

**COMMUNITY SUBSTANCE ABUSE SERVICE (CSAS)  
GENERAL REQUIREMENTS  
INITIAL CERTIFICATION APPLICATION  
Chapter DHS 75.03**

**Initial Certification**

- **Initial certification must meet all requirements, including staffing requirements (hired and in place) before services begin.**
- **This document paraphrases the rule language for application purposes.**
- **Applicants for a new outpatient service must demonstrate preparedness to comply with all Chapter DHS 75.03 standards.**  
Applicants will have completed all required policies, including Chapter DHS 94 (Patient Rights). Use the check boxes (  ) to affirm readiness to meet standards.
- **ATTENTION: The clinic must contact the regional Health Services Specialist to arrange a site visit following the submission of fee and this application.**

**Chapter DHS 75.01(1) Authority and Purpose**

This application is promulgated under the authority of ss. 46.973(2)(c), 51.42(7)(b), and 51.45(8) and (9), Wis. Stats., to establish standards for community substance abuse prevention and treatment services under ss. 51.42 and 51.45, Wis. Stats. Sections 51.42(1) and 51.45(1) and (7) provide that a full continuum of substance abuse services be available to Wisconsin citizens from county departments of community programs, either directly or through written agreements or contracts that document the availability of services. This application provides that service recommendations for initial placement, continued stay, level of care transfer, and discharge of a patient be made through the use of Wisconsin uniform placement criteria (WI-UPC), American Society of Addiction Medicine (ASAM) placement criteria, or similar placement criteria that may be approved by the department.

Use of approved placement criteria services as a contributor to the process of obtaining prior authorization from the treatment services funding source. It does not establish funding eligibility regardless of the funding source. The results yielded by application of these criteria serve as a starting point for further consultations among the provider, patient, and payer as to an initial recommendation for the type and amount of services that may be medically necessary and appropriate in the particular case. Use of WI-UPS or any other department-approved placement criteria does not replace and need to do a complete assessment and diagnosis of a patient in accordance with DSM-IV.

**Chapter DHS 75.01(2) Applicability**

This application applies to each substance abuse service that receives funds under Chapter DHS 51, Wis. Stats., is approved by the state methadone authority, is funded through the department as the federally designated single state agency for substance abuse services, receives substance abuse prevention and treatment funding or other funding specifically designated for providing services under ch. DHS 75.04 or 75.16, or is a service operated by a private agency that requests certification.

**Chapter DHS 75.03(1) General Requirements**

This section establishes general requirements that apply to the 13 types of community substance abuse services under ch. DHS 75.04 to 75.16. Not all general requirements apply to all services. Table Chapter DHS 75.03 indicates the general requirement subsections that apply to specific services.

**To Program Personnel**

- Read instructions carefully before completing this questionnaire.
- For clarity, the relevant standard is printed in ***italic letters*** immediately preceding the corresponding questionnaire item.
- Before starting this questionnaire, it is very important that you determine the sections of ch. DHS 75 which need to be completed. (See Table Chapter DHS 75.03 on page 2.)
- Using Table Chapter DHS 75.03, locate the appropriate service(s) in the left hand column for which certification is being sought. By following across the page, an "X" will appear under the subsections of the general requirements that are required for that program section.
- Complete only those subsections indicated (by an "X") in Table Chapter DHS 75.03.

- The general requirements section needs only to be completed **once**, regardless of the number of program sections (ch. DHS 75.04 – 75.16) for which certification is being sought.
- Respond to **every** item carefully. Do not omit a response to any item.
- The Behavioral Health Certification Section staff will be looking for verification of necessary documents during the survey process. We encourage you to list the type of documents or materials that will be presented to verify the statements in each service application. **DO NOT** forward the actual documents or material with the questionnaire; however, be sure that such are available for review at the time of the on-site survey.

