

State of Wisconsin
Department of Health Services
Division of Mental Health & Substance Abuse Services
Bureau of Prevention, Treatment & Recovery

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Crisis Intervention – Emergency Mental Health Services

November 19, 2013

Overview

- Introduction to Crisis
- Program Certification under DHS-34 Subchapter 3
- Regional Crisis Grant Progress on Deliverables
- “Crisis” & “Medical Necessity” Defined
- Service Eligibility Requirements
- Walk Through Required vs. Optional Crisis Services
- Staff Qualification, Training, Scope of Practice, Supervision and Reimbursement
- Relationship to Managed Care & Outpatient Services
- Other Stuff: Travel Time, Jails/IMDs, etc.

Disclaimer

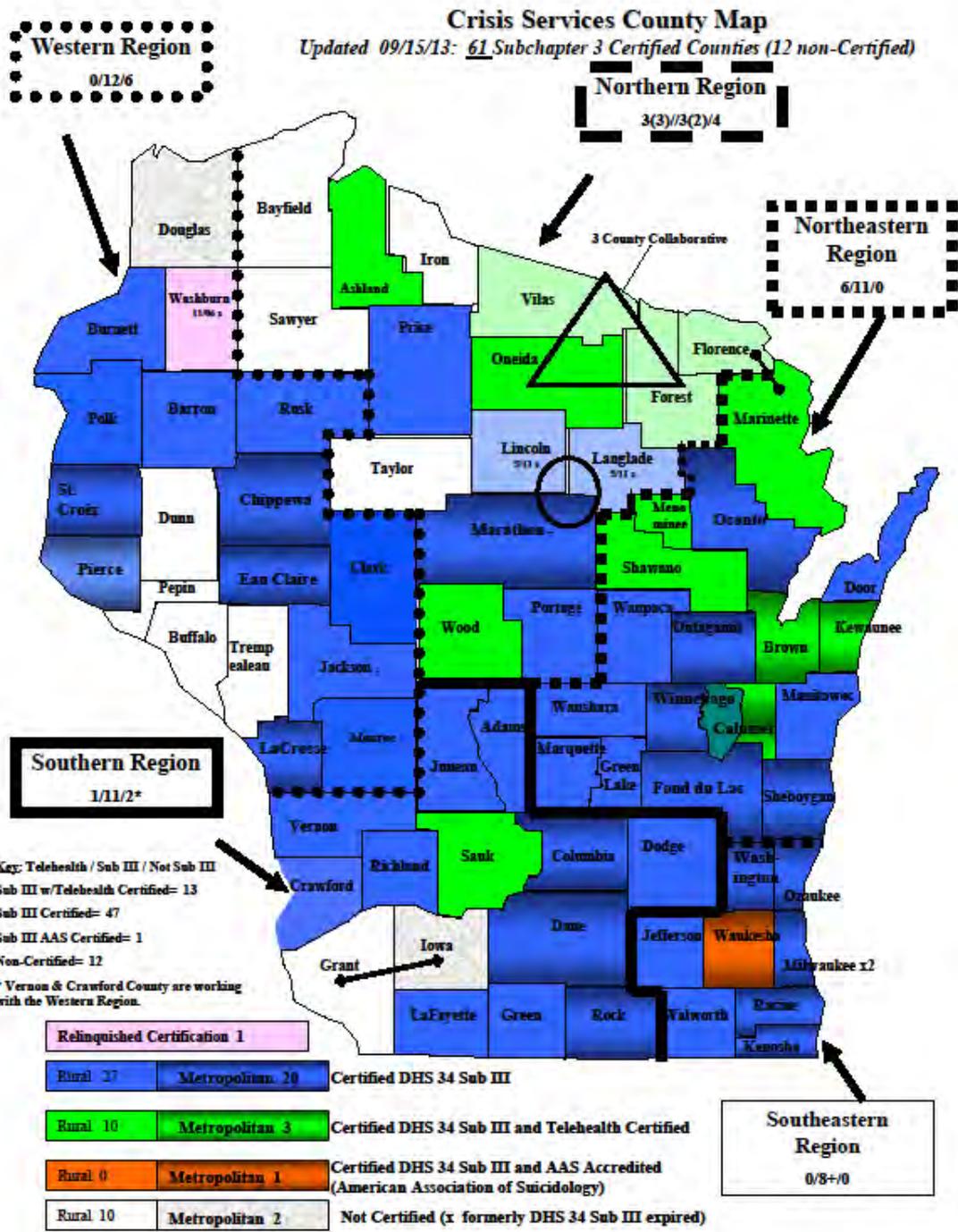
- ▶ Please be aware that regulations do change – both in administrative program rules as well as in Medicaid. Reimbursement rates also change; and there are other nuances of funding which are not covered herein. As such, this overview is designed to merely orient you to some of the highlights of current policy. It cannot encompass all details nor scenarios. Also it should be remembered that when it comes to Medicaid, the Online Handbook is the authoritative resource. Numbered informational memos are intended to guide and clarify but should *never* be regarded as trumping the Medicaid Handbook.

Introduction

- *Wisconsin's Emergency Mental Health Services Program* or "Crisis Intervention" is a State Medicaid Plan benefit which reimburses services and supports that are rehabilitative for a consumer. It is regulated under DHS 34.
- "*Emergency mental health services*" are a coordinated system of mental health services that provide an immediate response to assist a member experiencing a mental health crisis (DHS 34.02[8]).
- *Certification*. By Division of Quality Assurance (DQA)
- *County Holds Certification*. Completed Crisis Application is reviewed by DQA for approval – a county may operate or contract for Emergency Mental Health Service, but the certification is held by the county
- *Subchapter 3 Certification*. Required to derive Medicaid reimbursement.
- *Medicaid Certification*. A county certified by DQA and also must be certified by Medicaid.
- *Coordinated Emergency Mental Health Services Plan* must be in place.

61
 DHS-34,
 Subchapter 3
 Certified Crisis
 Counties in
 Wisconsin

 10+ Tele-Health
 1 AAS Certified



Regional Crisis Intervention Grants--Deliverables

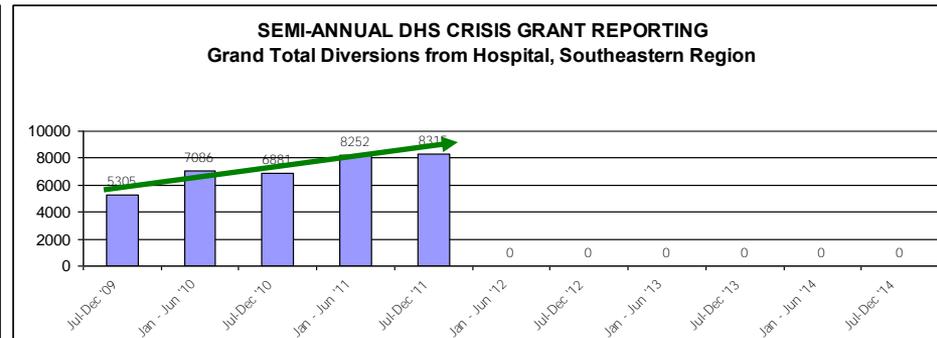
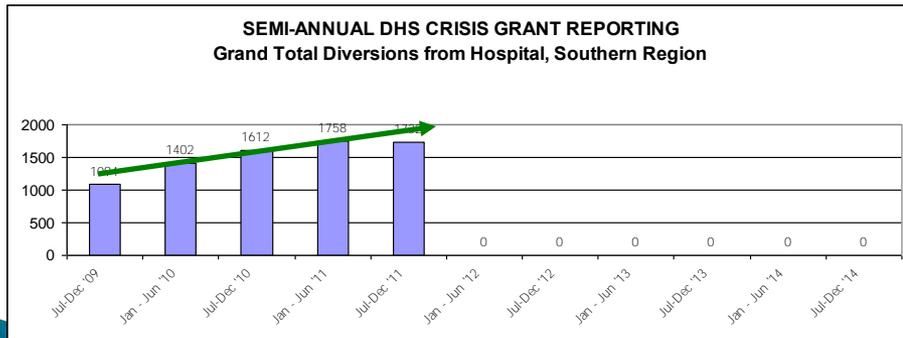
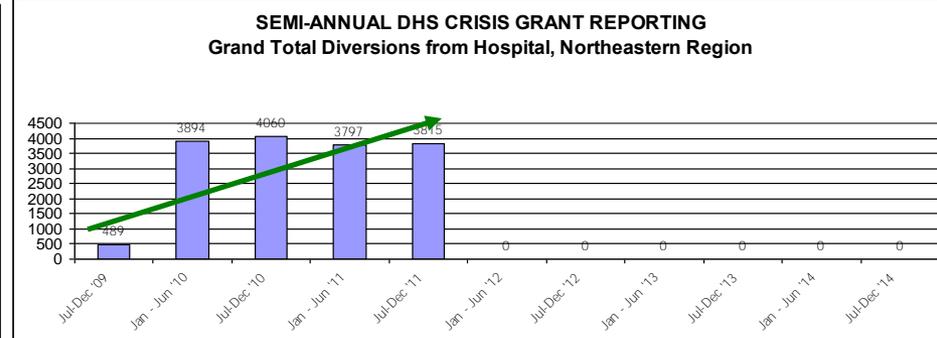
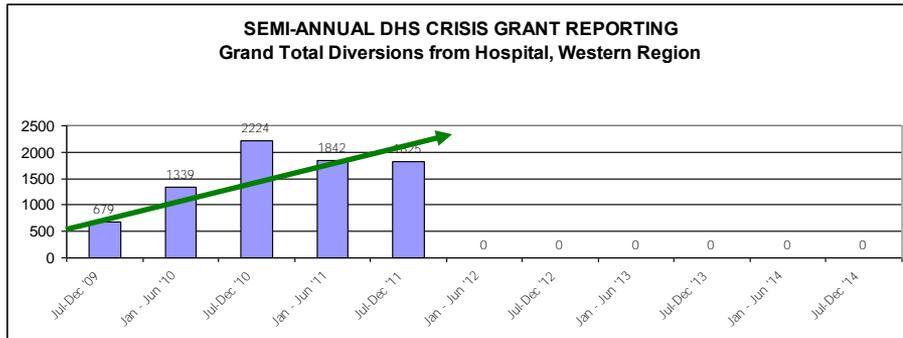
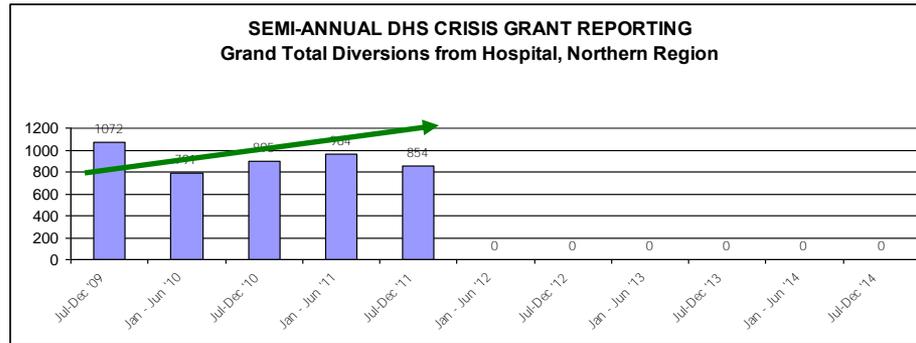
- ▶ Reduce hospitalizations & emergency detentions (EDs)
- ▶ Reduce hospital lengths of stay
- ▶ Develop & expand Subchapter 3 certified entities.
- ▶ Establish local coordinating committees to oversee collaborative community crisis program of all stakeholders.
- ▶ Develop interagency agreement that incorporates all aspects of Crisis Services (DHS-34.22)
- ▶ Establish regional coordinating committees to oversee grant activities.
- ▶ Focus on children & adults who are not part of the formal mental health system.
- ▶ Develop & use annual client satisfaction survey tool and/or procedure that is reported annually.
- ▶ Optional Outcomes:
 - Utilize telehealth where possible.
 - Provide for a regional coordinator.
 - Provide regional and site specific training and conferences.
 - Develop supportive/collaborative service links with CST and CCS.

