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Chapter DHS 63

COMMUNITY SUPPORT PROGRAMS FOR CHRONICALLY MENTALLY ILL PERSONS

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Note: Chapter HSS 63 was renumbered chapter HFS 63 under s. 13.93 (2m) (b) 1., Stats., and corrections made under s. 13.93 (2m) (b) 6. and 7., Stats., Register, July, 1997, No. 499. Chapter HFS 63 was renumbered to chapter DHS 63 under s. 13.92 (4) (b) 1., Stats., and corrections made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635.

DHS 63.01 Introduction. (1) AUTHORITY AND PURPOSE. This chapter is promulgated under authority set out in ss. 51.42 (7) (b), 51.421 (3) (a) and (c), and 227.11 (2) (a), Stats., to establish standards for community support programs under s. 51.421, Stats. These programs are for chronically mentally ill persons living in the community. The purpose of a community support program is to provide effective and easily accessible treatment, rehabilitation and support services in the community where persons with chronic mental illness live and work.

(2) TO WHOM THIS CHAPTER APPLIES. This chapter applies to any county establishing a community support program under s. 51.421, Stats., which wishes to receive reimbursement under the Wisconsin medical assistance program for community support program services, if medical assistance reimbursement is available for those services.

History: Cr. Register, April, 1989, No. 400, eff. 5−1−89.

DHS 63.02 Definitions. In this chapter:

(1) "Alcoholic" has the meaning prescribed in s. 51.01 (1), Stats., namely, a person who is suffering from alcoholism.

(2) "Alcoholism" has the meaning prescribed in s. 51.01 (1m), Stats., namely, a disease which is characterized by the dependency of a person on the drug alcohol, to the extent that the person's health is substantially impaired or endangered or his or her social or economic functioning is substantially disrupted.

(3) "Applicant" means a person who has begun, but not completed, the admissions process under s. DHS 63.09.

(4) "Assessment" means the process used to evaluate a client's presenting problems with an accompanying description of the reported or observed conditions which led to the classification or diagnosis of the client's chronic mental illness.

(5) "Case management" means an organized process for providing a full range of appropriate treatment, rehabilitation and support services to a client in a planned, coordinated, efficient and effective manner.

(6) "Certification" means the approval of a community support program by the department.

(7) "Chronic mental illness" means a mental illness which is severe in degree and persistent in duration, which causes a substantially diminished level of functioning in the primary aspects of daily living and an inability to cope with the ordinary demands of life, which may lead to an inability to maintain stable adjustment and independent functioning without long−term treatment and support and which may be of lifelong duration. "Chronic mental illness" includes schizophrenia as well as a wide spectrum of psychotic and other severely disabling psychiatric diagnostic categories, but does not include organic mental disorders or a primary diagnosis of intellectual disability or of alcohol or drug dependence.

(8) "Client" means an individual who has completed the admissions process under s. DHS 63.09 and is receiving treatment or services for mental illness.

(9) "Community support program" or "CSP" means a coordinated care and treatment program which provides a range of treatment, rehabilitation and support services through an identified treatment program and staff to ensure ongoing therapeutic involvement, individualized treatment, rehabilitation and support services in the community for persons with chronic mental illness.

(10) "County department" means a county department of community programs established under s. 51.42, Stats.

(11) "Department" means the Wisconsin department of health services.

(12) "Developmental disability" has the meaning given in s. 51.01 (5) (a), Stats.

(13) "Drug dependence" has the meaning prescribed in s. 46.973 (1) (c), Stats., namely, a condition arising from the periodic or continuous use of a drug which may result in psychic or physical dependence which would affect or potentially affect the public health, safety or welfare.

(13m) "Functionally equivalent" means a service provided via telehealth where the transmission of information is of sufficient quality as to be the same level of service as an in−person visit. Transmission of voices, images, data, or video must be clear and understandable.

(14) "Mental illness" means mental disorder to such an extent that an afflicted person requires care and treatment for his or her own welfare or the welfare of others or of the community. For purposes of involuntary commitment, "mental illness" means a substantial disorder of thought, mood, perception, orientation or memory which grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life, but does not include organic mental disorder or a primary diagnosis of intellectual disability, or of alcohol or drug dependence.

(15) "Organic mental disorder" means a disorder which has as its essential feature psychological or behavioral abnormalities, or both, associated with transient or permanent dysfunction of the brain that prevents a person from adequately providing for his or her own care.

(16) "Outreach" means procedures for identifying and contacting chronically mentally ill persons who are in need of CSP treatment and services, including referral agreements with psychiatric inpatient units, outpatient treatment clinics, and other community treatment and service providers.

(17) "Practitioner" means any of the CSP staff members specified under s. DHS 63.06 (2) and (4) (a).

(18) "Service provider" means a county department or a private agency that provides one or more services under this chapter.

(18m) "Signature" or "signed" means a signature that meets the requirements in s. 990.01 (38), Stats.

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

(20) (a) "Telehealth" means the use of telecommunications technology by a certified provider to deliver services allowable under this chapter, s. DHS 107.02 (5), and ss. 49.45 (61) and 49.46 (2) (b) 21. to 23., Stats., including assessment, diagnosis, consultation, treatment, or transfer of medically relevant data in a functionally equivalent manner of that of an in–person contact.