**TABLE CHAPTER DHS 75.03  
GENERAL REQUIREMENTS APPLICABLE TO EACH SERVICE**

(X = Required Service)

<b>DHS 75.03 GENERAL REQUIREMENTS</b>	<b>75.04</b>	<b>75.05</b>	<b>75.06</b>	<b>75.07</b>	<b>75.08</b>	<b>75.09</b>	<b>75.10</b>	<b>75.11</b>	<b>75.12</b>	<b>75.13</b>	<b>75.14</b>	<b>75.15</b>	<b>75.16</b>
(2) Certification	X	X	X	X	X	X	X	X	X	X	X	X	X
(3) Governing Authority	X	X	X	X	X	X	X	X	X	X	X	X	X
(4) Personnel	X	X	X	X	X	X	X	X	X	X	X	X	X
(5) Staff Development	X	X	X	X	X	X	X	X	X	X	X	X	X
(6) Training in Management of Suicidal Individuals	X	X	X	X	X	X	X	X	X	X	X	X	X
(7) Confidentiality	X	X	X	X	X	X	X	X	X	X	X	X	X
(8) Patient Case Records			X	X	X	X	X	X	X	X	X	X	
(9) Case Records for Emergency Services			X	X								X	
(10) Screening		X	X	X	X	X	X	X	X	X	X	X	
(11) Intake			X	X	X	X	X	X	X	X	X	X	
(12) Assessment							X	X	X	X	X	X	
(13) Treatment Plan							X	X	X	X	X	X	
(14) Staffing			X	X	X	X	X	X	X	X	X	X	
(15) Progress Notes			X	X	X	X	X	X	X	X	X	X	
(16) Transfer			X	X	X	X	X	X	X	X	X	X	
(17) Discharge or Termination			X	X	X	X	X	X	X	X	X	X	
(18) Referral	X	X	X	X	X	X	X	X	X	X	X	X	X
(19) Follow-up			X	X	X	X	X	X	X	X	X	X	
(20) Service Evaluation	X	X	X	X	X	X	X	X	X	X	X	X	
(21) Communicable Disease Screening			X	X	X	X	X	X	X	X	X	X	
(22) Unlawful Substance Use	X	X	X	X	X	X	X	X	X	X	X	X	X
(23) Emergency Shelter and Care			X	X		X	X	X			X		
(24) Death Reporting		X	X	X	X	X	X	X	X	X	X	X	

**DHS 75.03(2) Certification**

**(a) Approval**

Each service that receives funds under Chapter 51, Wis. Stats., is approved by the state methadone authority, is funded through the department’s division of prevention, treatment, and recovery, or receives other substance abuse prevention and treatment funding or other funding specifically designated to be used for providing services described under ss. DHS 75.04 - 75.16, shall be certified by the department under this chapter.

**(b) Application**

An individual or organization seeking certification of a service under this chapter shall apply to the department for certification on a form provided by the department.

**Note:** For a copy of the initial application for certification, write to: **DQA / Behavioral Health Certification Section  
P.O. Box 2969  
Madison, WI 53701-2969**

**(c) Determination**

Upon receipt of a completed application for certification, the department shall review the application for compliance with this chapter, which may include an on-site survey. Within 45 days after receiving a completed application, the department shall either approve or deny the application. If the application for certification is denied, the department shall give the individual or organization applying for certification reasons, in writing, for the denial and shall inform the individual or organization of a right to appeal that decision under par. (h).

**(d) Duration**

The department may issue a certification for a period of up to two years. The certification shall remain in effect for that period unless suspended or revoked prior to expiration.

**(e) Renewal**

The department shall send a renewal notice and instructions to the certificate holder 60 days before expiration of the certification.

**(f) Denial**

1. The department may refuse to issue a certification if an applicant fails to meet all requirements of this chapter or may refuse to renew a certification if the applicant no longer meets or has violated any provision of this chapter.
2. The department may refuse to issue a certification if the applicant has previously had a certification revoked for failure to comply with rules promulgated by the department or a comparable agency in another state.

**(g) Suspension or revocation**

The department may at any time, upon written notice to a certificate holder, suspend or revoke the certificate if the department finds that the service does not comply with this chapter. The notice shall state the reasons for the suspension or revocation and shall inform the certificate holder of the right under par. (h) to appeal that decision.

**(h) Responsibility for interpretation**

The department's bureau of prevention, treatment, and recovery is responsible for the interpretation of the meaning and intent of the provisions of this chapter.

**(h) Appeals**

1. If the department denies, refuses to renew, suspends, or revokes a certification, the individual, organization, or service applying for certification or renewal may request an administrative hearing under ch. 227, Wis. Stats. If a timely request for hearing is made on a decision to suspend or revoke or not renew a certification, that action is stayed pending the decision on the appeal except when the department finds that the health, safety, or welfare of patients requires that the action take effect immediately. A finding of a requirement for immediate action shall be made in writing by the department.
2. A client shall file his or her request for a fair hearing in writing with the Division of Hearings and Appeals in the Department of Administration within 30 days after the date of the notice of adverse action under par. (c) or (g). If a request is not received within 30 days, no hearing is available. A request is considered filed when received by the Division of Hearings and Appeals. Receipt of notice is presumed within five days of the date the notice is mailed.