Still...the discouraging finding, nationally...

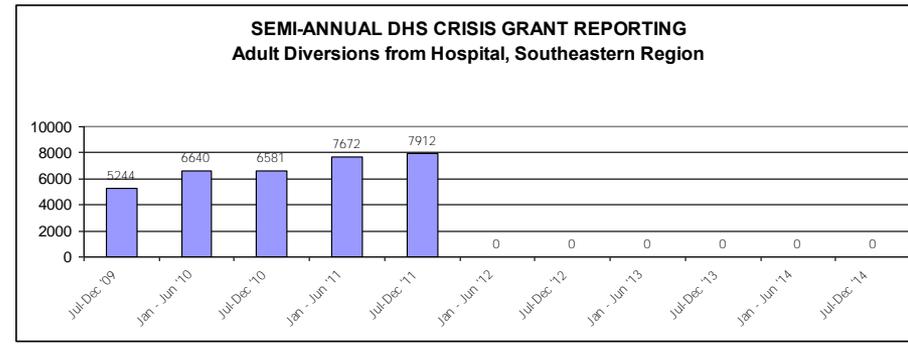
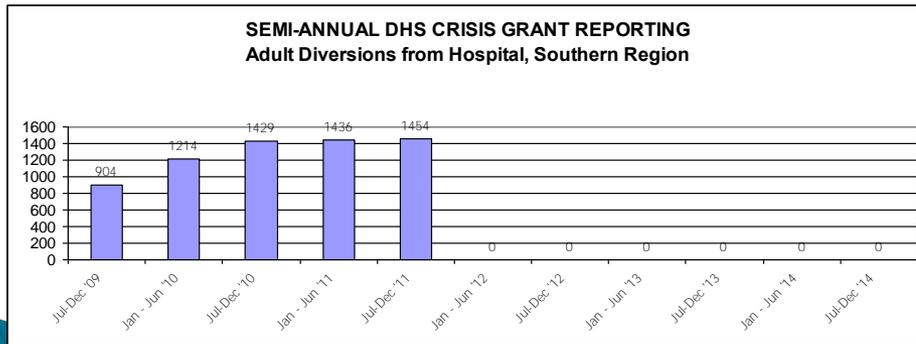
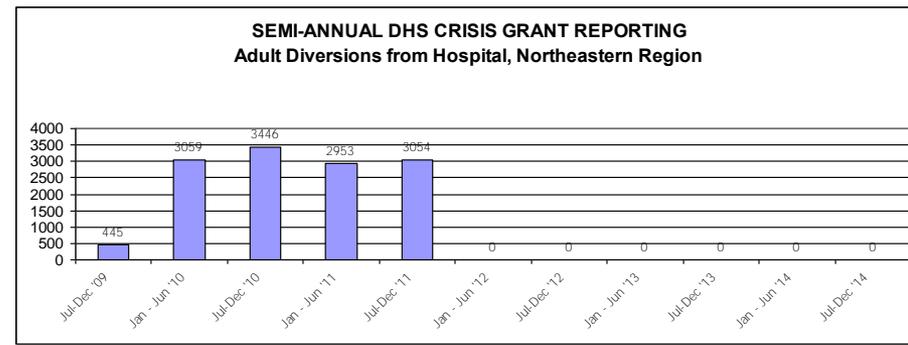
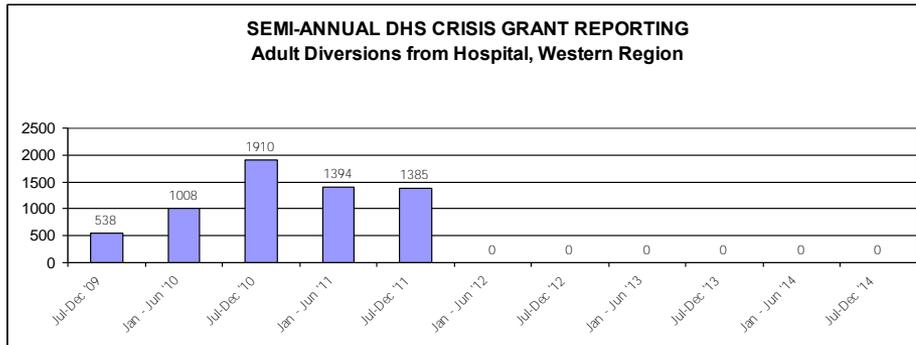
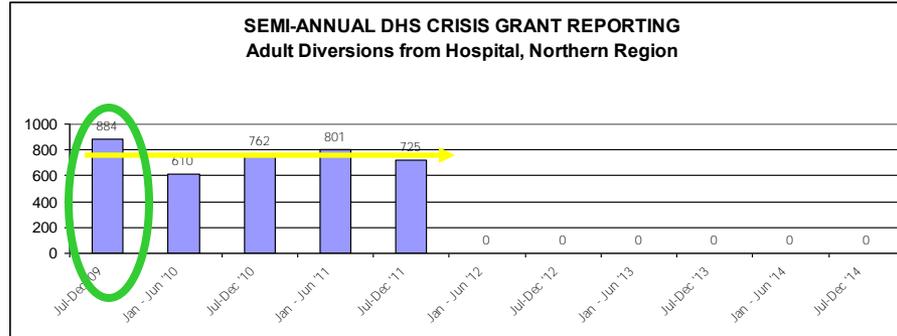
- ▶ **AAS Standard: Always Ask.** Accreditation standards with AAS maintain that *all* callers should be asked if they are considering suicide.
- ▶ **AAS Standard: Send Rescue.** Furthermore, "rescue should be sent when a caller has initiated a suicide attempt and his or her life appears to be in danger."
- ▶ **NOT Asking: Ideation.** Investigators found that "most helpers do not ask even the most basic question about suicidal ideations."
- ▶ **NOT Asking: Means & Availability.** Then, "when callers do indicate that they are considering suicide, the helpers usually do not proceed to ask about means." Even more startling is that, "when callers tell how they are planning suicide, helpers rarely ask if they have the means available or if they are in the process of an attempt" (p. 305).

These data are not a reflective of Wisconsin but are from a national study.
(Mishara *et al.* *SLBT*, 37[3], 291-307, 2007)