(b) "Telehealth" may include real–time interactive audio–only communication.

(c) "Telehealth" does not include communication between a certified provider and a recipient that consists solely of an electronic mail, text, or facsimile transmission.

History: Cr. Register, April, 1989, No. 400, eff. 5–1–89; correction in (11) made under s. 13.92 (4) (b) 6., Stats., Register November 2008 No. 635; 2019 Wis. Act 1: am. (7), (12), (14) Register May 2019 No. 761, eff. 6–1–19; CR 20–068: r. and recr. (12) Register December 2021 No. 792, eff. 1–1–22; **CR 23–053: cr. (13m), (18m), am. (19), cr. (20) Register September 2023 No. 813, eff. 10–1–23.**

DHS 63.03 Certification. (1) APPLICATION. A county department shall submit written application to the department to initiate the CSP certification process.

Note: The format for the written application can be obtained from the CSP Unit, Bureau of Community Mental Health, Division of Disability and Elder Services, P.O. Box 7851, Madison, WI 53707.

(2) CERTIFICATION PROCESS. (a) The department shall review the application submitted under sub. (1) to determine whether the requirements for certification set forth in this chapter have been met.

(b) A CSP shall make available for the department's review all documentation necessary to establish the CSP's compliance with this chapter.

(3) ISSUANCE OF CERTIFICATION. (a) Within 60 days after receiving a complete application for certification under sub. (1), the department shall either certify the CSP if all requirements for certification have been met or deny certification if requirements for certification have not been met. If the application for certification is denied, the department shall give the applicant reasons, in writing, for the denial. The denial notice shall specify the requirements under this chapter which the CSP has not met, shall specify the CSP's right to request a hearing in accordance with s. DHS 63.04 (3), and shall require the CSP to submit a plan to correct program deficiencies in accordance with par. (b).

(b) Within 10 days after receiving a notice of denial under par. (a), a CSP shall inform the department of a plan to correct program deficiencies and the date by which the corrections will be made.

(c) Within 60 days after the planned date for correcting the deficiencies noted under par. (a), the department shall conduct an on–site inspection of the CSP to determine whether the deficiencies have been corrected.

(4) CONTENT OF CERTIFICATION. Certification shall be issued only for the location and program named and may not be transferred or assigned to another program. A CSP shall notify the department of a change of administration, ownership, location, program name or any other program change that may affect compliance with this chapter no later than the effective date of the change.

(5) DATE OF CERTIFICATION. (a) The date of certification shall be the date that the department determines, by means of an on–site survey, that a CSP is in compliance with this chapter.

(b) The department may change the date of certification if the department made an error in the certification process. A date of certification which is adjusted under this paragraph may not be earlier than the date the written application under sub. (1) was submitted to the department.

(6) DURATION OF CERTIFICATION. (a) Certification remains valid until it is terminated or suspended by the department in accordance with s. DHS 63.04.

(b) Certification becomes invalid due to non–submission of the biennial report or non–payment of biennial fees in accordance with sub. (7) (c).

(7) BIENNIAL REPORT AND FEES. (a) Every 24 months, on a date determined by the department, the program shall submit a biennial report on the form provided by the department and shall submit payment of certification continuation fees under s. 51.04, Stats.

(b) The department shall send the certification continuation materials to the provider, which the provider is expected to complete and submit to the department according to instructions provided.

(c) A certification will be suspended or terminated if biennial reports and fees are not submitted prior to the end of the biennial cycle.

History: Cr. Register, April, 1989, No. 400, eff. 5–1–89; CR 22–078: r. and recr. (6), cr. (7) Register July 2023 No. 811, eff. 8–1–23.

DHS 63.04 Termination, suspension or denial of certification. (1) DEFINITION. In this section, "suspension" means a temporary withdrawal of certification.

(2) TERMINATION, SUSPENSION, OR DENIAL OF CERTIFICATION AFTER PRIOR NOTICE AND REQUESTED HEARING. The department may terminate, suspend, or deny a CSP's certification after providing the CSP with prior written notice of the proposed action which includes the reason for the proposed action and a notice of opportunity for a hearing whenever the department finds that:

(a) A staff member of the CSP has had sexual contact as defined in s. 940.225 (5) (b), Stats., or sexual intercourse, as defined in s. 940.225 (5) (c), Stats., with a client;

(b) A staff member requiring professional licensure claimed to be licensed when he or she was not licensed, has had his or her license suspended or revoked, or has allowed his or her license to expire;

(c) A CSP staff member has been convicted of a criminal offense related to the provision of or claiming reimbursement for services under the medicare program under 42 USC 1395 and 42 CFR 400 to 421, or under this state's or any other state's medical assistance program. For purposes of this paragraph, "convicted" means that a judgment of conviction has been entered by a federal, state or local court, regardless of whether an appeal from that judgment is pending;

(d) A staff member has been convicted of a criminal offense related to the provision of care, treatment or services to a person who is mentally ill, developmentally disabled, alcoholic or drug dependent;

(e) The program submitted or caused to be submitted statements, for purposes of obtaining certification under this chapter, which it knew, or should have known, to be false;

(f) The program failed to maintain compliance with one or more of the standards set forth in this chapter;

(g) Any of the program's practitioners signed billing or other documents as the provider of service when the service was not provided by the practitioner; or

(h) There is no documentary evidence in a client's treatment file that the client received services which were billed for.

