Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

Comprehensive Regional Review Tool

INDIVIDUAL'S NAME	AGE	REGION	DATE OF REVIEW

RESIDENTIAL PROGRAM NAME	BHO / BEHAVIORAL HEALTH PROVIDER	EMPLOYMENT/DAY PROGRAM PROVIDER

OTHER CARE PROVIDERS (LIST PROVIDERS THE INDIVIDUAL SEES REGULARLY)

REVIEW TEAM MEMBERS	TITLE

Imminent Risk

During the review was the individual's health and/or safety identified to be at imminent risk? ☐ Yes ☐ No
If yes, follow protocol in Reviewer Guidelines.

Describe issue and action taken:

General Summary

Briefly describe the person and their current situation.

Cross System Crisis Plan (CSCP)

REVIEWER(S)	CURRENT PLAN DATE	PREVIOUS PLAN DATE

YES	NO	N/A	
☐	☐		Is a CSCP in use?
☐	☐		Is a CSCP required by DDA Policy 5.18?
☐	☐	☐	Was the CSCP discontinued?
			If yes, date discontinued: Reason discontinued:
☐	☐	☐	Was team consulted per policy?
☐	☐	☐	Has the plan been reviewed in the last year as required by DDA Policy 5.18?

COMPONENTS PRESENT

YES	NO	INCOMPLETE	
☐	☐	☐	Contact information
☐	☐	☐	Diagnoses current
☐	☐	☐	Communication
☐	☐	☐	Preferred language
☐	☐	☐	Challenges
☐	☐	☐	Contact for updated medications
☐	☐	☐	Current medications attached to form
☐	☐	☐	Risk issues
☐	☐	☐	Symptoms / Behaviors description
☐	☐	☐	Response (intervention strategies)
☐	☐	☐	CSCP consistent with PBSP
☐	☐	☐	CSCP reflects team participation
☐	☐	☐	CSCP reviewed/updated following significant events (if no significant events, leave blank)

GENERAL OBSERVATIONS

FINDINGS	CORRECTIVE ACTION REQUIRED

DDA QUALITY COMPLIANCE REVIEW (Specify sources, include completion dates)

REVIEWER	DATE OF REVIEW

BHO / MENTAL HEALTH REVIEW (Specify sources, include completion dates)

REVIEWER	DATE OF REVIEW

Functional Assessment (FA) / Positive Behavior Support Plan (PBSP)

REVIEWER	DATE OF FA	DATE OF PBSP

YES	NO		
☐	☐	☐	Is a FA required by DDA Policy 5.14?
☐	☐		Does a psychosexual evaluation substitute for the FA? Date of evaluation:
☐	☐	☐	Does the individual have challenging behaviors other than those identified in the psychosexual evaluation?
☐	☐	☐	If yes, are there a FA and a PBSP for these behaviors?
☐	☐	☐	Is a PBSP required by DDA Policy 5.14?

COMPONENTS PRESENT

YES	NO	NA	INCOMPLETE	
☐	☐		☐	FA contains description of person and pertinent history
☐	☐		☐	FA includes description of skills
☐	☐		☐	FA contains current psychiatric diagnoses
☐	☐		☐	FA defines challenging behaviors in observable terms
☐	☐		☐	FA includes description of antecedents (setting events and predictors)
☐	☐		☐	FA contains complete Summary Statements (hypotheses)
☐	☐		☐	FA is the basis for development of PBSP
☐	☐		☐	PBSP defines challenging behaviors
☐	☐		☐	PBSP contains prevention strategies
☐	☐		☐	PBSP has suggestions for skill building, replacement behaviors and associated rewards
☐	☐		☐	PBSP contains clear strategies for responding to target behaviors
☐	☐		☐	PBSP data collection adequate to determine plan effectiveness
☐	☐		☐	PBSP interventions are consistent with CSCP
☐	☐	☐	☐	Evidence PBSP is reviewed/updated following significant events/incidents
☐	☐		☐	Evidence PBSP data is reviewed and revised as necessary
☐	☐	☐	☐	Restrictive procedures meet administration policy requirements

GENERAL OBSERVATIONS

FINDINGS	CORRECTIVE ACTION REQUIRED

DDA QUALITY COMPLIANCE REVIEW (Specify sources, include completion dates)

REVIEWER	DATE OF REVIEW

Residential Supports

REVIEWER

LIVING SITUATION TYPE

- ☐ AFH
- ☐ Alternative Living
- ☐ ARC
- ☐ Assisted Living
- ☐ Community ICF/IID
- ☐ Community Protection
- ☐ Companion Home
- ☐ Group Home
- ☐ Family Residence
- ☐ Independent Living
- ☐ Supported Living (specify hours/month): _____
- ☐ Supported Living 24/7
- ☐ RHC
- ☐ SOLA
- ☐ Other (specify): _____

YES	NO	NA	
☐	☐	☐	Daily schedule reflects balance of structured and unstructured time
☐	☐	☐	Evidence of weekly activities in the community
☐	☐	☐	Clear strategies exist to promote habilitation and engage individual in meaningful day and evening activities
☐	☐	☐	Positive relationships with housemates

If no, explain:

Number of housemates:

