. Information regarding contacts with parents shall be made part of the clinical record. There shall be appropriate educational programs for families designed to enhance their understanding of the goals of the facility and to help them feel welcome as active and participating partners. Participation for families should be scheduled at times when they can reasonably be expected to attend. Family therapy can be included at the discretion of the therapist.

(c) *Special education program.* Each inpatient service is responsible to see that all patients shall be helped to secure a formal education. There shall be flexibility in the special education program and each program shall be tailored to each individual in order to maximize potential growth.

(d) *Vocational program.* If appropriate, plans for work experience shall be developed as part of the overall treatment plan for each adolescent, 14 years of age and older. In planning such experiences, the vocational counselor shall consider the individual's aptitudes and abilities, interests, sensorimotor coordination, and self and vocational perception. When appropriate, work experiences shall be utilized to promote structured activity, provide opportunities for accomplishment, increase the patient's self–confidence and self–esteem, and provide vocational training and preparation.

(e) *Activity therapy.* Appropriate programs of activity therapy and social activities shall be provided for all patients for daytime, evenings and weekends, (emphasis on latter 2), to meet the needs of the patient and the goals of the program. Programs shall be structured to reflect patterns and conditions of everyday life. These programs shall be planned to aid the patients in exploring the nature of their individuality and creativity, in motor, cognitive and social skills, and integrating these into a positive sense of self and to meet therapeutic goals as described.

History: Cr. Register, March, 1977, No. 255, eff. 4–1–77; renum. from PW–MH 60.71, Register, September, 1982, No. 321, eff. 10–1–82.

HFS 61.80 Children and adolescent outpatient program. (1) REQUIRED PERSONNEL. Of the treatment personnel required for any out–patient service, a minimum of 30% staff time must be devoted to children and adolescents services. If qualified children and adolescents mental health professionals are not available on a full or part–time basis, arrangements shall be made to obtain their services on a consulting basis. The staffing patterns of the facility shall be adequate for the provision of high quality of care and shall be appropriate in relationship to: characteristics of patient population; the hours and days the facility operates; chronological and developmental ages of patients; assessment, therapeutic and follow–up programs; intensity and kinds of treatment; nature of disorders, amount of work done with families and significant others; geographic characteristics of territory to be covered; community education and consultation programs; amount of training and research done by facility.

(2) PROGRAM OPERATION AND CONTENT. (a) *Accessibility.* Outpatient services insofar as possible should be scheduled at times that are reasonably convenient to the patients and families served, in relation to the availability of transportation and considering work or school requirements. The outpatient service shall make

provision for walk–in clients, provide for home visits, if clinically indicated, offer clinical consultation to clients in day care services, head start programs, schools, youth centers, jails, alternate care facilities and other community programs. An appointment system that serves to minimize waiting time, in addition to a system for follow–up of broken appointments, should be established.

(b) *Program content.* 1. The patient shall participate in the intake process and in the decision that outpatient treatment is indicated to the extent appropriate to age, maturity and clinical condition. The patient's family, wherever possible, shall have explained to them the nature and goals of the outpatient treatment program and their expected participation and responsibilities. Insofar as possible, the family shall be informed and involved appropriately in decisions affecting the patient during intake treatment, discharge and follow–up.

2. The psychiatric outpatient service shall document about each patient: responsibility for financial support, arrangements for appropriate family participation in the treatment program when indicated; authorization and consent for emergency medical care if the patient becomes ill or has an accident while in treatment and the family cannot be reached; arrangements for transportation to and from the facility; and authorization if the patient is to go to other community areas, facilities or events as part of the outpatient program; releases for sharing of confidential materials when necessary; appropriate consents for participation in research programs.

3. Assessment shall include clinical consideration of the physical, psychological, development, chronological age, environmental, family, social, educational and recreational factors related to the child and adolescent.

4. The relationship between any adult, who has current and/or continuing responsibility for the child's and adolescent's life, and the patient shall be carefully evaluated at regular intervals.

History: Cr. Register, March, 1977, No. 255, eff. 4–1–77; renum. from PW–MH 60.72, Register, September, 1982, No. 321, eff. 10–1–82.