(3) RIGHT TO A HEARING. In the event that the department denies, terminates, or suspends a certification, a CSP may request a hearing under s. 227.42, Stats. The request for a hearing shall be submitted in writing to and received by the department of administration's division of hearings and appeals within 30 days after the date on the notice required under sub. (2).

Note: The mailing address of the Division of Hearings and Appeals is P.O. Box 7875, Madison, WI 53707.

History: Cr. Register, April, 1989, No. 400, eff. 5–1–89; CR 22–078: am. (2) (intro.), (3) Register July 2023 No. 811, eff. 8–1–23.

DHS 63.05 Waivers. (1) POLICY. The department may grant a waiver of any requirement of this chapter when the department determines that granting a waiver would not diminish the effectiveness of the CSP, violate the purposes of the program, or adversely affect clients' health and welfare. The department may not grant a waiver of clients' rights under ch. DHS 94 or under other administrative rules, state statutes or federal regulations.

(2) WAIVER. A CSP may submit a request to the department for a waiver of any requirement in this chapter, except a requirement specified under s. DHS 63.08 (1) (a).

(3) APPLICATION. An application for a waiver under sub. (2) shall be made in writing to the department and shall specify:

1. The rule from which the waiver is requested;
2. The time–period for which the waiver is requested;
3. Any alternative action which the CSP proposes;
4. The reason for the request; and
5. Assurances that sub. (1) would be satisfied.

Note: A request for a waiver should be addressed to the CSP Unit, Bureau of Community Mental Health, Division of Disability and Elder Services, P.O. Box 7851, Madison, WI 53707.

(4) GRANT OR DENIAL. (a) The department may require additional information from the CSP before acting on a request for a waiver.

(b) The department shall grant or deny each request for waiver in writing. Notice of denial shall contain the reasons for denial. If a notice of a denial is not issued within 60 days after the receipt of a complete request, the waiver shall be automatically approved.

(c) The department may impose any conditions on the granting of a waiver which it deems necessary.

(d) The department may limit the duration of a waiver.

(e) The department's decision to grant or deny a waiver shall be final.

History: Cr. Register, April, 1989, No. 400, eff. 5–1–89; correction in (1) made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635.

DHS 63.06 Personnel. (1) POLICIES. (a) A CSP shall have written personnel policies to ensure that employment practices do not discriminate against any employee or applicant for employment on the basis of age, race, religion, color, sexual orientation, marital status, arrest and conviction record, ancestry, creed, national origin, disability, sex or physical condition.

(b) A CSP shall maintain written documentation of employees' qualifications and shall make that information available for inspection by clients and by the department.

(2) REQUIRED STAFF. A CSP shall employ:

(a) A director, who shall have overall responsibility for the program. The director shall meet the qualifications for any of the program staff listed under sub. (4) (a) 1. to 8.;

(b) A psychiatrist on a full–time, part–time or consulting basis to provide necessary psychiatric services. The psychiatrist shall meet the qualifications specified under sub. (4) (a) 2.; and

(c) A clinical coordinator who shall have overall responsibility for and provide direct supervision of the CSP's client treatment services and supervision of CSP clinical staff. The clinical coordinator shall be a psychiatrist or psychologist or have a master's degree in social work, clinical psychology or psychiatric mental health nursing or have met equivalent requirements. The coordinator shall have either 3,000 hours of supervised clinical experience in a practice where the majority of clients are adults with chronic mental illness or 1,500 hours of supervised clinical experience in a CSP.

(3) STAFFING RATIOS. The client–to–staff ratio may not exceed 20 clients to one full–time equivalent staff person, except that the department may permit, in accordance with a request for a waiver under s. DHS 63.05, that the ratio may not exceed 25 clients to one full time equivalent staff person. Only staff who meet the qualifications under subs. (2) and (4) (a) may be counted in the staff–to–client ratio.

(4) QUALIFICATIONS. (a) CSP staff shall have the following qualifications:

1. A CSP professional shall have a bachelor's degree in a behavioral science or a related field with 1,000 hours of supervised post–degree clinical experience with chronically mentally ill persons, or a bachelor's degree in a field other than behavioral sciences with 2,000 hours of supervised postdegree clinical experience with persons with chronic mental illness;

2. A psychiatrist shall be a physician licensed under ch. 448, Stats., to practice medicine and surgery and shall have satisfactorily completed 3 years' residency training in psychiatry in a program approved by the American medical association;

3. A clinical psychologist shall be licensed under ch. 455, Stats.;

4. A clinical social worker shall have a master's degree from a graduate school of social work accredited by the council on social work education;

5. A registered nurse shall hold a current certificate of registration under ch. 441, Stats., and shall have experience or education related to the responsibilities of his or her position;

6. Occupational therapists and recreational therapists shall have bachelor's degrees in their respective professions;

7. A rehabilitation counselor shall be certified or eligible for certification by the commission on rehabilitation counselor certification;

8. A vocational counselor shall possess or be eligible for a provisional school counselor certificate and shall have a master's degree in counseling and guidance; and

9. A mental health technician shall be a paraprofessional who is employed on the basis of personal aptitude. A mental health technician shall have a suitable period of orientation and in–service training and shall work under the supervision of a clinical coordinator under sub. (2) (c).