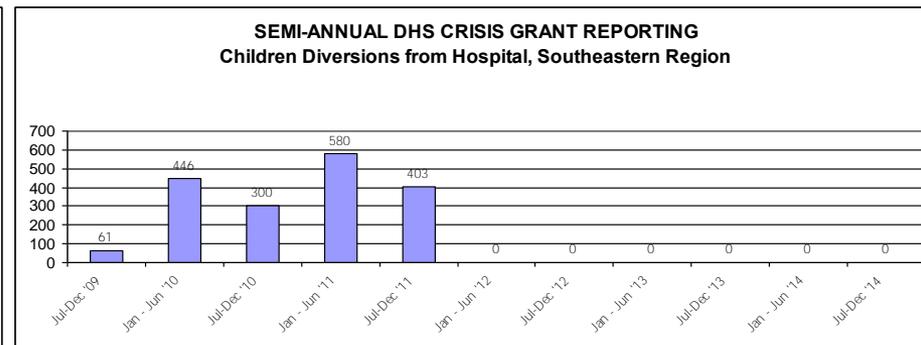
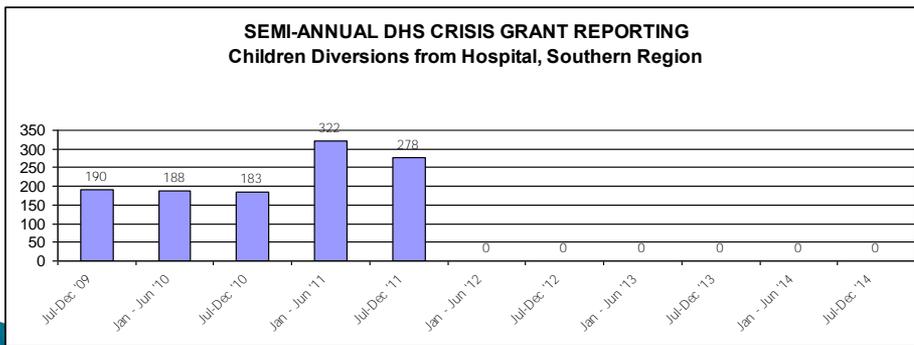
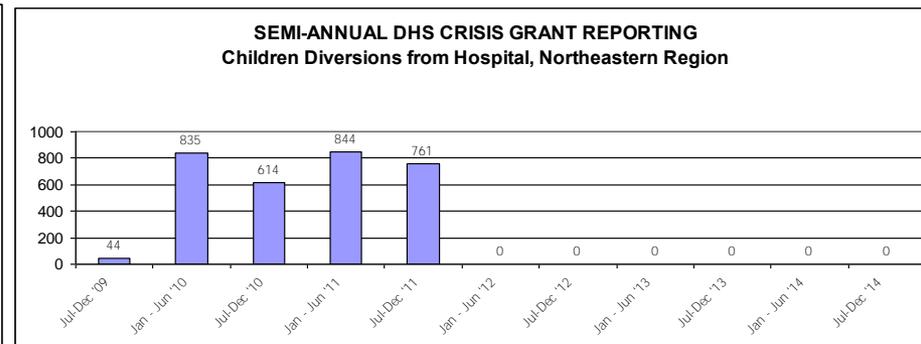
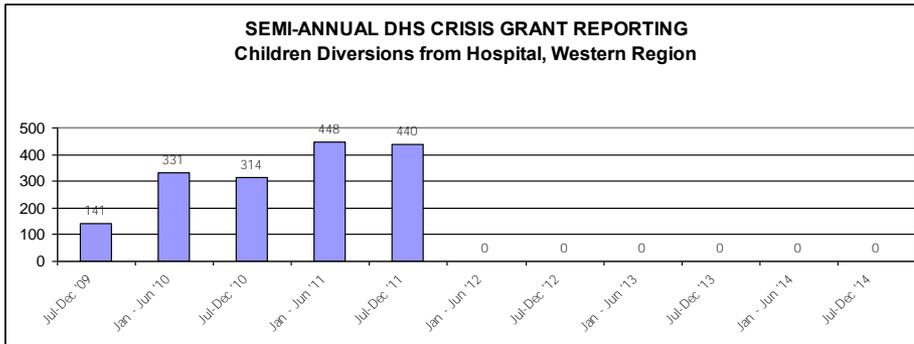
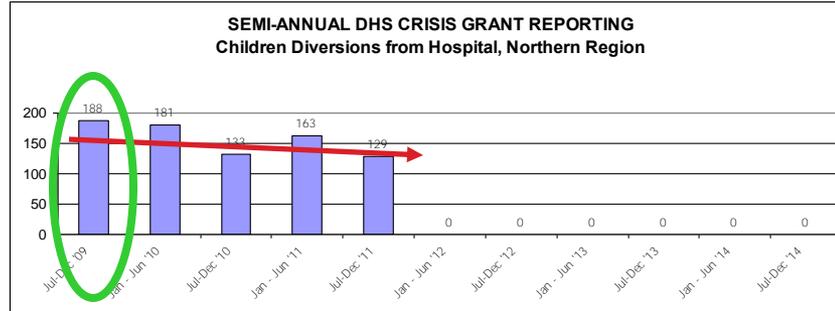
State Diversions Increasing



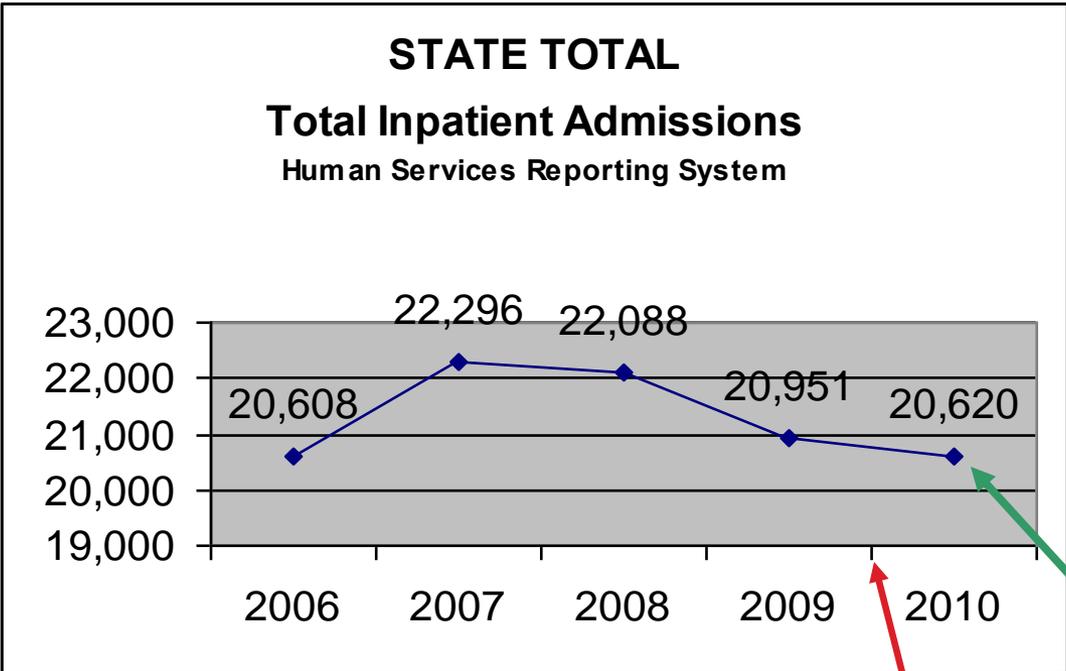
Regional Adult Diversions Increasing



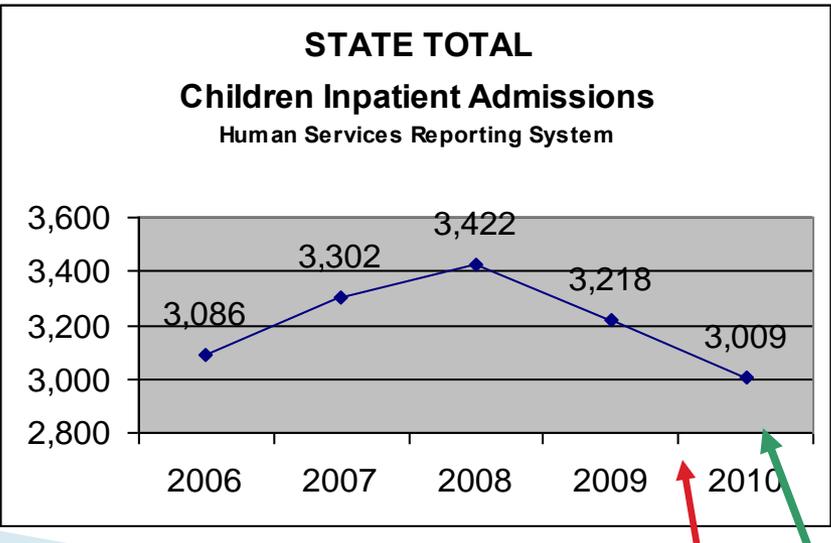
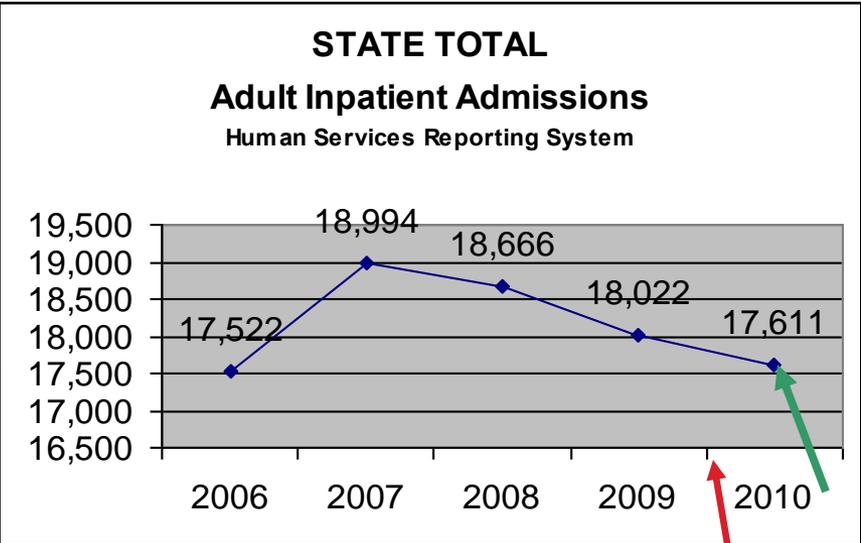
Regional Child Diversions Increasing