**Note:** The mailing address and telephone for the Division of Hearings and Appeals are:

**Division of Hearings and Appeals  
P.O. Box 7875  
Madison, WI 53707  
(608) 266-3096**

**Note:** Hearing requests may be delivered in person to: **Division of Hearings and Appeals  
5005 University Ave. / Room 201  
Madison, WI**

3. In accordance with Chapter HA 3, the Division of Hearings and Appeals shall consider and apply all standards and requirements of this chapter.

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**Chapter DHS 75.03**

**By completing and submitting this form, the clinic indicates that it is in compliance with the program standards as required by state statutes.**

Name – Facility					
Address – Physical		City	State	Zip Code	County
Telephone Number			E-mail Address <input type="checkbox"/> <i>May be published in Provider Directory</i>		
Fax Number			Internet Address <input type="checkbox"/> <i>May be published in Provider Directory</i>		
Name – Contact Person	Telephone Number		E-mail Address <input type="checkbox"/> <i>May be published in Provider Directory</i>		
Name – Person Who Completed this Form	Telephone Number		E-mail Address <input type="checkbox"/> <i>May be published in Provider Directory</i>		

**I hereby attest that all statements made in this application and any attachments are correct to the best of my knowledge and that I will comply with all laws, rules, and regulations governing alcohol and other drug abuse intervention services.**

FULL SIGNATURE – Director	Date Signed	Full Name – Director ( <i>Print or type.</i> )
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**Chapter DHS 75.03(3) Governing Authority**

The governing authority or legal owner of this service has complied with all of the following:

- Yes  No (a) Established written policies and procedures for the operation of the service and exercised general direction over this service.
- Yes  No (b) Appointed a director whose qualifications, authority, and duties are defined in writing.
- Yes  No (c) Developed and provided a policy manual that describes the policies and procedures for the delivery of services.
- Yes  No (d) Complied with local, state, and federal laws.
- Yes  No (e) Established a written policy stating that the service will comply with patient rights requirements as specified in this chapter and in ch. DHS 94.
- Yes  No (f) Established written policies and procedures stating that services will be available and accessible, and that with the exception of par. (g), no person will be denied service or discriminated against on the basis of sex, race, color, creed, sexual orientation, handicap or age, in accordance with the Title VI of the Civil Rights Act of 1964, as amended, 42 USC 2000d, Title XI of the Education Amendments of 1972, 20 USC 1681-1686 and s. 504 of the Rehabilitation Act of 1973, as amended, 29 USC 794, and the Americans with Disabilities Act of 1990, as amended, 42 USC 12101-12213.
- Yes  No (g) Stated clearly in writing the criteria for determining the eligibility of individuals for admission, with first priority for services given to pregnant women who are alcohol or drug abusers.
- Yes  No (h) Developed written policies and procedures stating that, in the selection of staff, consideration will be given to each applicant's competence, responsiveness and sensitivity toward and training in serving the characteristics of the service's patient population, including gender, age, cultural background, sexual orientation, development, cognitive or communication barriers, and physical or sensory disabilities.
- Yes  No (i) Developed written policies and procedures to ensure that recommendations relating to a patient's initial placement, continued stay, level of care, transfer and discharge recommendations are determined through the application of approved uniform placement criteria.

**Chapter DHS 75.03(4) Personnel**

- Yes  No (a) This service has a director appointed by the governing authority or legal owner and is responsible for administration of this service.
- Yes  No (b) This service complies with ch. DHS 12, which directs the service to perform background information checks on applicants for employment and persons with whom the service contracts and who have direct, regular contact with patients and, periodically, on existing employees and to not hire or retain persons who, because of specified past actions, are prohibited from working with patients.
- Yes  No (c) If this service uses volunteers, there is written policies and procedures governing their activities.
- Yes  No (f) All staff who provide mental health treatment services to dually diagnosed clients meet the appropriate qualifications under appendix B.
- Yes  No (g) Provision of clinical supervision for a substance abuse counselor are evidenced in that person's personnel file by documentation which identifies hours of supervision provided, issues addressed in the areas of counselor development, counselor skill assessment and performance evaluation, management and administration, and professional responsibility and plans for problem resolution. This documentation is signed by the clinical supervisor.