HFS 61.81 Child and adolescent day treatment program. History: Cr. Register, March, 1977, No. 255, eff. 4–1–77; renum. from PW–MH 60.73, Register, September, 1982, No. 321, eff. 10–1–82; r. Register, August, 1996, No. 488, eff. 9–1–96.

Subchapter V —Outpatient Psychotherapy Clinic Standards

HFS 61.91 Scope. (1) This subchapter applies to private psychotherapy clinics providing psychotherapy and related outpatient services and receiving payments through the Wisconsin Medical Assistance Program and mandatory benefits required by s. 632.89, Stats., (Insurance Code), and to clinics operated by local community boards authorized by ch. 46 or 51, Stats.

(2) This subchapter is not applicable to outpatient programs providing services to only persons with alcohol and drug abuse problems governed by ss. HFS 61.50 to 61.68.

History: Cr. Register, May, 1981, No. 305, eff. 6–1–81; am. Register, September, 1982, No. 321, eff. 10–1–82.

HFS 61.92 Statutory authority. This subchapter is promulgated pursuant to ss. 49.45 (10), 51.04, 51.42 (5) (b) to (d), 51.42 (12), 227.11 (2) (a) and 632.89, Stats.

History: Cr. Register, May, 1981, No. 305, eff. 6–1–81; correction made under s. 13.93 (2m) (b) 7., Stats., Register, June, 1995, No. 474.

HFS 61.93 Purpose. (1) This subchapter is established to provide uniform standards for outpatient services provided by private clinics requesting payments from the Wisconsin Medical Assistance Program and mandatory benefits required in s. 632.89 (1) (a), Stats., and clinics operated by local community boards authorized by ch. 46 or 51, Stats.

(2) The outpatient psychotherapy clinic standards have been developed to ensure that services of adequate quality are provided to Wisconsin citizens in need of treatment for mental disorders or alcohol and drug abuse problems. A continuum of treatment services shall be available to the patient, either through direct provision of services by the certified clinic or through written procedures which document how additional services from other service providers will be arranged to meet the overall treatment needs of the patient. The standards are designed to assist clinics in the organization and delivery of outpatient services.

History: Cr. Register, May, 1981, No. 305, eff. 6–1–81; am. (1), Register, September, 1982, No. 321, eff. 10–1–82; am., Register, September, 1996, No. 496, eff. 10–1–96.

HFS 61.94 Definitions. (1) "Certification" means the approval of a clinic for a specific purpose.

(2) "Clinic" means an outpatient psychotherapy clinic.

(3) "Department" means the department of health and social services.

(4) "Division" means the division of community services which is the approving agency for certification under this subchapter.

(5) "Employed" means working for a clinic and receiving compensation which is subject to state and federal income tax, or being under written contract to provide services to the clinic.

(6) "Mental disorders" 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.

(7) "Outpatient psychotherapy clinic" means an outpatient treatment facility as defined in s. 632.89 (1) (a), Stats., and which meets the requirements of this rule or is eligible to request certification.

(8) "Provide" means to render or to make available for use.

(9) "Psychotherapy" has the meaning designated in s. HFS 101.03.

(10) "Supervision" means intermittent face to face contact between a supervisor and a staff member to review the work of the staff member.

History: Cr. Register, May, 1981, No. 305, eff. 6–1–81; r. and recr. (6), Register, September, 1996, No. 489, eff. 10–1–96.

HFS 61.95 Procedures for approval. (1) PRINCIPALS GOVERNING CERTIFICATION. (a) The method by which a clinic is reviewed for approval by the department is set forth in this section. A certification survey is used to determine the extent of the compliance with all standards specified in this subchapter. Decisions shall be based on a reasonable assessment of each clinic. The extent to which compliance with standards is assessed shall include:

1. Statements of the clinic's designated agent, authorized administrator or staff member;

2. Documentary evidence provided by the clinic;

3. Answers to detailed questions concerning the implementation of procedures, or examples of implementation, that will assist the department to make a judgement of compliance with standards; and

4. Onsite observations by surveyors.

(b) The clinic shall make available for review by the designated representative of the department all documentation necessary to establish compliance with standards, including but not limited to policies and procedures of the clinic, work schedules of staff, master and individual appointment books, patient billing charts, credentials of staff and patient clinical records not elsewhere restricted by statute or administrative rules.