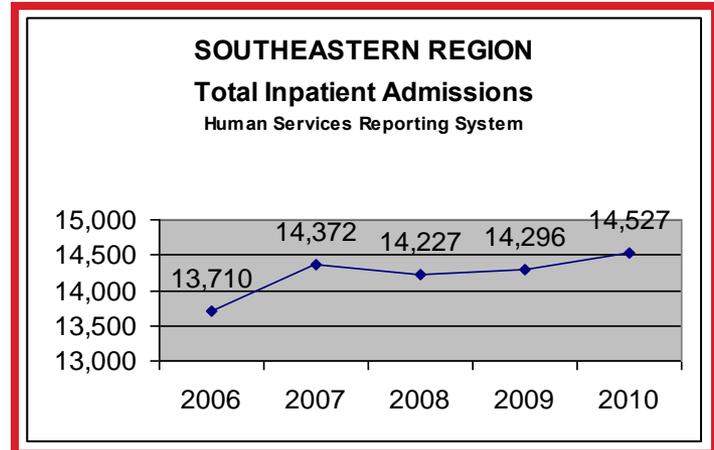
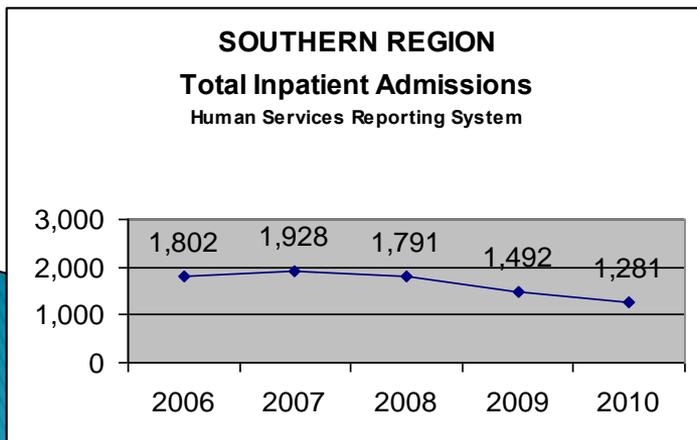
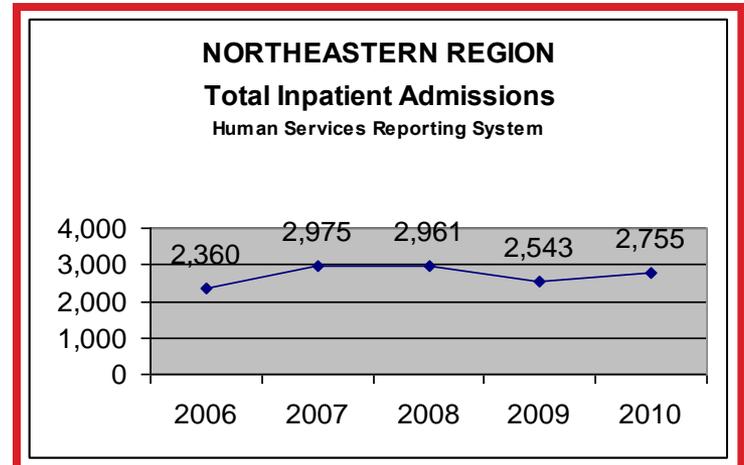
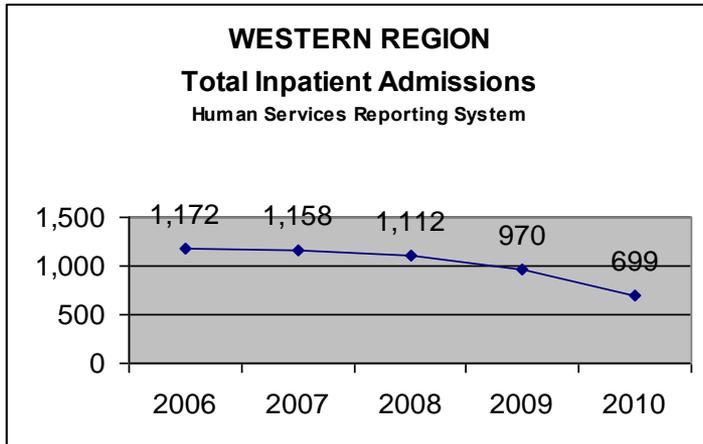
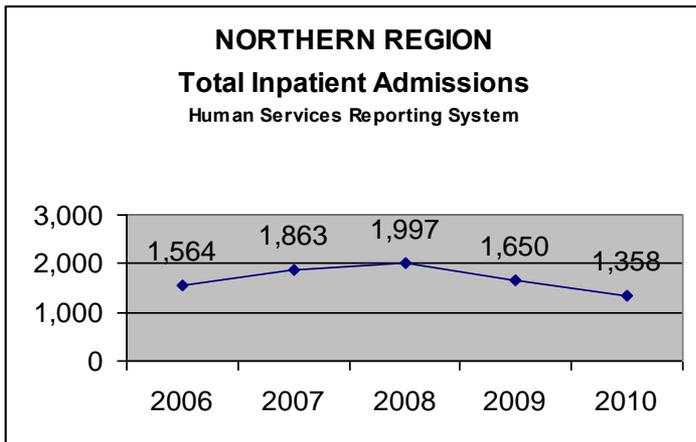
State Inpatient Admissions Declining



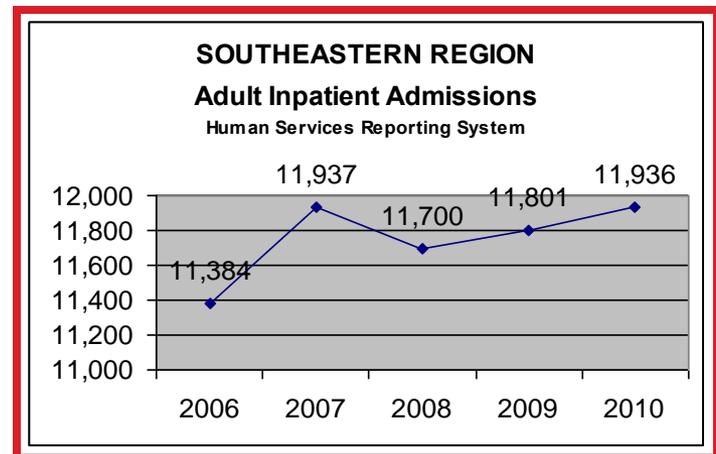
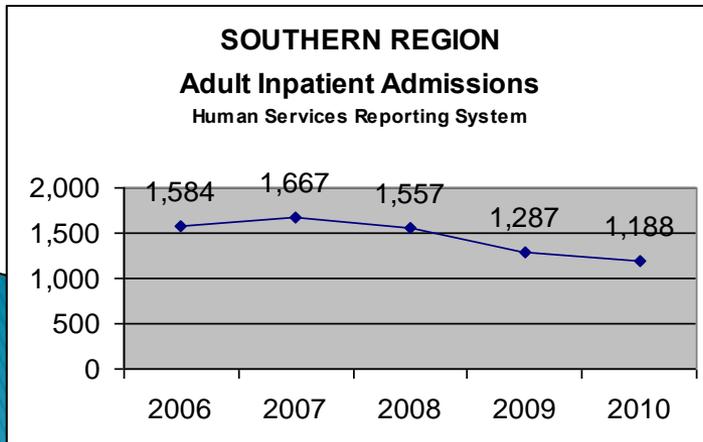
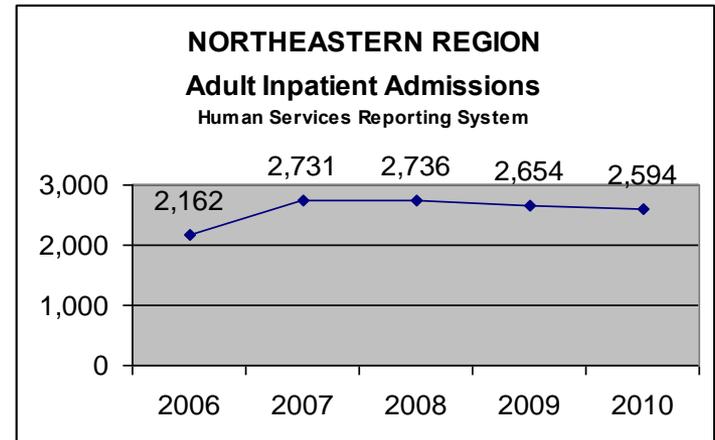
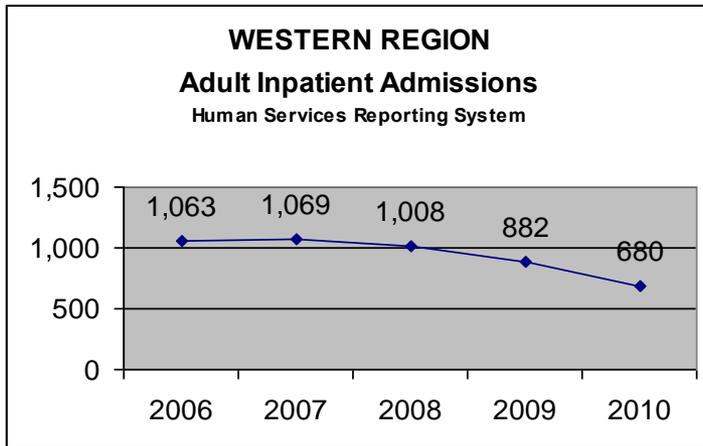
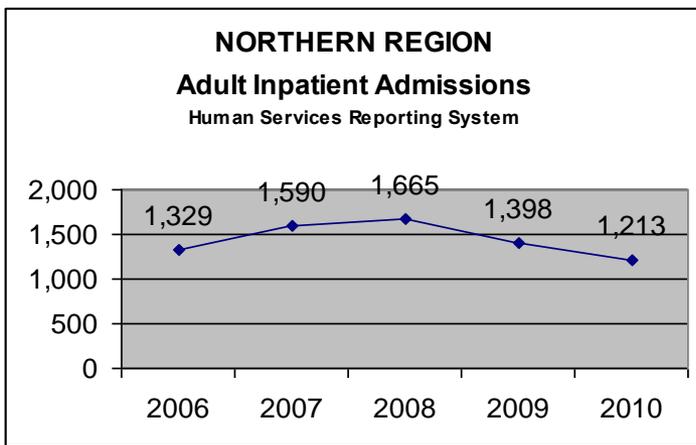
Counties pay non-federal MA for services for patients under 21 & over 64 years of age.