(b) When volunteers are used, they shall be supervised by professional staff under par. (a) 1. to 8. The CSP shall have written procedures for the selection, orientation and inservice training of volunteers.

(5) CLINICAL SUPERVISION. (a) Each CSP shall develop and implement a written policy for clinical supervision of all staff who provide treatment, rehabilitation and support services to CSP clients.

(b) Clinical supervision of individual CSP staff shall include direct clinical review, assessment and feedback regarding their delivery of treatment, rehabilitation and support services to individual CSP clients and teaching and monitoring of the application of CSP principles and practices.

(c) Clinical supervision shall be provided by a clinical coordinator meeting the qualifications under s. DHS 63.06 (2) (c) or by staff who meet the qualifications under s. DHS 63.06 (2) (c) and who are designated by the clinical coordinator to provide clinical supervision.

(d) Clinical supervision shall be accomplished by one or more of the following means:

1. Individual sessions with staff to review cases, assess performance and give feedback;

2. Individual sessions in which the supervisor accompanies an individual staff member to meet with individual clients in regularly scheduled sessions or crisis situations and in which the supervisor assesses, teaches and gives feedback regarding the staff member's performance regarding the particular client;

2m. Any other form of professionally recognized method of supervision designed to provide sufficient guidance to assure the delivery of effective services to consumers by the staff member;

3. Regular client report or review staff meetings and treatment planning staff meetings to review and assess staff performance and provide staff direction regarding individual cases.

(e) For every 20 clients or every 40 hours of direct service in the CSP, the clinical supervisor shall spend at least 4 hours a week providing supervision.

(f) Clinical supervision provided to individual CSP staff shall be documented in writing.

(6) ORIENTATION AND TRAINING. (a) Each CSP shall develop and implement an orientation and training program which all new staff and regularly scheduled volunteers shall complete. The orientation shall include:

1. Review of the applicable parts of this chapter.

2. Review of CSP policies.

3. Review of job responsibilities specified in the job description.

4. Review of ch. DHS 94, patient rights.

5. Review of ch. DHS 92, confidentiality of treatment records.

6. Review of agency's use of telehealth, including when telehealth can be used and by whom, privacy and security considerations, and the right to decline services provided via telehealth.

(b) Each CSP shall develop and implement a training plan for all staff, including:

1. Use of staff meeting time which is set aside for training.

2. Presentations by community resource staff from other agencies.

3. Attendance at conferences and workshops.

4. Discussion and presentation of current principles and methods of treatment, rehabilitation and support services for chronically mentally ill persons.

History: Cr. Register, April, 1989, No. 400, eff. 5–1–89; correction in (6) (a) 4. made under s. 13.93 (2m) (b) 7., Stats., Register December 2004 No. 588; corrections in (6) (a) 4. and 5. made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635; CR 20–068: am. (1) (a) Register December 2021 No. 792, eff. 1–1–22; **CR 23–053: am. (5) (d) 1., 2., cr. (5) (d) 2m., am. (6) (a) 1. to 4., cr. (6) (a) 6., am. (6) (b) 1. to 3. Register September 2023 No. 813, eff. 10–1–23.**

DHS 63.07 Outreach and screening. A CSP shall have written procedures for contacting and identifying persons with chronic mental illness and for having those persons referred to the CSP. The procedures shall include:

(1) Outreach activities and direct contact with potential CSP clients;

(2) Outreach referral agreements with psychiatric inpatient units, outpatient units and community service providers; and

(3) Screening by a clinical coordinator of each person referred to the CSP under sub. (2) to determine whether the person meets the admission criteria in s. DHS 63.08.

History: Cr. Register, April, 1989, No. 400, eff. 5–1–89.

DHS 63.08 Criteria for admission. (1) CRITERIA. Admission to a CSP shall be limited to an individual who has chronic mental illness which by history or prognosis requires repeated acute treatment or prolonged periods of institutional care and who exhibits persistent disability or impairment in major areas of community living as evidenced by:

(a) 1. A condition of chronic mental illness and a diagnosis listed in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM–III–R) within one of the following classification codes:

a. 295.1, .2, .3, .6 and .9 – Schizophrenia;

b. 296.2, .3, .4, .5, .6 and .7 – Affective disorders;

c. 297.1 – Delusional disorder; or

d. 295.7 and 298.9 – Other psychotic disorders.

2. A significant risk of either continuing in a pattern of institutionalization or living in a severely dysfunctional way if CSP services are not provided; and

3. Impairment in one or more of the functional areas listed under sub. (2); or

(b) 1. A condition of chronic mental illness with another diagnosis listed in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM–III–R), provided that documentation in the client record shows that:

a. There have been consistent and extensive efforts to treat the client, such as use of special structured housing, more frequent outpatient appointments combined with proactive efforts such as home visiting when the client does not come in for appointments, cooperative efforts by various outpatient, housing, vocational and crisis agencies to coordinate and plan treatment and face–to–face crisis intervention services on a regular basis, with or without crisis housing. The efforts have persisted for at least a year, except in unusual circumstances such as a serious and sudden onset of dysfunction, causing the client's condition to move beyond basic outpatient clinical standards of practice; and

b. The client exhibits persistent dangerousness to self or others;

2. A significant risk of either continuing in a pattern of institutionalization or living in a severely dysfunctional way if CSP services are not provided; and