**Chapter DHS 75.03(5) Staff Development**

- Yes  No This service has written policies and procedures for determining staff training needs, formulating individualized training plans and documenting the progress and completion of staff development goals.

**Chapter DHS 75.03(6) Training Staff in Assessment and Management of Suicidal Individuals**

- (a) This service has a written policy requiring each new staff person who may have responsibility for assessing or treating patients who present significant risks for suicide to do one of the following:

- Yes  No 1. Receive documented training in assessment and management of suicidal individuals within two months after being hired by the service.
- Yes  No 2. Provide written documentation of past training or supervised experience in assessment and management of suicidal individuals
- Yes  No (b) Staff providing crisis intervention or who are on call to provide crisis intervention shall, within one month of being hired to provide these services, receive specific training in crisis assessment and treatment of persons presenting a significant risk for suicide or document that they have already received the training.
- Yes  No (c) There are written policies and procedures covering the nature and extent of this training to ensure that crisis and on-call staff will be able to provide the necessary services given the range of needs and symptoms generally exhibited by patients receiving care through the service.
- Yes  No (d) Staff employed by the program on August 1, 2000 have either received training in assessment and management of suicidal individuals within one year from that date or provide documentation of past training.

**Chapter DHS 75.03(7) Confidentiality**

- Yes  No This service has written policies, procedures, and staff training to ensure compliance with provisions of 42 CFR Part 2, confidentiality of alcohol and drug abuse patient records, and s. 51.30, Wis. Stats., and ch. DHS 92, confidentiality of records.
- Yes  No Each staff member has signed a statement acknowledging his or her responsibility to maintain confidentiality of personal information about patients.

**Chapter DHS 75.03(8) Patient Case Records**

- Yes  No (a) There is a case record for each patient. (Note: For a person receiving only emergency services under s. DHS 75.06, 75.07, and 75.15, the case record requirements are found in sub. (9).
- Yes  No (b) A staff person of this service has been designated to be responsible for the maintenance and security of patient case records.
- Yes  No (c) Patient case records are safeguarded as provided in sub. (7) and maintained with the security precautions specified in 42 CFR Part 2.
- Yes  No (d) The case record format provides for consistency and facilitates information retrieval.
- Yes  No (e) A patient's case record includes all of the following:
1. Consent for treatment forms signed by the patient or, as appropriate, the patient's legal guardian.
  2. An acknowledgement by the patient or the patient's legal guardian, if any, that the service policies and procedures were explained to the patient or the patient's legal guardian.
  3. A copy of the signed and dated patient notification that was reviewed with and provided to the patient and patient's legal guardian, if any, which identifies patient rights, and explains provisions for confidentiality and the patient's recourse in the event that the patient's rights have been abused.
  4. Results of all screening, examinations, test, and other assessment information.
  5. A completed copy of the most current placement criteria summary for initial placement or for documentation of the applicable approved placement criteria or WI-UPC assets and needs criteria if the patient has been transferred to a level of care different from the initial placement. Alternative forms that include all the information from the WI-UPC summary or other approved placement criteria may be used in place of the actual scoring document.
  6. Treatment plans
  7. Medication records that allow for ongoing monitoring of all staff-administered medications and the documentation of adverse drug reactions.
  8. All medication orders, which specify the name of the medication, dose, route of administration, frequency of administration, person administering, and name of the physician who prescribed the medication.
  9. Reports from referring sources, each including the name of the referral source, the date of the report, and the date the patient was referred to the service.
  10. Records of referral by the service, including documentation that referral follow-up activities occurred.
  11. Multi-disciplinary case conference and consultation notes signed by the primary counselor.
  12. Correspondence relevant to the patient's treatment, including all letters and dated notations of telephone conversations.
  13. Consent forms authorizing disclosure of specific information about the patient.
  14. Progress notes, including staffings, in accordance with the service's policies and procedures.
  15. A record of services provided that includes documentation of all case management, education, services, and

referrals.

16. Staffing notes signed by the primary counselor and the clinical supervisor, and by the mental health professional if the patient is dually diagnosed.
17. Documentation of transfer from one level of care to another, which identifies the applicable criteria from approved placement criteria, and includes the dates the transfer was recommended and initiated.
18. Discharge documentation.