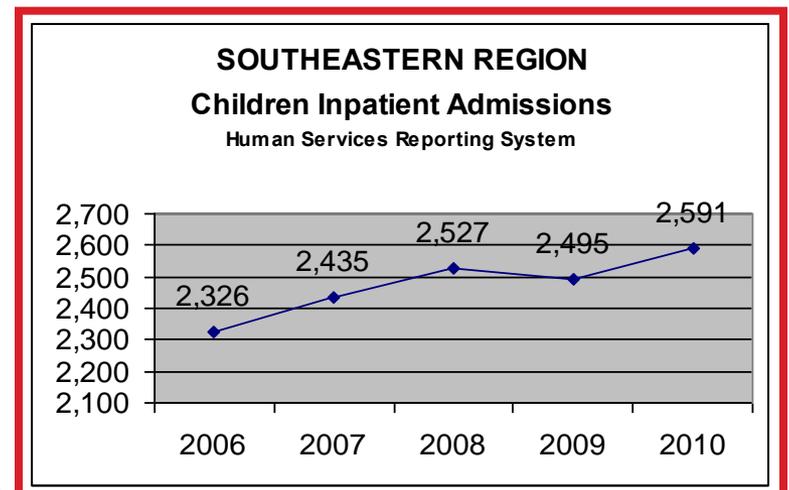
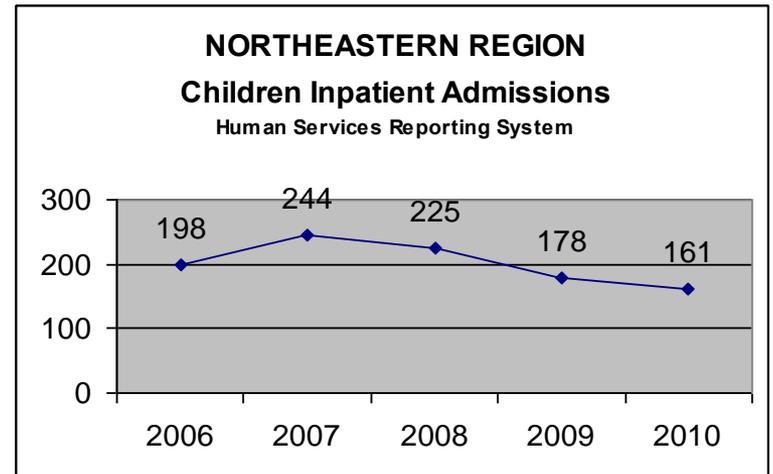
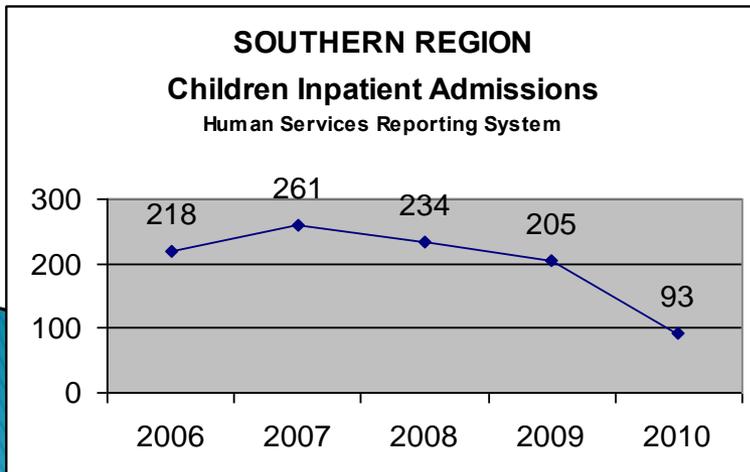
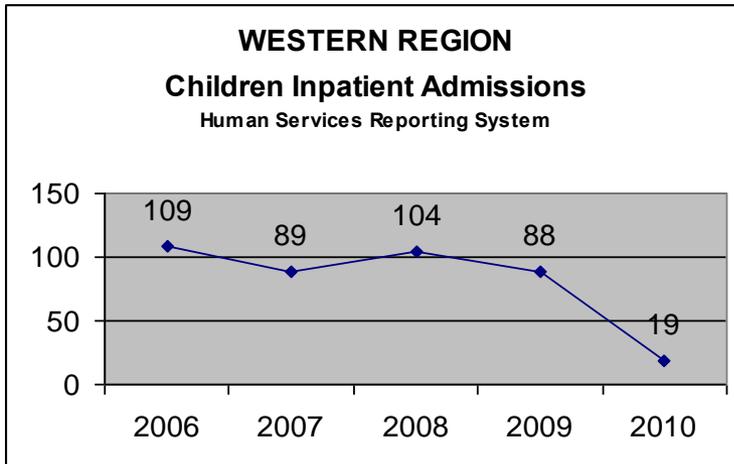
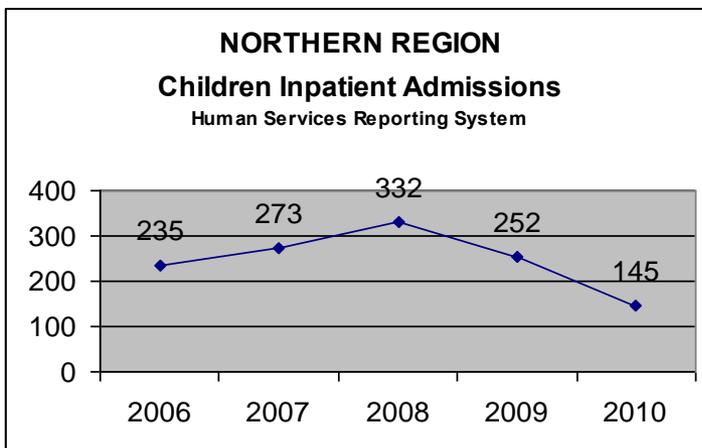
Total State Inpatient Admissions Declining: By Region



Adult State Inpatient Admissions Declining: By Region



Child State Inpatient Admissions Declining: By Region

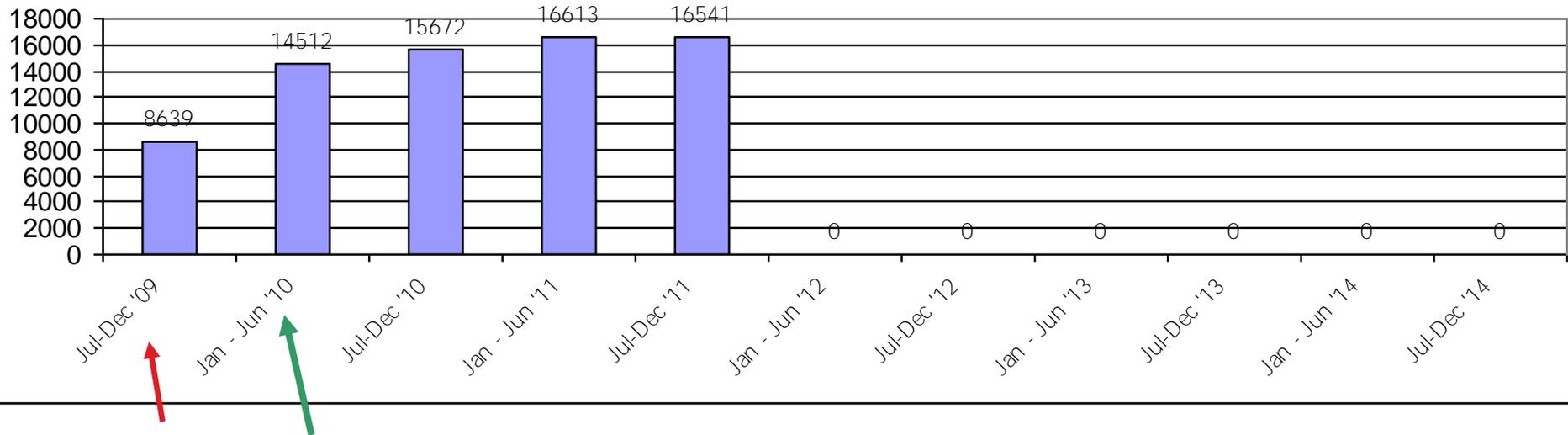


Regional Crisis Intervention Grants—Diversion Defined: With the Intervention of Crisis Worker the Person Does *Not* Go to Hospital Under Circumstances Below

- ▶ **Law enforcement** officer has identified that a person should go to a hospital behavioral health.
- ▶ **Person in crisis** or a family member expresses that the person needs to go to a hospital behavioral health unit.
- ▶ Person expresses **suicidal intention**.
- ▶ Person presents with **unstable behavior/emotions** and crisis worker believes the person would have gone to the hospital if they had not provided intervention. For example:
 - Off of medication and experiencing signs and symptoms of mental illness
 - Extreme anxiety
 - Extreme depression (withdrawn, agitated, possible danger to self/others)
 - Active psychosis (hallucinations, delusions)
 - Any other situation that the crisis worker deems to be threatening and/or unsafe

Hospital Diversions Trending Upward in State Totals

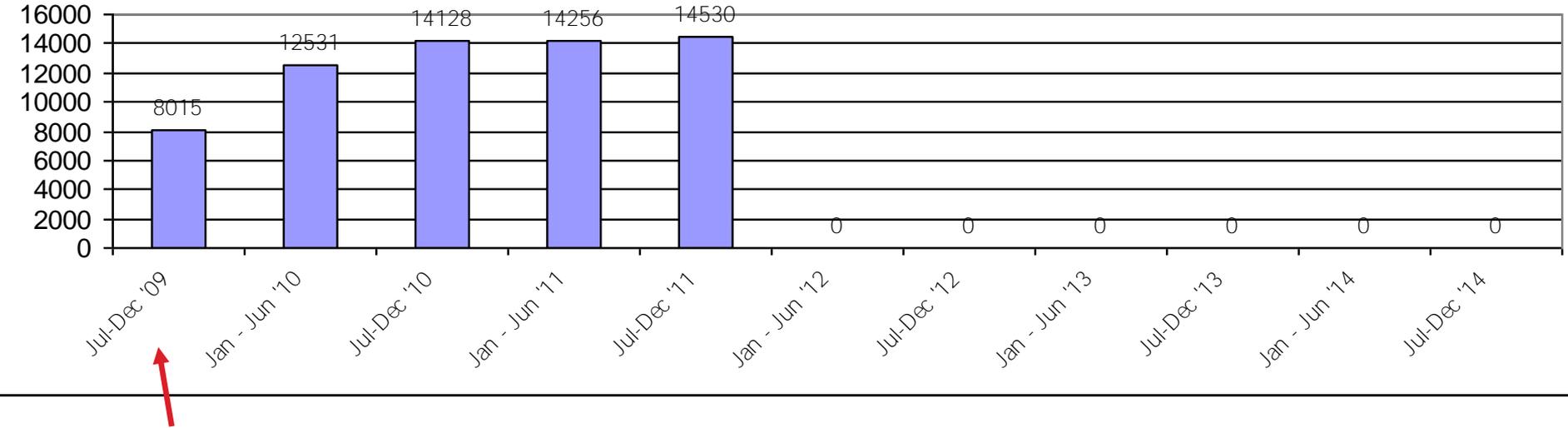
SEMI-ANNUAL DHS CRISIS GRANT REPORTING
Grand Total Diversions from Hospital, State Totals