3. Impairment in one or more areas listed under sub. (2).

(2) AREAS OF FUNCTIONAL IMPAIRMENT. The functional areas in which individuals admitted to a CSP may show impairment are as follows:

(a) *Vocational, educational or homemaker functioning.* 1. Impairment in vocational functioning is manifested by an inability to be consistently employed at a self–sustaining level or an ability to be employed only with extensive supports, except that a person who is able to earn sustaining income but is recurrently unemployed because of acute episodes of mental illness shall be considered vocationally impaired;

Note: The following are examples of persons who function at a fairly high level in general terms but still manifest vocational impairment:

A person who works 30 hours a week for years at a sheltered workshop at minimum wage, enough to sustain himself or herself, but who has shown repeated inability to work in competitive job sites because of loss of support and of the structure of sheltered work; and

A person who works 40 hours a week at a wage that may be somewhat more than minimum without extensive supports but who is unemployed 2 to 4 months of most years because of acute psychosis and loses his or her job when psychotic.

2. Impairment in educational functioning is manifested by an inability to establish and pursue educational goals within a normal time frame or without extensive supports;

Note: As an example, protracted part–time or intermittent full–time courses of study indicate impairment when goals are not being met or repeated class failure or frequent changes in major areas of study manifest an impairment in educational functioning.

3. Impairment in homemaker functioning is manifested by an inability to consistently and independently carry out home management tasks, including household meal preparation, washing clothes, budgeting and child care tasks and responsibilities; and

4. When part–time homemaker and educational or vocational roles coexist, the functional level of the combined roles shall be assessed according to existing community norms;

(b) *Social, interpersonal or community functioning.* 1. Impairment in social or interpersonal functioning is manifested by a person's inability to independently develop or maintain adult social relationships or to independently participate in adult social or recreational activities and is evidenced by:

a. Repeated inappropriate or inadequate social behavior or an ability to behave appropriately or adequately only with extensive or consistent support or coaching or only in special contexts or situations, such as social groups organized by treatment staff; or

b. Consistent participation in adult activities only with extensive support or coaching and when involvement is mostly limited to special activities established for the mentally ill or other persons with interpersonal impairments;

2. Impairment in community functioning is manifested by a pattern of significant community disruption, including family disruption or social unacceptability or inappropriateness, that may not recur often but is of such magnitude that it results in severe consequences, including exclusion from the person's primary social group or incarceration, or in severe impediments to securing basic needs such as housing; and

Note: The following are examples of higher functioning persons who still manifest the impairments under par. (b):

A person who socialized appropriately and effectively in one–to–one contacts with staff or in social groups organized by a CSP but is very isolative otherwise and does not socialize on his or her own;

A person who anxiously participates in a community group or activity only with much weekly coaching by and frequent accompaniment of treatment staff, but who does not reach the point of going to this activity on his or her own or with only minimal coaching;

A person who socializes on his or her own in relationships and groups, but who, after a period of time, drives away many friends because of inappropriate or ineffective behavior and therefore is recurrently lonely; and

A divorced woman's periodic threats to "steal" her children (who are in the custody of her ex–husband) from their day care center that lead to loss of visiting privileges with the children and therefore loss of the emotional sustenance the children bring.

(c) *Self–care or independent living.* Impairment in self–care or independent living is manifested by:

1. A person's inability to consistently perform the range of practical daily living tasks required for basic adult functioning in the community, including:

a. Grooming, hygiene, washing of clothes and meeting nutritional needs;

b. Care of personal business affairs;

c. Transportation and care of residence;

d. Procurement of medical, legal and housing services; and

e. Recognition and avoidance of common dangers or hazards to self and possessions; or

2. A person's persistent or recurrent failure to perform daily living tasks specified in subd. 1., except with significant support or assistance by others such as friends, family or relatives.

History: Cr. Register, April, 1989, No. 400, eff. 5–1–89.

DHS 63.09 Admission. **(1)** A CSP may not deny admission to an applicant solely on the basis of the number of previous admissions to any program or service provider.

(2) A CSP shall have written policies and procedures governing the admissions process. The policies and procedures shall include:

(a) The criteria for admission;

(b) The types of information to be obtained on all applicants prior to admission;

(c) The procedures to be followed when accepting referrals from outside agencies; and

(d) The procedures to be followed in referring an applicant to other service providers when the applicant is found ineligible for admission. The reason for nonadmission shall be recorded in CSP records.

(3) During the admissions process, unless an emergency situation is documented, each applicant and guardian, if any, shall be informed of the following:

(a) The general nature and purpose of the program;

(b) Program regulations governing client conduct, the types of infractions that may lead to corrective action or discharge from the program and the process for review and appeal;

(c) The hours during which services are available;

(d) The service costs that may be billed to the client, if any;

(e) The program's procedures for follow–up if a client is discharged; and

(f) Clients' rights as provided under ch. DHS 94.

(4) The CSP shall ensure that no client is denied any benefits or services or is subjected to discrimination on the basis of age, race, religion, color, sexual orientation, marital status, arrest and conviction record, ancestry, creed, national origin, disability, sex or physical condition.

(5) A CSP shall have a telehealth policy, including when telehealth would be used and by whom, privacy and security considerations, and the right to decline services provided via telehealth.