(2) APPLICATION FOR CERTIFICATION. The application for approval shall be in writing and shall contain such information as the department requires.

(3) CERTIFICATION PROCESS. The certification process shall include a review of the application and supporting documents,

plus an interview and onsite observations by a designated representative of the department to determine if the requirements for certification are met.

(4) ISSUANCE OF CERTIFICATION. Within 60 days after receiving a complete application for outpatient psychotherapy clinic certification, the department shall issue the certification if all requirements for certification are met. If the application for certification is denied, the department shall give the applicant reasons, in writing, for the denial.

(5) UNANNOUNCED INSPECTIONS. (a) The department may, during the certification period, make unannounced inspections of the clinic to verify continuing compliance with this subchapter.

(b) Unannounced inspections shall be made during normal working hours of the clinic and shall not disrupt the normal functioning of the clinic.

(6) CONTENT OF CERTIFICATION. The certification shall be issued only for the location and clinic named and shall not be transferable or assignable. The department shall be notified of changes of administration, ownership, location, clinic name, or program changes which may affect clinic compliance by no later than the effective date of the change.

(7) DATE OF CERTIFICATION. (a) The date of certification shall be the date when the onsite survey determines the clinic to be in compliance with this subchapter.

(b) The date of certification may be adjusted in the case of an error by the department in the certification process.

(c) In the event of a proven departmental error, the date of certification shall not be earlier than the date the written application is submitted.

(8) RENEWAL. (a) Certification is valid for a period of one year unless revoked or suspended sooner.

(b) The applicant shall submit an application for renewal 60 days prior to the expiration date of certification on such form as the department requires. If the application is approved, certification shall be renewed for an additional one year period beginning on the expiration date of the former certificate.

(c) If the application for renewal is not filed on time, the department shall issue a notice to the clinic within 30 days prior to the expiration date of certification. If the application is not received by the department prior to the expiration a new application shall be required for recertification.

(9) RIGHT TO HEARING. In the event that the department denies, revokes, suspends, or does not renew a certificate, the clinic has a right to request an administrative hearing under s. HFS 61.98 (4).

History: Cr. Register, May, 1981, No. 305, eff. 6–1–81; r. and recr. (4), Register, October, 1985, No. 358, eff. 11–1–85.

HFS 61.96 Required personnel. (1) Staff of a certified clinic shall include:

(a) A physician who has completed a residency in psychiatry, or a licensed psychologist who is listed or eligible to be listed in the national register of health services providers in psychology; and

(b) A social worker with a masters degree from a graduate school of social work accredited by the council on social worker education or a registered nurse with a master's degree in psychiatric–mental health nursing or community mental health nursing from a graduate school of nursing accredited by the national league for nursing.

(2) Other mental health professionals with training and experience in mental health may be employed as necessary, including persons with masters degrees and course work in clinical psychology, psychology, school psychology, counseling and guidance, or counseling psychology.

(3) Mental health professionals designated in subs. (1) (b) and (2) shall have 3,000 hours of supervised experience in clinical practice, which means a minimum of one hour per week of face to face supervision during the 3,000 hour period by another mental health professional meeting the minimum qualifications, or shall be listed in the national registry of health care providers in clinical social work or national association of social workers register of clinical social workers or national academy of certified mental health counselors or the national register of health services providers in psychology.

(4) Professional staff employed in clinics operated by community boards authorized by ch. 46 or 51, Stats., shall meet qualifications specified by s. HFS 61.06 for purposes of complying with recruitment practices required by s. 230.14 (3m), Stats.

History: Cr. Register, May, 1981, No. 305, eff. 6–1–81; am. (1) and (3), cr. (4), Register, September, 1982, No. 321, eff. 10–1–82; am. (1) (b), (2) and (3), Register, April, 1984, No. 340, eff. 5–1–84.