Hospital Diversions

Trending Upward in State Totals for Adults

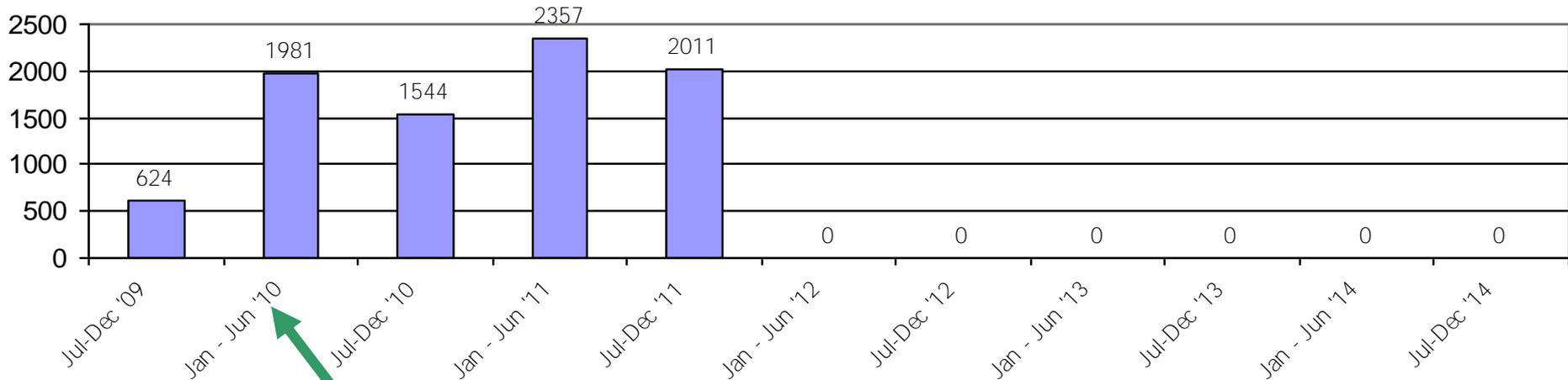
SEMI-ANNUAL DHS CRISIS GRANT REPORTING
Adult Diversions from Hospital, State Totals



Hospital Diversions

Increasing Trend in State Totals for Children

SEMI-ANNUAL DHS CRISIS GRANT REPORTING
Children Diversions from Hospital, State Totals



Effective January 1, 2010, s.49.45 (30r) requires county to provide the non-federal portion of the Medicaid payment for services for patients under 21 years of age (or who are under 22 years of age and who were receiving services immediately prior to reaching age 21) or who are 65 years of age or older. In April 2010, MMHI stopped serving children and adolescents.*

* http://www.dhs.wisconsin.gov/dsl_info/numberedmemos/DMHSAS/CY2011/nm2011-06.pdf

What is a Crisis?

- ▶ **Eligibility.** To receive emergency mental health services, a person shall *be in a mental health crisis* or be in a situation which is *likely to develop into a crisis* if supports are not provided.
- ▶ **Crisis.** A situation caused by a member's **apparent mental disorder** that results in a **high level of stress or anxiety** for the individual, persons providing care for the individual, or the public that cannot be resolved by the available coping methods of the individual or by the efforts of those providing ordinary care or support for the individual. (DHS 34.02[5])
- ▶ **Medical Necessity.** Wisconsin Medicaid reimburses only for services that are medically necessary (DHS 101.03[96]) – failure to meet this standard can lead to denial or recoupment of payment.

What's Medical Necessity?

- ▶ **Required to prevent, identify or treat illness, injury or disability; and**
 1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
 2. Consistent with standards of acceptable quality of care;
 3. Appropriate to accepted standards of medical practice;
 4. Is not medically contraindicated;
 5. Is of proven medical value or usefulness and, consistent with [DHS 107.035](#), is not experimental in nature;
 6. Is not duplicative with respect to other services being provided to the recipient;
 7. Is not solely for the convenience of the recipient, the recipient's family or a provider;

A Medical Assistance service under [ch. DHS 107](#).

Required Services

- 24-Hours Per Day And 7-Days Per Week:



- Telephone Services
- Short-Term Voluntary or Involuntary Hospital Care
- Linkage & Coordination

- 8-Hours Per Day:

- Mobil Crisis Services: 7 days week when most needed.

- Walk-In Services:

5 days a week excluding holidays.



- Services for Adolescents and Children and Their Families



Services to Adolescents & Children

All of the required components of a DHS-34 Crisis program must be **provided in ways that meet the unique needs of young children and adolescents experiencing mental health crises and their families and be provided by appropriately trained and supervised staff.*** Interventions are to be geared toward a reduction of family conflicts when a child has a mental health crisis and prevention of out-of-home placement of the child; improvement in the young child's or adolescent's coping skills and reduction in the risk of harm to self or others; and assistance to the child and family in obtaining and using ongoing mental health and other supportive services in the community.

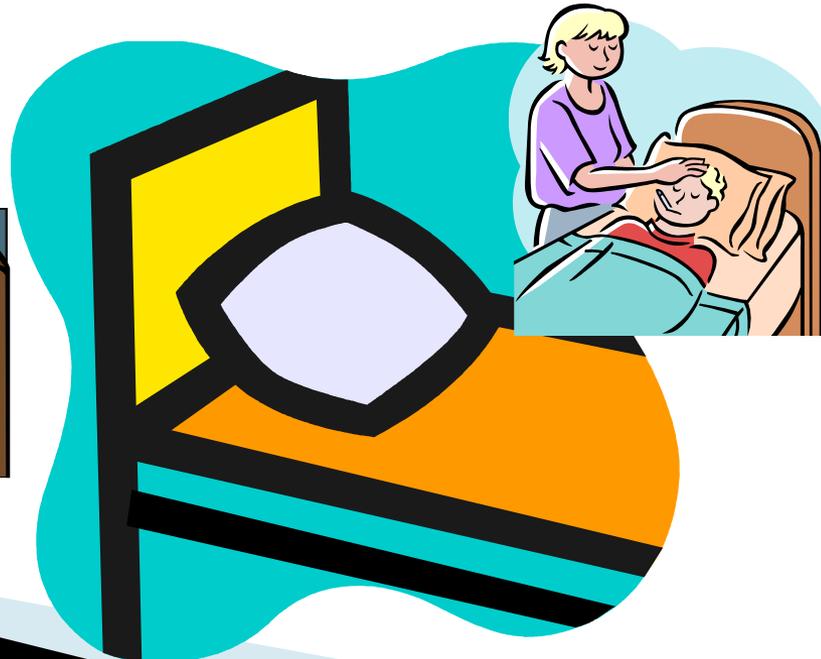
* Staff must have one year of experience providing mental health services to young children or adolescents or receive a minimum of 20 hours of training in providing the services within 3 months after being hired. They must be supervised by a staff person qualified under DHS 34.21 (3) (b) 1. to 8. who has had at least 2 years of experience in providing mental health services to children. A qualified staff person may provide supervision either in person or be available by phone.



Optional Services

Adults and Youth

Stabilization services are optional emergency mental health services under DHS 34.22(4) that provide short-term, intensive, community-based services to avoid the need for inpatient hospitalization.



Required Plan for Coordination of Services Describing

- Nature & extent of the emergency MH services in the county.
- County's overall system of care re persons with MH problems.
- Adaptation of services to meet strengths & needs of residents.
- Services offered with criteria & priorities for decision-making and how those services can be accessed.
- Specific responsibilities of other health providers in the county with respect to emergency MH services along with process for communication, confidentiality and info exchange.
- Agreements to receive or provide backup coverage for any other provider and role with respect to emergency protective placement (55.06[11]).
- Criteria for selecting and identifying clients presenting a high risk for a MH crisis and process for developing, maintaining and implementing Crisis Plans on their behalf.

Required Plan for Coordination of Services (Cont.)

- Must also describe agreements including MOUS with law enforcement, hospital EDs, state institutes (WMHI, MMHI), county corporation council which describe:
 - Role of program staff for persons needing hospitalization.
 - Role in screening to determine need for hospitalization.
 - Process for supporting person being discharged to the community from an inpatient stay.
- *If* the program provides emergency services in **conjunction with AODA, CPS, or other emergency services**, the plan shall describe how services are coordinated and delivered.
- Must be reviewed and adjusted in light of Department surveys, and comments/suggestions from staff, consumers, family members, other providers and interested community members.

Crisis Intervention Coordination With Chapter 51

Community mental health, developmental disabilities, alcoholism and drug abuse services, among other things, are responsible for “**continuous planning, development and evaluation** of programs and services for all population groups” {51.42(3)(ar)4.e} *and* “prepare a local plan which includes an **inventory** of all existing resources, identifies needed new resources and services and contains a plan for meeting the needs of the mentally ill...[including] the establishment of **long-range goals and intermediate-range plans**, detailing priorities and estimated costs and providing for coordination of local services and continuity of care.” “The plan shall state how the needs of **homeless** persons and adults with serious and persistent mental illness, children with serious emotional disturbances and minorities will be met....” {51.42(3)(ar)5.}

Coordination With Chapter 51

Liability of the County

The county board of supervisors has the primary responsibility for the well-being, treatment and care of the mentally ill, developmentally disabled, alcoholic and other drug dependent citizens residing within its county and for ensuring that those individuals in need of such emergency services found within its county receive emergency services.* This primary responsibility is limited to the programs, services and resources that the county board of supervisors is reasonably able to provide within the limits of available state and federal funds and of county funds required to be appropriated to match state funds. {51.42(1)4.(b)}

*County liability for “emergency services” includes those provided under statutes 55.05(4), 55.06(11)(a), 51.15, 51.45(11)(a) or (b) or (12), 55.13, or 55.135 for not more than 72 hours.

Service Locations & Revenues

- ▶ Types of Programs: County Operated vs. Contract
- ▶ Insurance must cover Crisis Services as transitional services (INS 3.37):

See: http://oci.wi.gov/bulletin/1102ins3_37.htm

- ▶ Place of Service: Providers are required to document the means and POS (place of service) in the client's record:



- Telephone.



- Mobil – In person at any location where a member is experiencing a crisis or receiving services to respond to a crisis

- Walk-in.