History: Cr. Register, April, 1989, No. 400, eff. 5–1–89; correction in (3) (f) made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635; CR 20–068: am. (4) Register December 2021 No. 792, eff. 1–1–22; **CR 23–053: cr. (5) Register September 2023 No. 813, eff. 10–1–23.**

DHS 63.10 Assessment and treatment planning. **(1)** ASSESSMENT. (a) An initial assessment shall be done at the time of the client's admission to the CSP, and an in–depth assessment shall be completed within one month after a client's admission. The physician shall make a psychiatric assessment of the client's need for CSP care and appropriate professional personal shall make a psychiatric and psychosocial assessment of the client's need for CSP care.

(b) The assessments shall:

1. Be clearly explained to the client or guardian, if any, and, when appropriate, to the client's family;

2. Include available information on the client's family and the client's legal, social, vocational and educational history; and

3. Be incorporated into review and revisions of the client's treatment plan under sub. (2).

(c) A clinical coordinator shall include a signed statement in the client's treatment record that the assessments under par. (a) were performed by appropriate professional personnel specified under s. DHS 63.06 (4) (a) 1. to 8.

(d) The in–depth assessment shall include evaluation of the client's:

1. Psychiatric symptomatology and mental status, by a psychiatrist and by the clinical coordinator or a designated staff member meeting qualifications under s. DHS 63.06 (2) (c). Utilizing information derived from the evaluation required under this subdivision, a psychiatrist or a clinical psychologist shall make a psychiatric diagnosis;

2. Use of drugs or alcohol, or both, by a CSP professional supervised by the clinical coordinator or a designated staff member meeting qualifications under s. DHS 63.06 (2) (c);

3. Vocational and educational functioning, by a CSP professional supervised by the clinical coordinator or a designated staff member meeting qualifications under s. DHS 63.06 (2) (c);

4. Social functioning, by a CSP professional supervised by the clinical coordinator or a designated staff member meeting qualifications under s. DHS 63.06 (2) (c);

5. Self–care and independent living capacity, by a CSP professional supervised by the clinical coordinator or a designated staff member meeting qualifications under s. DHS 63.06 (2) (c);

6. Relationship with his or her family, by a CSP professional supervised by the clinical coordinator or a designated staff member meeting qualifications under s. DHS 63.06 (2) (c);

7. Medical health, by a psychiatrist or physician. A registered nurse may collect health–related information and history and perform partial examinations under supervision of a physician;

8. Dental health information and history may be collected by a psychiatrist, a physician or a CSP professional under the supervision of a physician; and

9. Other specified problems and needs, by a CSP professional supervised by the clinical coordinator or a designated staff member meeting qualifications under s. DHS 63.06 (2) (c).

(e) Evidence that a service is medically necessary shall be indicated through the signature of a psychiatrist on the client's treatment record following the psychiatrist's review and approval of the service.

(2) TREATMENT PLANNING. (a) The case manager assigned to a client under s. DHS 63.12 (1) shall ensure that an initial written treatment plan is developed at the time of the client's admission to the CSP and that a comprehensive treatment plan is developed and written within one month after admission and is reviewed and updated in writing at least once every 6 months.

(b) The treatment plan shall:

1. Be based on the initial assessment required under sub. (1) (a) and, when appropriate, on the in–depth assessment required under sub. (1) (a) and (d);

2. Be developed in collaboration with other CSP professional and paraprofessional staff, service provider staff, the client or guardian, if any, and, when feasible, the client's family. The client's participation in the development of treatment or service goals shall be documented;

3. Specify treatment goals along with the treatment, rehabilitation and service actions necessary to accomplish the goals. The goals shall be developed with both short–range and long–range expectations and shall be written in measurable terms;

4. Identify the expected outcomes and the staff or agencies responsible for providing the client's treatment, rehabilitation and support services;

5. Describe criteria for termination of treatment, rehabilitation and support services; and

6. Be reviewed, approved and signed by the CSP's psychiatrist and clinical coordinator and be included in the client's treatment record.

(c) Treatment or provision of services may begin before the treatment plans are completed.

(d) The client's progress and current status in meeting the goals set forth in the plan shall be reviewed by the staff working with the client at regularly scheduled case conferences at least every 6 months and shall be recorded in the client's treatment record as follows:

1. The date and results of the review and any changes in the plan shall be recorded; and

2. The names of participants in the case conference shall be recorded.

(e) The case manager shall discuss the results of the review required under par. (d) with the client or guardian, if any, and, if appropriate, the client's parent and shall record the client's or guardian's acknowledgement of any changes in the plan.

(3) PLACE OF TREATMENT. Each CSP shall set a goal of providing over 50% of service contacts in the community, in non–office based or non–facility based settings. For a period of 2 years following the effective date of this chapter, a CSP shall submit to the department records of the places where treatment and services are provided to each client. The records shall cover time periods specified by the department.

History: Cr. Register, April, 1989, No. 400, eff. 5–1–89.

DHS 63.11 Required program components. (1) SERVICES. A CSP shall provide or make arrangements for the provision of the services specified in this section.