- Yes  No (f) This service has policies and procedures to ensure security and confidentiality of all case records when clinical supervision is provided off site.
- Yes  No (g) This service has knowledge that, if it should discontinue operations or is taken over by another service, records containing patient identifying information may be turned over to the replacement service or any other service provided the patient consents in writing. If no patient consent is obtained, the records shall be sealed and turned over to the department to be retained for 7 years and then destroyed.
- Yes  No (h) This service will maintain a patient's case for a period of 7 years from the date of termination of treatment or service.
- Yes  No (i) This service understands that it is the custodian and owner of the patient file and may release information only in compliance with sub. (7).

#### **Chapter DHS 75.03(9) Case Records for Persons Receiving Emergency Services**

- Yes  No (a) This service keeps a case record for every person requesting or receiving emergency services under ch. DHS 75.06, 75.07, or 75.15, except where the only contact made is by telephone.
- Yes  No (b) Case records prepared under this subsection comply with requirements under s. DHS 124.14, if the service is operated by a hospital or include all of the following.
1. The individual's name and address
  2. The individual's date of birth, sex, and race or ethnic origin
  3. Time of first contact with the individual
  4. Time of the individual's arrival, means of arrival, and method of transportation
  5. Presenting problem
  6. Time emergency services began
  7. History of recent substance use, if determinable
  8. Pertinent history of the problem, including details of first aid or emergency care given to the individual before being seen by the emergency service
  9. Description of clinical and laboratory findings
  10. Results of emergency screening, diagnosis, or other assessment completed
  11. Detailed description of services provided
  12. Progress notes
  13. Condition of the individual on transfer or discharge
  14. Final disposition, including instructions given to the individual regarding necessary follow-up care
  15. Records of services provided, which shall be signed by the physician in attendance when medical diagnosis or treatment has been provided
  16. Name, address, and phone number of a person to be notified in case of an emergency provided that there is a release of information signed by the patient that enables the agency to contact that person, unless the person is incapacitated and is unable to sign a release of information.

#### **Chapter DHS 75.03(10) Screening**

- Yes  No (a) This service will complete withdrawal screening for a patient who is currently experiencing withdrawal symptoms or who presents the potential to develop withdrawal symptoms.
- Yes  No (b) Acceptance of a patient for substance abuse services is based on a written screening procedure and the application of approved patient placement criteria, which clearly states the criteria for determining eligibility for admission.
- Yes  No (c) All substance abuse screening procedures include the collection of data relating to impairment due to substance use consistent with the WI-UPC, ASAM patient placement criteria, or other similar patient placement criteria approved by the department.

**Chapter DHS 75.03(11) Intake**

- Yes  No (a) *Basis for admission*  
Admission of an individual to this service for treatment is based upon an intake procedure that includes screening, placement, initial assessment, and required administrative tasks.
- Yes  No (b) *Policies and procedures for intake*  
This service has written policies and procedures to govern the intake process, including all of the following
1. A description of the types of information to be obtained from an applicant before admission.
  2. A written consent to treatment statement attached to the initial service plan, which shall be signed by the prospective patient before admission is completed.
  3. A method of informing the patient about and ensuring that the patient understands all of the following, and for obtaining the patient's signed acknowledgment of having been informed and understanding all of the following:
    - a. The general nature and purpose of the service
    - b. Patient rights and the protection of privacy provided by the confidentiality laws
    - c. Service regulations governing patient conduct, the types of infractions that result in corrective action or discharge from the service and process for review or appeal
    - d. The hours during which services are available
    - e. Procedures for follow-up after discharge
    - f. Information about the cost of treatment, who will be billed and the accepted methods of payment if the patient will be billed.
- Yes  No (c) *Initial assessment*  
The initial assessment includes all of the following:
1. An alcohol and drug history that identifies:
    - a. The substance or substances used
    - b. The duration of use for each substance
    - c. Pattern of use in terms of frequency and amount
    - d. Method of administration
    - e. Status of use immediately prior to entering into treatment
  2. Available information regarding the patient's family, significant relationships, legal, social and financial status, treatment history, and other factors that appear to have a relationship to the patient's substance abuse and physical and mental health
  3. Documentation of how the information identified in subds. 1. and 2. relate to the patient's presenting problem
  4. Documentation about the current mental and physical health status of the patient
- Yes  No (d) *Preliminary service plan*  
A preliminary service plan has been developed, based upon the initial assessment.
- Yes  No (e) *Explanation of initial assessment and service plan*  
The initial assessment and preliminary service plan are clearly explained to the patient and, when appropriate, to the patient's family member during the intake process.
- Yes  No (f) *Information and referral relating to communicable diseases*  
The service provides patients with information concerning communicable diseases, such as sexually transmitted diseases (STDs), hepatitis B, tuberculosis (TB), and human immunodeficiency virus (HIV), and refers patients with communicable diseases for treatment when appropriated.
- Yes  No (g) *Court-ordered admission*  
Admission of a person under court order is in accordance with ss. 51.15 and 51.45, Wis. Stats.