EBP, Best Practices & Other Connections

- National Registry of Evidence Based Practices & Programs-- NREBPP – <http://nrepp.samhsa.gov>
- Evidence-Based and Best practices on suicide prevention available at:
 - Suicide Prevention Resource Center (SPRC) www.sprc.org
 - American Association of Suicidology (AAS) www.suicidology.org
 - Risk Assessment Protocols
- Work with Wisconsin resources on suicide prevention: Prevent Suicide Wisconsin (PSW) at www.preventsuicidewi.org
- Check out HOPES: www.hopes-wi.org

Flow of Service Provision Through Crisis

- **Initial Contact and Assessment**
- **Response Plan**
- ***Optional* SBIRT**
- **Crisis Plan**
- **Hospitalization vs. *Optional* Stabilization Service**
 - **Adult**
 - **Youth**
- **Linkage and Follow-up**

Initial Contact & Assessment

- ▶ The initial contact and assessment (including referral to other services and resources, as necessary) **should be accomplished, even if further crisis intervention services are not required.** If the member is not in need of further crisis intervention services but could benefit from other types of assistance, staff should refer the member to other appropriate service providers in the community.
- ▶ Prior approval of licensed treatment professional is not required for an Initial Contact, Assessment, and development of a Response Plan; however, the **response plan must be approved and signed after its development.**

Telephone Services Interpretive Memo

- ▶ **Stressed Callers.** People who call a crisis line are under stress so assistance needs to be offered in the least complex way. Therefore, without exception, when someone calls a crisis line a person should answer the phone, not a recording.
- ▶ **Free of Phone Navigation.** Callers should not have to know extension numbers or names of crisis service providers.
- ▶ **Trained and Supervised.** Crisis phone responder is expected to have training and/or experience in crisis counseling and in assessment and triaging of mental health emergencies, including risk for suicide. He/she must be prepared to respond to the full range of potential needs presented by the caller, from referral and linkage to immediate, emergency, on-site response.
- ▶ **Immediate Back-up Available.** Crisis phone responders must have the capacity to immediately arrange for clinical backup and other needed emergency services, i.e., law enforcement, ambulance, and face-to-face mobile outreach.
- ▶ **Live Contacts.** A good crisis program is built upon a system of live contacts, minimizing the need to use pagers, callbacks and/or requiring the caller to place another call.
- ▶ **Prompt & Adequate Treatment.** Under Wisconsin Administrative Code HFS 94.08 and in accordance with state statutes 51.61(1)(f), people have the right to expect prompt and adequate treatment.

• http://www.dhs.wisconsin.gov/dsl_info/NumberedMemos/DSL/CY_2001/NMemo2001-03.htm

Response Plan

- ▶ **A response plan is required** if it is determined after the initial contact that the member is in need of emergency mental health services. It is plan of action developed by the program staff consisting of services and referrals necessary to reduce or eliminate the person's immediate distress, de-escalate the present crisis, and help the person return to a safe and more stable level of functioning.
- ▶ It must be reviewed and signed by supervisor within 14 days and then at least monthly.*

* See: <https://www.forwardhealth.wi.gov/kw/pdf/2006-55.pdf>

SBIRT (Optional)

Screening, Brief Intervention, Referral to Treatment

- ▶ **SBIRT is an evidence-based and cost-saving approach** which addresses risky alcohol use and illicit drug use.
- ▶ **Training Required.** Licensed health care professionals must complete the DHS (Department of Health Services)-approved training to directly deliver the screening and intervention services.
 - **Licensed Professionals** Complete **4 hours** in person or via the internet. DHS may exempt licensed professionals with expertise in the field of substance abuse screening and motivational enhancement or motivational interviewing on a case by case basis.
 - **Unlicensed Individuals.** Successfully complete at least **60 hours** of training (at least 30 hours in-person) related to SBIRT (other than tobacco). Includes the DHS-approved training to deliver SBIRT.
- ▶ **Quality Assurance.** Follow protocols for evidence-based practice during the delivery of screening and intervention services. Provide the screening and intervention services under the supervision of a licensed health care professional.
- ▶ **Reimbursement** per 15 minute (quarter-hour) unit of services with no match requirement:
 - **\$14.70** Trained Licensed or Unlicensed staff.
 - **\$20.23** Trained Advanced Nurse Prescribers with a psychiatric specialty.

Crisis Plan—for 6 Months

- ▶ Reimbursement if the crisis plan has been reviewed, updated, and signed by a licensed treatment professional **within the past six months** and at least once every six months thereafter, even if the changes are made more often.
- ▶ Crisis Plans are prepared for a consumer at high risk of experiencing a mental health crisis so that, if a crisis occurs, staff responding to the situation will have the information and resources needed to meet the member's individual service needs. It is developed or revised to better meet the member's needs based on what has been learned during the mental health crisis. A crisis plan must meet the following requirements:
 - Assessed to be at *high risk for a recurrent mental health crisis* under the criteria established in the coordinated community services plan.
 - **Developed in cooperation with the consumer**, parents or guardians where their consent is required for treatment, the case manager (if any) and the people and agencies providing treatment and support for the individual, and the plan shall identify to the extent possible the services most likely to be effective in helping the consumer resolve or manage a crisis, given the consumer's unique strengths and needs and the supports available to him or her.

Optional Stabilization Services

- ▶ **Purpose:** Stabilization services for a temporary transition period with **weekly reviews** to determine the need for continued stabilization services only when necessary to:
 - Reduce or eliminate symptoms of mental illness so that the consumer does not need inpatient hospitalization.
 - Assist in the transition to a less restrictive placement or living arrangement when the crisis has passed.
- ▶ **Settings:** Response or Crisis plan identifies crisis stabilization and support services in the following settings: Consumer's own home, Outpatient clinic, School, Crisis hostel, Adult family home, CBRF, Foster or group home, Other community nonresidential settings. Other settings are not allowable (including nursing facilities, hospitals, etc.)
- ▶ **Reimbursement** of *residential staff* either hourly or per day (per diem). Providers may choose to bill hourly or per day, **but not both**, for all members. Room & Board Costs are *not* covered.

Requirements for Crisis Stabilization

- ▶ **Weekly Documentation** (at minimum) of the factors that support a consumer continuing to receive crisis stabilization services in order to bill to Medicaid. Factors that support continued crisis stabilization include all of the following:
 - Continued risk of self-harm.
 - Continued risk of harm to others.
 - Impaired functioning due to sx of a mood &/or thought disorder.
 - Recent failure of less restrictive options.
 - Lack of available/effective supports (including family) to maintain functioning and safety (e.g., "If supports are withdrawn, the person would be at high risk for relapse, which would lead to a more restrictive placement").
 - Need for intensive monitoring of sx &/or response to recent med change.
 - Recent history of the above that supports the belief that if supports are withdrawn, the risk for a more restrictive setting would be imminent.

Out-of-Home Optional Crisis Stabilization for Youth

- ▶ A residential stabilization policy youth has been developed for Use of Out-of-Home Care for Mental Health Crisis Stabilization.
- ▶ Numbered Memo describing this option:
http://www.dhs.wisconsin.gov/dsl_info/InfoMemos/DMHSAS/CY2011/imemo2011-01.pdf

Linkage & Follow-up Services

- ▶ Reviewing & updating plans or developing a crisis plan.
- ▶ Follow-up interventions as prescribed in a response or crisis plan:
 - Relieve immediate distress in a crisis or pre-crisis.
 - Reduce the risk of a worsening crisis.
 - Reduce the level of risk of physical harm to self or others.
 - Resolve or manage family crises to prevent out-of-home placements of children, improve the child's and family's coping skills, and assist the family in using or obtaining ongoing mental health and other supportive services.
 - Assist in making the transition least restrictive LOC (level of care).
- ▶ Follow-up interventions can include, but are not limited to, the following:
 - Providing evaluations, referral options, and other information to a consumer or involved others.
 - Coordinating resources needed to respond to the situation (e.g., contact and coordination with MH/SA providers, conferring with family members or others providing support)
 - Assisting in the consumers transition to the least restrictive level of care required.
 - Following up to ensure intervention plans are carried out and meeting needs.
 - Providing follow-up contacts until the member has begun to receive assistance from an ongoing service provider, unless the member does not consent to further services if ongoing support is needed.

Importance of Follow-Up

- Data to show that minimal long-term contact (4x/year) with people at risk for SU can actually *lower* SU risk – esp. in the first two years.
- NIATx:

Plan Approvals & Signatures

- ▶ **Time Frames.** Under a variance described in DMHSAS-DQA Numbered Memo 2009-08, a licensed treatment professional must approve the Initial Response Plan within **14 working days** after services are first delivered. After the Initial Response Plan has been approved, signed, and implemented, the licensed treatment professional must review and sign the response plan **at least monthly**, even if changes are made more often.
- ▶ **Licensed Treatment Professionals** (under 1-7) are permitted to approve and sign Response and Crisis Plans.
- ▶ **Previously** only licensed professionals (under 1-2) were allowed to approve plans and the time frame for response plan approval was five days.

Supervising Providers, Allowable Services, & Reimbursement

Service Categories Provider Type (Blue=Supervisor—Dark Blue Can Approve Response & Crisis Plans) ¹	Telephone, <i>or</i> Linkage & Coordination	Mobil Crisis With Team for 15-19	Walk- in	Children, Adolescents, & Families	Optional Stabilization	Reimbursement: SBIRT=\$14.70 for a 15 minute units
1) Psychiatrist	Yes	Yes	Yes	Provided by staff who either have had one year of experience providing mental health services to young children or adolescents or receive a minimum of 20 hours of training in providing the services within 3 months after being hired and supervised by (1-8) who has had at least 2 years of experience in providing mental health services to children.	Yes	\$148.16 or \$85.41 fed/hr. (same rate for advanced nurse practitioner) ²
2) Psychologist/PhD						\$110.23 or \$63.55 fed.
3) Psychology Residents						
4) Psychiatric Residents						
5) Licensed ICSWs						
6) Psychiatric Nurses						
7) Professional Counselors and MFTs						
8) Masters Clinicians (mental health) with 3000 hrs <i>but may not</i> approve Response nor Crisis Plans.						Masters or Bachelors Degree Rate: \$88.90 or \$51.25 fed/hr.