(2) TREATMENT. The CSP shall provide or make arrangements for provision of treatment services, which shall include:

(a) Crisis intervention services, including 24–hour telephone service, short–term emergency hospitalization and in–home or in–community emergency care by a CSP professional who has direct accessibility to the clinical coordinator or designated qualified staff member for consultation and assistance;

(b) Symptom management or supportive psychotherapy by a CSP professional, including:

1. Ongoing assessment of the client's mental illness symptoms and the client's response to treatment;

2. Symptom education to enable the client to identify his or her mental illness symptoms;

3. Teaching of behavioral symptom management techniques to alleviate and manage symptoms not reduced with medication; and

4. Promotion of personal growth and development by assisting the client to adapt to and cope with internal and external stresses;

(c) Medication prescription, administration, monitoring and documentation, as follows:

1. A psychiatrist or physician shall:

a. Assess the client's mental illness symptoms and behavior and prescribe appropriate medication;

b. Regularly review and document the client's mental illness symptoms and behavior response to the medication; and

c. Monitor, treat and document any medication side effects;

2. A registered nurse may administer medication from a multidose container or by injection at the direction of a psychiatrist or another physician;

3. Staff may administer only single–unit oral medication doses that have been dispensed and labeled by a psychiatrist, another physician, a licensed pharmacist or a registered nurse at the direction of a psychiatrist or another physician;

4. Staff shall assess and document the client's mental illness symptoms and behavior in response to medication and shall monitor for psychotropic medication side effects; and

5. Registered nurses shall report to the program psychiatrist and clinical coordinator and document in the chart adverse drug reactions and potential medication conflicts when drugs are prescribed by more than one physician; and

(d) Psychiatric and psychological services, including:

1. Psychiatric evaluation by a psychiatrist; and

2. Psychological evaluation by a clinical psychologist; and

(e) Family, individual or group psychotherapy by the clinical coordinator or designated staff member meeting qualifications under s. DHS 63.06 (2) (c).

(3) REHABILITATION. The CSP shall provide or make arrangements for provision of rehabilitation services, which shall include:

(a) Employment–related services provided in community–based settings to assess the effect of the client's mental illness on employment and to develop an ongoing employment rehabilitation plan to enable the client to get and keep a job. Employment–related services include:

1. Individualized initial and ongoing assessment by a CSP professional, including a thorough work and academic history and on–site work assessments in community–based, structured jobs;

2. Identification of behaviors that interfere with the client's work performance and development of interventions to alleviate the problem behaviors by a CSP professional;

3. Individual vocational supportive counseling by a CSP professional to enable the client to identify and cope with symptoms of mental illness that affect his or her work;

4. Work–related supportive services, such as assistance with grooming and personal hygiene, securing appropriate clothing, wake–up calls, transportation, on–the–job support and crisis assistance; and

5. On–the–job performance assessment and evaluation by a CSP professional;

(b) Social and recreational skill training, including supervised teaching activities and experiences provided individually or in small groups to:

1. Improve communication skills;

2. Facilitate appropriate interpersonal behavior; or

3. Familiarize clients with available social and recreational opportunities and increase their use of these opportunities; and

(c) Activities of daily living services provided in community–based settings including individualized support, problem solving, training and supervision to assist the client to gain or utilize the skills required to:

1. Carry out personal hygiene and grooming tasks;

2. Carry out household activities, including housecleaning, cooking, grocery shopping and laundry;

3. Develop or improve money management skills; and

4. Use available transportation.

(4) SUPPORT SERVICES. The CSP shall provide or make arrangements for provision of support services, which shall include case management under s. DHS 63.12 and individualized support, problem solving, training and supervision to help the client obtain:

(a) Services to meet physical health or dental health needs;

(b) Needed legal services;

(c) Needed transportation services;

(d) Financial support such as supplemental security income, social security disability insurance and general relief and money management services; and

(e) Living accommodations, including locating, financing and maintaining safe and normal living arrangements and enabling the client to relate to his or her landlord and neighbors in an acceptable manner.

History: Cr. Register, April, 1989, No. 400, eff. 5–1–89.

DHS 63.12 Case management. (1) SINGLE POINT OF CONTACT FOR A CLIENT. Each CSP client shall have a designated case manager who shall be responsible for maintaining a clinical treatment relationship with the client on a continuing basis whether the client is in the hospital, in the community, or involved with other agencies. Case managers shall meet the qualifications for clinical coordinators under s. DHS 63.06 (2) (c) or staff under s. DHS 63.06 (4) (a) 1. to 8.

(2) COORDINATION OF TREATMENT. (a) The case manager shall work with other CSP professional and paraprofessional staff and other agencies to:

1. Coordinate the assessment under s. DHS 63.10 (1) and ensure that a diagnosis is made;

2. Develop and implement the treatment plan under s. DHS 63.10 (2); and

3. Directly provide or coordinate treatment and services.

(b) The case manager shall work with other CSP staff and community agency staff to ensure that treatment plans are updated in accordance with s. DHS 63.10 (2) (a).

(c) The case manager shall organize and conduct case–specific staffings with other agencies, as needed.

(3) COORDINATION OF REFERRALS. (a) A CSP shall have policies and procedures that facilitate coordination of referrals and ensure follow–up of clients referred to other community service providers.

(b) The case manager shall work with other community agency or community service staff to:

1. Coordinate linkages and referrals;

2. Coordinate contracting for specialized assessment and diagnosis or treatment, rehabilitation and support services; and

3. Integrate other agency or service activities into the CSP treatment plan.

(4) MONITORING SYMPTOM STATUS. (a) The case manager shall assess, on a consistent basis, the client's symptom status. Changes in status shall be documented in the client's treatment record to measure progress or decompensation.