**Chapter DHS 75.03(12) Assessment**

- Yes  No (a) The staff of this service assess each patient through screening interviews, data obtained during intake, counselor observation, and talking with people who know the patient, which includes all of the following:
- Yes  No 1. The substance abuse counselor's evaluation of the patient and documentation of psychological, social and physiological signs and symptoms of substance abuse and dependence, mental health disorders, and trauma, based on criteria in DSM-IV.

- Yes  No 2. The summarized results of all psychometric, cognitive, vocational, and physical examinations taken for, or as a result of, the patient's enrollment into treatment.
- Yes  No (b) The counselor's recommendations for treatment are included in a written case history that includes a summary of the assessment information leading to the conclusions and outcomes determined from the counselor's evaluation of the patient's problems and needs.
- Yes  No (c) If the counselor identifies symptoms of a mental health disorder and trauma in the assessment process, this service will refer the individual for a mental health assessment conducted by a mental health professional.
- Yes  No (d) If the counselor identifies symptoms of a physical health problem in the assessment process, this service will refer the individual for a physical health assessment conducted by medical personnel
- Yes  No (e) Initial assessment is conducted for treatment planning. This service implements an ongoing process of assessment to ensure that a patient's treatment plan is modified if the need arises as determined through a staffing at least every 30 days.

#### Chapter DHS 75.03(13) Treatment Plan

- Yes  No (a) *Basis and signatures*
- This service develops a treatment plan for each patient, which is based on the assessment under sub.(12) and a discussion with the patient to ensure that the plan is tailored to the individual patient's needs.
- Yes  No The treatment plan is developed in collaboration with other professional staff, the patient and, when feasible, the patient's family or another person who is important to the patient and addresses culture, gender disability, if any, and age-responsive treatment needs related to the substance use disorders, mental disorders, and trauma.
- Yes  No The treatment plan is reviewed and signed, first, by the clinical supervisor and the counselor and secondly reviewed and signed by the patient and consulting physician.
- Yes  No (b) *Content*
1. The treatment plan describes the patient's individualized or distinct problems and specifies short and long-term individualized treatment goals that are expressed in behavioral and measurable terms and are explained as necessary in a manner that is understandable to the patient.
  2. The goals are expressed as realistic expected outcomes.
  3. The treatment plan specifies the treatment, rehabilitation, and other therapeutic interventions and services to reach the patient's treatment goals.
  4. The treatment plan describes the criteria for discharge from services.
  5. The treatment plan provides specific goals for treatment of dual diagnosis for those who are not identified as being dually diagnosed, with input from a mental health professional.
  6. Tasks performed in meeting the goals are reflected in progress notes and in the staffing reports.
- Yes  No (c) *Contract*
1. This service acknowledges that a patient's treatment plan constitutes a treatment contract between the patient and the service.
- Yes  No (d) *Review*
1. A patient's treatment plan is reviewed at regular intervals as identified in sub.(14) and modified as appropriate with date and results documented in the patient's case record through staffing reports.

#### Chapter DHS 75.03(14) Staffing

- Yes  No (a) Staffing is completed for each patient and is documented in the patient's case record as follows:
1. Staffing for patients in an outpatient treatment service who attend treatment sessions on day per week or less frequently is completed at least every 90 days.
  2. Staffing for patients who attend treatment sessions more frequently than one day per week is completed at least every 30 days.
- Yes  No (b) A staffing report includes information on treatment goals, strategies, objectives, amendments to the treatment plan, and the patient's progress or lack of progress, including applicable criteria from the approved placement criteria being used to recommend the appropriate level of care for the patient.
- Yes  No (c) The counselor and clinical supervisor reviews the patient's progress and the current status of the treatment plan in regularly scheduled case conferences and discusses with the patient the patient's progress and status and makes an appropriate notation in the patient's progress notes.
- Yes  No (d) If the patient is dually diagnosed, the patient's treatment plans are reviewed by the counselor and a mental health professional and appropriate notation made in the patient's progress notes.