¹ See DMHSAS-DQA Numbered Memo: 2009-08 Variance Response Plan DHS-34
http://www.dhs.wisconsin.gov/dsl_info/NumberedMemos/DMHSAS/CY2009/nmemo200908.htm

² SBIRT rate for Advanced Nurse Prescribers with a psychiatric specialty is \$20.23 per 15 minute units.

Supervised Providers, Allowable Services, & Reimbursement

Service Categories Provider Type (Blue=Supervisor)	Telephone, or Linkage & Coordination	Mobil Crisis With Team for 15-19	Walk-in	Children, Adolescents, & Families	Optional Stabilization	Reimbursement: SBIRT=\$14.70 for a 15 minute units		
9) Post-masters clinicians w/ 1500 hrs.	Under Supervision either on-site or by phone	Under Supervision either on- site or by phone	Under Superv ision either on-site or by phone	Supervised by (1-8) who has at least 2 years of experience in providing mental health services to children: Provided by staff who have had: one year of experience providing MH services to children or adolescents <u>or</u> Who receive a minimum of 20 hours of training providing within 3 months of being hired	Under Supervision either on-site or by phone	Masters or Bachelors Degree Rate: \$88.90 or \$51.25 fed/hr.		
10) PAs								
11) RNs								
12) OTs w/1-yr MH								
13) CSWs								
14) QMHPs w/min of Bachelors and 1-yr MH or equivalent		Can work as a team with 1-14 as long as under supervision of 1-8	No				No	\$47.42 or \$27.34 fed/hr.
15) RT/MT, etc.			No				No	
16) COTAs			No				No	
17) LPNs			No				No	
18) MHTs or paraprofessionals		No	No				No	No
19) Clinical students								
20) Volunteers	No	No	No	No				

Certified Peer Specialists in Crisis

For more information on Certified Peer Specialist contact:

Lelena Lampe

608-267-9308

or

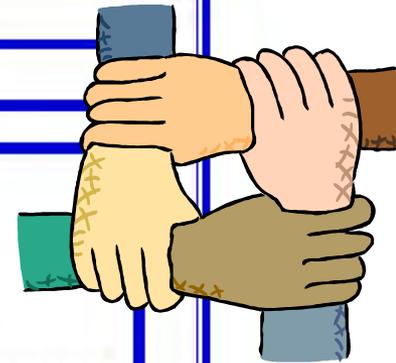
Alice Pauser

608-242-8484

WISCONSIN PEER SPECIALIST EMPLOYMENT INITIATIVE



Peer Specialists
Igniting Recovery



ARE YOU INTERESTED IN BECOMING A CERTIFIED PEER SPECIALIST? BASIC OVERVIEW OF PROGRAM CRITERIA

- A WISCONSIN CERTIFIED PEER SPECIALIST MUST HAVE THE LIVED EXPERIENCE OF MENTAL ILLNESS, BE IN RECOVERY AND BE WILLING TO APPROPRIATELY DISCLOSE THIS IN YOUR WORK WITH A PEER.
- YOU WILL NEED TO SUCCESSFULLY COMPLETE ONE OF THE FOUR STATE-APPROVED TRAININGS (DETAILS ON WWW.WICPS.ORG) OR APPLY FOR A TRAINING WAIVER IN THE CERTIFICATION EXAM APPLICATION PACKET. DOWNLOAD THE PACKET AT: WWW.SCE-PEERSPECIALIST.UWM.EDU
- ONCE YOU PASS THE CERTIFICATION EXAM YOU WILL NEED TO COMPLETE 20 HOURS OF CONTINUING EDUCATION EVERY TWO YEARS AND PAY THE \$50 RECERTIFICATION FEE. SEE WWW.WICPS.ORG FOR DETAILS.
- CERTIFIED PEER SPECIALISTS ARE PROFESSIONALS THAT FOLLOW A CODE OF CONDUCT AND ARE EXAMPLES OF RECOVERY TO THEIR PEERS.

Access to Independence, Inc.
3810 Milwaukee Street
Madison, WI 53714
Phone: 608-242-8484 ext 224
TTY: 608-242-8485
Toll-Free: 800-362-9877
Fax: 608-242-0383
E-mail: info@accesstoind.org
www.accesstoind.org



FOR FURTHER INFORMATION CONTACT:
ALICE F. PAUSER, CPS, NCWF
WI PEER SPECIALIST PROGRAM COORDINATOR
608-242-8484 EXT. 224
1-800-362-9877 EXT. 2224
ALICEP@ACCESSTOIND.ORG

WWW.WICPS.ORG

Staff Orientation & Training Requirement

- ▶ **New staff with less than 6 months** of experience in providing emergency mental health services shall complete a minimum of **40 hours** of documented orientation training within 3 months after beginning work with the program.
- ▶ **New staff with 6 months or more** of prior experience in providing emergency mental health service shall complete a minimum of **20 hours** of documented orientation training within 3 months after beginning work with the program.
- ▶ **Staff Providing Services to Youth** see above.
- ▶ **Volunteers** shall receive at least **40 hours** of orientation training before working directly with clients or their families.

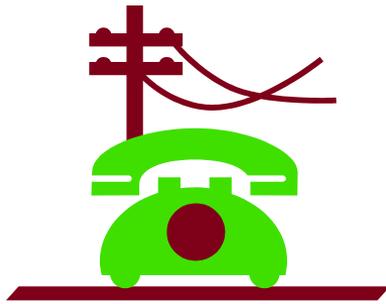


Crisis Supervision Requirements

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

- **Non-Master's Staff or Masters-level with less than 3000 hours** of supervised clinical experience must receive a minimum of:
 - **one hour of per week** *or* for every 30 clock hours of face-to-face mental health services provided.
- **Masters-level Staff with 3000 hours** of supervised clinical experience must participate in a minimum of:
 - **one hour of peer clinical consultation per month** *or* for every 120 clock hours of face-to-face mental health services they provide.

Masters-Qualified Staff under DHS-34.21 sub. (3) (b) 1. to 8.

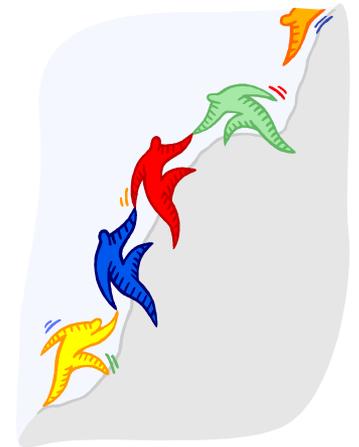


Telemedicine

- **Telemedicine** services (also known as "Telehealth") are services provided from a remote location using a combination of interactive video, audio, and externally acquired images through a networking environment. Requires sufficient audio and visual fidelity and clarity as to be functionally equivalent to a face-to-face contact. Telemedicine services do not include telephone conversations or Internet-based communication between providers or between providers and members.
- ▶ **Providers.** The following individual providers are reimbursed for selected telemedicine-based services: Physicians and physician clinics, RHCs (rural health clinics), FQHCs (federally qualified health centers), Physician assistants, Nurse practitioners, Nurse midwives, Psychiatrists in private practice, Ph.D. psychologists in private practice.
- ▶ **Reimbursement** for these services is subject to the same restrictions as face-to-face contacts (e.g., POS (place of service), allowable providers, multiple service limitations, PA (prior authorization)).

Multiple Staff to Assure Safety

- **Ensuring Safety.** Medicaid will reimburse for more than one staff person providing crisis intervention services to one individual simultaneously if this ensures the consumer's or the provider's safety (e.g., the member is threatening to hurt others).
- **Documentation of Rationale.** Providers are required to clearly identify the number of staff involved when billing for more than one staff person and the rationale for multiple staff in their documentation. In addition, if necessary, by outside professional staff who come into the facility for a limited time at the same time.



Travel & Service Hours



- **Travel time** to deliver covered crisis intervention services is included in the time counted as a part of the covered services.
- **No Maximum on Crisis Service Hours** provided to a member per day nor per member under BadgerCare Plus and Wisconsin Medicaid.
 - Providers are required to use the response and crisis plans to document service needs and to justify the need for continued services.
 - All services must be directed toward solving and preventing crises. Crisis or response plans must be used to document how services are related to these goals.
 - BadgerCare Plus and Wisconsin Medicaid monitor use retrospectively through data analysis and auditing.

Crisis is Fee-For-Service: Not Part of MCO Capitation

- ▶ BadgerCare Plus and Wisconsin Medicaid members enrolled in state-contracted MCOs (managed care organizations) may receive crisis intervention services on a fee-for-service basis. Not part of the HMO's capitation rate.
- ▶ CCF (Children Come First) or WAM (Wraparound Milwaukee) members may receive the service on a fee-for-service basis.

Interaction With Other Programs

- ▶ Backing-Up Other Programs – Each required to have their own after-hours response system:
 - Outpatient
 - CSP
 - CCS
 - CRS
- ▶ Targeted Case Management
- ▶ Family Care-efforts under way

Outpatient Emergency Services

- ▶ **Outpatient Mental Health Clinics are Required to Have Policies for Emergencies {DHS-35.165(1)}:**
- ▶ Written policy required on how the clinic will *provide or arrange for* the provision of services to address a consumer's mental health emergency or crisis during hours when its offices are closed, or when staff members are *not available* (physical presence in clinic offices) to provide outpatient mental health services.
- ▶ Written policies and procedures for identifying risk of attempted suicide or risk of harm to self or others.

Services That are Not Covered

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

Ineligibility for Medicaid Services

- **Periods of Incarceration** (e.g., in jail or secure detention), including when members receive a day or overnight pass from these facilities
- **Institutes for Mental Disease (IMD)** between ages 21 and 64
- Providers may provide services during these periods; however, they are not reimbursable.



Accommodations & Adaptations

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



Three D's of Civil Liability

(But hey, I'm not an attorney...check with your legal counsel)



- **Dereliction** – failure to adhere to the standard of practice
- **Duty** – Expected standard of practice for the clinic and provider
- **Damages** – That causes injury or damages.



Three D's of Revenue Protection

(But hey, I'm not a Medicaid auditor...check with the Medicaid Handbook!) *em*

- Document —
- Document —
- Documenter



Please visit the Crisis Webpages at:

<http://www.dhs.wisconsin.gov>

or Contact Brad Munger

Brad.Munger@Wisconsin.gov

(608) 266-2754