HFS 61.97 Service requirements. (1) The clinic shall ensure continuity of care for persons with mental disorders or alcohol and drug abuse problems by rendering or arranging for the provision of the following services and documenting in writing how the services shall be provided:

(a) Diagnostic services to classify the patients presenting problem.

(b) Evaluation services to determine the extent to which the patient's problem interferes with normal functioning.

(c) Initial assessment of new patients.

(d) Outpatient services as defined in s. 632.89 (1) (d), Stats.

(e) Residential facility placement for patients in need of a supervised living environment.

(f) Partial hospitalization to provide a therapeutic milieu or other care for non–residential patients for only part of a 24–hour day.

(g) Pre–care prior to hospitalization to prepare the patient for admission.

(h) Aftercare for continuing treatment in the community to help the patient maintain and improve adjustment following a period of treatment in a facility.

(i) Emergency care for assisting patients believed to be in danger of injuring themselves or others.

(j) Rehabilitation services to achieve maximal functioning, optimal adjustment, and prevention of the patient's condition from relapsing.

(k) Habilitation services to achieve adjustment and functioning of a patient in spite of continuing existence of problems.

(L) Supportive transitional services to provide a residential treatment milieu for adjustment to community living.

(m) Professional consultation to render written advice and services to a program or another professional on request.

(2) The clinic shall provide a minimum of 2 hours each of clinical treatment by a psychiatrist or psychologist and a social worker for each 40 hours of psychotherapy provided by the clinic.

(3) Personnel employed by a clinic as defined in s. HFS 61.96 (1) (b) and (2) shall be under the supervision of a physician or licensed psychologist who meets the requirements of s. HFS 61.96 (1) (a).

(a) There shall be a minimum of 30 minutes of supervision which shall be documented by notation in the master appointment book for each 40 hours of therapy rendered by each professional staff person.

(b) Supervision and review of patient progress shall occur at intake and at least at 30 day intervals for patients receiving 2 or more therapy sessions per week and once every 90 days for patients receiving one or less therapy sessions per week.

(4) The supervising physician or psychologist shall meet with the patient when necessary or at the request of the patient or staff person.

(5) A physician must make written referrals of patients for psychotherapy when therapy is not provided by or under the clinical

supervision of a physician. The referral shall include a written order for psychotherapy and include the date, name of the physician and patient, the diagnosis and signature of the physician.

(6) Emergency therapy shall be available, for those patients who are determined to be in immediate danger of injuring themselves or other persons.

(7) The patient receiving services may not be a bed patient of the clinic rendering services.

(8) Outpatient services shall be provided at the office or branch offices recognized by the certification of the clinic except in instances where therapeutic reasons are documented to show an alternative location is necessary.

(9) Group therapy sessions should not exceed 10 patients and 2 therapists.

(10) A prospective patient shall be informed by clinic staff of the expected cost of treatment.

(11) An initial assessment must be performed by staff to establish a diagnosis on which a preliminary treatment plan is based which shall include but is not limited to:

(a) The patient's presenting problems with the onset and course of symptoms, past treatment response, and current manifestation of the presenting problems;

(b) Preliminary diagnosis;

(c) Personal and medical history.

(12) A treatment plan shall be developed with the patient upon completion of the diagnosis and evaluation.

(13) Progress notes shall be written in the patient's clinical record.

(a) The notes shall contain status and activity information about the patient that relates to the treatment plan.

(b) Progress notes are to be completed and signed by the therapist performing the therapy session.

(14) A discharge summary containing a synopsis of treatment given, progress and reasons for discharge shall be written in the patient's clinical record when services are terminated.

(15) All patient clinical information received by the clinic shall be kept in the patient's clinical record.

(a) Patient clinic records shall be stored in a safe and secure manner.

(b) Policy shall be developed to determine the disposition of patient clinical records in the event of a clinic closing.

(c) There shall be a written policy governing the disposal of patient clinical records.

(d) Patient clinical records shall be kept at least 5 years.

(e) Upon termination of a staff member the patient clinical records for which he or she is responsible shall remain in the custody of the clinic where the patient was receiving services unless the patient requests in writing that the record be transferred.

(f) Upon written request of the patient the clinic shall transfer the clinical information required for further treatment as determined by the supervising physician or psychologist.