- Yes  No (e) A staffing report is signed by the primary counselor and the clinical supervisor and by a mental health professional, if the patient is dually diagnosed. The consulting physician also reviews and signs the staffing report.

#### Chapter DHS 75.03(15) Progress Notes

- Yes  No (a) This service enters progress notes into the patient's case record for each contact the service has with a patient or with a collateral source regarding the
- Yes  No (b) Notes are entered by the counselor and may be entered by the consulting physician, clinical supervisor, mental health professional, and other staff members to document the content of the contact with the patient or with a collateral source for the patient.
- Note:** In this paragraph, "collateral source" means a source from which information may be obtained regarding a patient, which may include a family member, clinical records, a friend, a co-worker, a child welfare worker, a probation and parole agent, or a health care provider.
- Yes  No (c) Progress notes include, at a minimum, all of the following:
1. Chronological documentation of treatment that is directly related to the patient's treatment plan.
  2. Documentation of the patient's response to treatment.
- Yes  No (d) The person making the entry signs and dates progress notes that are continuous and unbroken. Blank lines or spaces between the narrative statement and the signature of the person making the entry are connected with a continuous line to avoid the possibility of additional narrative being inserted.
- Yes  No (e) Staff make efforts to obtain reports and other case records for a patient receiving concurrent services from an outside source. When obtained, they are made part of the patient's case record.

#### Chapter DHS 75.03(16) Transfer

- Yes  No (a) If this service transfers a patient to another provider or if a change is made in the patient's level of care, documentation of the transfer or change in the level of care is made in the patient's case record.
- Yes  No The transfer documentation includes the date the transfer is recommended and initiated, the level of care from which the patient is being transferred, and the applicable criteria from approved placement criteria that are being used to recommend the appropriate level of care to which the patient is being transferred.
- Yes  No (b) This service forwards a copy of the transfer documentation to the service to which the patient has been transferred within one week after the transfer date.

#### Chapter DHS 75.03(17) Discharge or Termination

- Yes  No (a) This service makes a patient's discharge date the date the patient no longer meets criteria for any level of care in the substance abuse treatment service system and is excluded from each of these levels of care, as determined by approved placement criteria.
- Yes  No (b) A discharge summary is entered in the patient's case record within one week after the discharge date.
- Yes  No (c) The discharge summary includes all of the following:
1. Recommendations regarding care after discharge.
  2. A description of the reasons for discharge.
  3. The patient's treatment status and condition at discharge
  4. A final evaluation of the patient's progress toward the goals set forth in the treatment plan
  5. The signature of the patient, the counselor, the clinical supervisor and, if the patient is dually diagnosed, the mental health professional, with the signature of the consulting physician included within 30 days after the discharge date.
- Yes  No (d) The patient is informed of the circumstances under which return to treatment services may be needed.
- Yes  No (e) Treatment terminated before its completion is also documented in a discharge summary.

Treatment termination occurs only if the patient requests in writing that treatment be terminated or if the service terminates treatment upon determining and documenting that the patient cannot be located, refuses further services, or is deceased.

#### Chapter DHS 75.03(18) Referral

- Yes  No (a) This service has written policies and procedures for referring patients to other community service providers.

- Yes  No (b) The service director approves all relationships of the service with outside resources.
- Yes  No (c) Any written agreement with an outside resource specifies all of the following:
1. The services the outside resource will provide
  2. The unit costs for the services, if applicable
  3. The duration of the agreement
  4. The maximum extent of services available during the period of the agreement
  5. The procedure to be followed in making referrals to the outside resource
  6. The reports that can be expected from the outside resource and how and to whom this information is to be communicated
  7. The agreement of the outside resource to comply with this chapter
  8. The degree to which the service and the outside resource will share responsibility for the patient's care
- Yes  No (d) There is documentation that the service director has annually reviewed and approved the referral policies and procedures.