(b) The case manager shall keep the CSP program director and clinical coordinator informed of all changes in symptom status by signed notation in the client's treatment record.

(c) The case manager shall coordinate the provision of emergency services when a client is in crisis and shall provide documentation in the client's treatment record of emergency services provided.

(5) SUPPORTIVE PSYCHOTHERAPY AND EDUCATION. The case manager shall coordinate the provision of or provide supportive psychotherapy and education in symptom and illness management to the client.

(6) ADVOCACY. (a) The case manager shall advocate for and help his or her clients obtain needed benefits and services, including general relief, supplemental security income, housing subsidies, food stamps, medical assistance and legal services.

(b) The case manager shall work with existing community agencies to develop needed CSP resources, including housing, employment options and income assistance.

(7) EDUCATION, SUPPORT AND CONSULTATION TO CLIENTS' FAMILIES AND OTHER MAJOR SUPPORTS. (a) The case manager shall determine what support, consultation and education the client's family may need from the CSP to manage the symptoms and illness of the client family member.

(b) The case manager shall coordinate support and consult with the client's family at time intervals as specified in the client's treatment plan.

(c) The case manager shall provide the client's other support systems with education and information about chronic mental illness and community support program treatment.

History: Cr. Register, April, 1989, No. 400, eff. 5–1–89.

DHS 63.13 Client rights. A CSP shall have policies and procedures that ensure that client rights are protected in accordance with s. 51.61, Stats., and ch. DHS 94. The CSP shall require all case managers to assist clients in asserting their rights under s. 51.61, Stats., and ch. DHS 94.

History: Cr. Register, April, 1989, No. 400, eff. 5–1–89; corrections made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635.

DHS 63.14 Complaints. A CSP shall have procedures for reporting and investigating alleged unethical, illegal or grossly negligent acts affecting clients and violation of written policies and procedures. The procedures shall also address both client and staff reporting of complaints regarding program procedures, staff and services.

History: Cr. Register, April, 1989, No. 400, eff. 5–1–89.

DHS 63.15 Client records. (1) A CSP shall maintain a treatment record for each client. The record shall include information that is sufficiently detailed to enable a person not familiar with the CSP to identify the types of services the client has received.

(2) The CSP director is responsible for the maintenance and security of client treatment records.

(3) Client treatment records shall be maintained in a central location.

(4) Client treatment records shall be kept confidential and safeguarded as required under s. 51.30, Stats., and ch. DHS 92.

(5) The treatment recordkeeping format shall provide for consistency within the CSP and shall facilitate information retrieval. Treatment records shall include:

(a) Results of all examinations, tests and other assessment information;

(b) Reports from referring sources;

(c) Treatment and service plans, except for records of hospital emergency services;

(d) Medication records, which shall document ongoing monitoring of administration of medications and the detection of adverse drug reactions. All medication orders in the client treatment record shall specify the name of the medication, dose, route of administration, frequency of administration, person administering and name of the physician who prescribed the medication;

(e) Records of referrals of the client to outside resources;

(f) Reports from outside resources;

(g) Multidisciplinary case conference and consultation notes;

(h) Consent for disclosure of information release forms;

(i) Progress notes which shall document the location where the service was provided; and

(j) Discharge documentation.

(6) There shall be a policy governing the disposal of client records.

(7) There shall be a policy concerning the disposition of client records in the event of the CSP closing.

History: Cr. Register, April, 1989, No. 400, eff. 5–1–89; correction in (4) made under s. 13.93 (2m) (b) 7., Stats., Register December 2004 No. 588; correction in (4) made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635.

DHS 63.16 Discharge. Documentation by the client's case manager, clinical coordinator and psychiatrist of a client's discharge from a CSP shall be entered in the client's treatment record within one week after termination of treatment or services. Documentation of discharge shall include:

(1) The reasons for discharge;

(2) The client's status and condition at discharge;

(3) A written final evaluation summary of the client's progress toward the goals set forth in the treatment plan;

(4) A plan developed, in conjunction with the client, for care after discharge and for follow–up; and

(5) The signature of the case manager, clinical coordinator and psychiatrist.

History: Cr. Register, April, 1989, No. 400, eff. 5–1–89.

DHS 63.17 Program evaluation. (1) Each CSP shall have an evaluation plan, which shall include:

(a) A statement of the program's objectives. The objectives shall relate directly to the program's clients or target population;

(b) Measurable criteria to be applied in determining whether or not the objectives under par. (a) are achieved;

(c) Methods for documenting achievements not related to the program's stated objectives; and

(d) Methods for assessing the effective utilization of staff and resources toward the attainment of the objectives.

(2) In addition to the evaluation plan required under sub. (1), a CSP shall have a system for regular review that is designed to evaluate the appropriateness of admissions to the program, length of stay, treatment or service plans, discharge practices and other factors that may contribute to effective use of the program's resources.

(3) An annual report on the program's progress in meeting its objectives shall be prepared, distributed to interested persons and made available to the department upon request.

(4) The CSP's governing body or appropriate authority shall review the annual report.

History: Cr. Register, April, 1989, No. 400, eff. 5–1–89.