(16) Reimbursement under the Wisconsin medical assistance program for any services listed in this section is governed by chs. HSS 101 to 106.

History: Cr. Register, May, 1981, No. 305, eff. 6–1–81; am. (1) (j) and (3), Register, September, 1982, No. 321, eff. 10–1–82; am. (1) (intro.), Register, September, 1996, No. 489, eff. 10–1–96.

HFS 61.98 Involuntary termination, suspension or denial of certification. The department may terminate, suspend or deny certification of any clinic after prior written notice and summary of the basis for termination, suspension or denial.

(1) TERMINATION OR SUSPENSION OF CERTIFICATION WITHOUT PRIOR HEARING. Certification may be terminated or suspended without prior hearing whenever the department finds:

(a) Any of the clinic's licenses or required local, state or federal approvals have been revoked, suspended or have expired; or

(b) The health or safety of a patient is in imminent danger because of knowing failure of the clinic to comply with requirements of this rule or any other applicable local, state or federal law or regulation.

(2) TERMINATION, SUSPENSION OR DENIAL OR CERTIFICATION AFTER PRIOR NOTICE AND REQUESTED HEARING. Certification may be terminated, suspended or denied only after prior notice of proposed action and notice of opportunity for a hearing whenever the department finds:

(a) A staff member of a clinic has been convicted of a criminal offense related to the provision of or claiming reimbursement for services under Medicare (Title XVIII, Social Security Act), or under this or any other state's medical assistance program. For purposes of this section, "convicted" means that a judgment of conviction has been entered by a federal, state or local court, irrespective of whether an appeal from that judgment is pending.

(b) The clinic submitted or caused to be submitted false statements, for purposes of obtaining certification under these rules, which it knew, or should have known, to be false.

(c) The clinic failed to maintain compliance with standards for which it was certified.

(3) EXPIRATION OF CERTIFICATION. Clinics which allow certification to expire and do not initiate an application for renewal prior to the date of expiration will be terminated on the date of expiration without right to a hearing. Thereafter, a clinic must submit a new application in order to be certified.

(4) CLINIC REQUEST FOR HEARING. Any clinic which has been served notice of termination, suspension or denial of certification may submit a written request for a hearing pursuant to provisions under ch. 227, Stats., within 10 days after receipt of the notice of termination, suspension or denial of certification.

(a) Upon receipt of a timely request for hearing, the department's office of administrative hearings shall schedule and mail a notice of hearing to the division and to the clinic. Such notice shall be mailed to the parties at least 10 working days before the scheduled hearing.

(b) The failure of the clinic to submit a timely request for hearing shall constitute a default. Accordingly, the findings of the department which served as the basis for the action shall be construed as being admitted by the provider, and the administrative remedy or relief sought by the department by means of the action may be effected.

(5) VIOLATION AND FUTURE CERTIFICATION. A person with direct management responsibility for a clinic and all employes of a clinic who were knowingly involved in any of the following acts which served as a basis for termination shall be barred from employment in a certified clinic for a period of not to exceed 5 years.

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

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

(6) TIME PERIOD FOR COMPLIANCE. All clinics approved as outpatient facilities pursuant to s. 632.89, Stats., must demonstrate compliance with this subchapter within 6 months after the effective date.

(7) FAILURE TO COMPLY. Failure to demonstrate compliance will cause termination of certification as provided in this section.

(8) STAFF QUALIFICATION GRACE PERIOD. A grace period of 3 years shall be granted for mental health professionals with bachelor degrees who have practiced in an approved outpatient facility prior to the effective date of this rule, to obtain the degree requirements set forth in s. HFS 61.96 with the following conditions:

(a) The person shall have had one year of experience as a full-time psychotherapist;

(b) The person shall have completed 150 hours of professional training in the mental health field beyond the bachelor degree;

(c) The person shall document the requirements in pars. (a) and (b) and notify the division within 90 days of the effective date of this subchapter of the intent to comply with the provisions of this section;

(d) The person shall submit annual reports of progress toward compliance to the division to demonstrate good faith effort.

History: Cr. Register, May, 1981, No. 305, eff. 6–1–81.

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