#### Chapter DHS 75.03(19) Follow-up

- Yes  No (a) All follow-up activities undertaken by this service for a current patient or for a patient after discharge is done with written consent.
- Yes  No (b) When this service refers a patient to an outside resource for additional, ancillary, or follow-up services, it determines the disposition of the referral within one week from the day the referral is initiated.
- Yes  No (c) When this service refers a patient to an outside resource for additional or ancillary services while still retaining treatment responsibility, it requests information on a regular basis as to the status and progress of the patient.
- Yes  No (d) The date, method, and results of follow-up attempts are entered in the former patient's or current patient's case record and is signed and dated by the individual making the entry. If follow-up information cannot be obtained, the reason is entered in the former patient's or current patient's case.
- Yes  No (e) This service follows up on a patient transfer through contact with the service the patient is being transferred to within five days following initiation of the transfer and every ten days after that until the patient is either engaged in the service or has been identified as refusing to participate.

#### Chapter DHS 75.03(20) Service Evaluation

- Yes  No (a) This service has an evaluation plan, which includes all of the following:
1. A written statement of the service's goals, objectives, and measurable expected outcomes that relate directly to the service's patients or target population.
  2. Measurable criteria and a statistical sampling protocol which are to be applied in determining whether or not established goals, objectives, and desired patient outcomes are being achieved
  3. A process for measuring and gathering data on progress and outcomes achieved with respect to individual treatment goals on a representative sample of the population served, and evaluations of some or all of the following patient outcome areas, but including at least those in subd. 3.1., b., c., and f.:
    - a. Living situation
    - b. Substance use
    - c. Employment, school, or work activity
    - d. Interpersonal relationships
    - e. Treatment recidivism
    - f. Criminal justice system involvement
    - g. Support group involvement
    - h. Patient satisfaction
    - i. Retention in treatment
    - j. Self-esteem
    - k. Psychological functioning
  4. Methods for evaluating and measuring the effectiveness of services and using the information for service improvement.
- Yes  No (b) This service has a process in place for determining the effective utilization of staff and resources toward the attainment of patient treatment outcomes and the service's goals and objectives.

- Yes  No (c) This service has a system for regular review of the appropriateness of the components of the treatment service and other factors that may contribute to the effective use of the service's resources.
- Yes  No (d) This service obtains a completed patient satisfaction survey from a representative sample of all patients at or following their discharge from this service. This service keeps all satisfaction surveys on file for two years and makes them available for review by authorized representatives of the department upon request.
- Yes  No (e) This service collects data on patient outcomes at patient discharge and may collect data on patient outcomes after discharge.
- Yes  No (f) The service director completes an annual report on this service's progress in meeting goals, objectives, and patient outcomes, and keeps the report on file and makes it available for review to an authorized representative of the department upon request.
- Yes  No (g) The governing authority or legal owner of this service and the service director review all evaluation reports and make changes in service operations, as appropriate.
- Yes  No (h) This service acknowledges that, if this service holds current accreditation from a recognized accreditation organization such as the Joint Commission on Accreditation of Health Organizations, the Commission on Accreditation of Rehabilitation Facilities, or the National Committee for Quality Assurance, the requirements under this section may be waived by the department.

**Chapter DHS 75.03(21) Communicable Disease Screening**

- Yes  No Service staff discuss risk factors for communicable diseases with each patient upon admission and at least annually while the patient continues in the service and includes in the discussion the patient's prior behaviors that could lead to sexually transmitted diseases (STDs), human immunodeficiency virus (HIV), hepatitis B and C or tuberculosis (TB).

**Chapter DHS 75.03(22) Unlawful Alcohol or Psychoactive Substance Use**

- Yes  No This service prohibits unlawful, illicit, or unauthorized use of alcohol or psychoactive substances at this service location.

**Chapter DHS 75.03(23) Emergency Shelter and Care**

- Yes  No If this service provides 24-hour residential care, it has a written plan for the provision of shelter and care for patients in the event of an emergency that would render the facility unsuitable for habitation.

**Chapter DHS 75.03(24) Reporting Deaths Due to Suicide or the Effects of Psychotropic Medicine**

- Yes  No This service has adopted written policies and procedures for reporting deaths of patients due to suicide or the effects of psychotropic medicines, as required by s. 51.64(2), Wis. Stats. A report shall be made on a form furnished by the department.

**Note:** DQA form **F-62470, *Client / Patient Death Determination***, used for reporting deaths under this subsection, may be obtained from any DQA regional office or from the department website at: <http://www.dhs.wisconsin.gov/forms/DQAnum.asp>