Is there a written plan to resolve housemate issues? ☐ Yes ☐ No ☐ NA

☐	☐	☐	Assigned caregivers are trained in how to implement the current PBSP
☐	☐	☐	Assigned caregivers are trained in how to implement the current CSCP
☐	☐	☐	Caregivers have received training in dual diagnosis

GENERAL OBSERVATIONS (Include information gathered during home visit and individual interview)

FINDINGS	CORRECTIVE ACTION REQUIRED

DDA QUALITY COMPLIANCE REVIEW (Specify sources, include completion dates)

REVIEWER	DATE OF REVIEW

BHO / MENTAL HEALTH REVIEW (Specify sources, include completion dates)

REVIEWER	DATE OF REVIEW

Residential Site Visit

REVIEWER(S)	DATE OF VISIT

YES NO NA

- ☐ ☐ ☐ Presentation and interaction by staff is friendly and appropriate
- ☐ ☐ ☐ Home environment is clean and free of debris or odor
- ☐ ☐ ☐ Home environment appears to be in good repair
- ☐ ☐ ☐ Home environment reflects the interests and choice of the individual
- ☐ ☐ ☐ There is adequate supply of food items in the home
- ☐ ☐ ☐ Home has access to community transportation
- ☐ ☐ ☐ Accommodations to the home meet the needs of the individual

PRESENTATION OF INDIVIDUAL

YES NO NA

- ☐ ☐ ☐ Individual's appearance was clean
- ☐ ☐ ☐ Individual expressed satisfaction with the environment
- ☐ ☐ ☐ Individual expressed satisfaction with support staff
- ☐ ☐ ☐ Individual expressed satisfaction with the overall support being received.

RESIDENTIAL PROVIDER RECORDS INCLUDE CURRENT

YES NO NA

- ☐ ☐ ☐ CSCP
- ☐ ☐ ☐ ISP
- ☐ ☐ ☐ FA
- ☐ ☐ ☐ PBSP

GENERAL OBSERVATIONS (Include description of the home environment and presentation of the individual)

FINDINGS	CORRECTIVE ACITON REQUIRED

DDA QUALIFY COMPLIANCE REVIEW (Specify sources, include completion dates)

REVIEWER	DATE OF REVIEW

Employment / Day Program

REVIEWER

SPECIFY TYPE

- ☐ Community Access
- ☐ Group Supported Employment
- ☐ Individual Supported Employment
- ☐ Person to Person
- ☐ Prevocational Services
- ☐ Retired (age 62+)
- ☐ RHC Adult Program
- ☐ None (explain in General Observations)

EMPLOYMENT / DAY PROGRAM DESCRIPTION AND SETTING (Indicate if volunteer work)

Description and work site: _____ Hrs/day: _____ Days/wk: _____

Description and work site: _____ Hrs/day: _____ Days/wk: _____

YES	NO	NA	
☐	☐	☐	Is the individual on a pathway to employment? If no or N/A, explain:
☐	☐	☐	Clear strategies exist to promote employment
☐	☐	☐	Staff have received training in dual diagnosis
☐	☐	☐	Staff have received training in the current CSCP
☐	☐	☐	Staff have received training in the current PBSP

EMPLOYMENT / DAY PROGRAM PROVIDER RECORDS INCLUDE CURRENT

YES	NO	NA	
☐	☐	☐	CSCP
☐	☐	☐	ISP
☐	☐	☐	FA
☐	☐	☐	PBSP

GENERAL OBSERVATIONS

FINDINGS	CORRECTIVE ACTION REQUIRED

DDA QUALITY COMPLIANCE REVIEW (Specify sources, include completion dates)

REVIEWER	DATE OF REVIEW

BHO / MENTAL HEALTH REVIEW (Specify sources, include completion dates)

REVIEWER	DATE OF REVIEW

Incident Reports (IR) (previous one year)

If individual did NOT receive incident reports within the past one year, check this box ☐ and skip to next section.

REVIEWER

COMPONENTS PRESENT

YES	NO	NA	
☐	☐	☐	IRs include description of services used to facilitate resolution (diversion, crisis services)
☐	☐	☐	IR follow-up section is complete and up to date
☐	☐	☐	DDA IRs were completed on all Central Office reportable incidents as required by DDA Policy 12.01
☐	☐	☐	Evidence that PBSP was implemented, if appropriate
☐	☐	☐	CSCP and other treatment plans (e.g., PBSP) were updated following significant incident
☐	☐		During review, was information discovered that should have triggered an IR? If yes, specify date and incident type:

IMMINENT RISK

YES	NO	
☐	☐	During review, was individual identified as having been at imminent risk to his/her health or safety at anytime within the past year? If yes, please describe circumstances and resolution:

DOCUMENTS REVIEWED

YES	NO	NA	
☐	☐	☐	Provider IRs
☐	☐	☐	DDA Central Office IRs
☐	☐	☐	Service Episode Records

GENERAL OBSERVATIONS (Include number and type of IRs)

FINDINGS	CORRECTIVE ACTION REQUIRED

DDA QUALITY COMPLIANCE REVIEW (Specify sources, include completion dates)

REVIEWER	DATE OF REVIEW

BHO/Medicaid Funded Mental Health Services

Are appropriate mental health records available? If no, then check this box ☐ and skip to next section.

REVIEWER

YES	NO	
☐	☐	Was the individual referred for RSN services but determined to not meet access to care standards?
☐	☐	Has the individual received any RSN funded mental health services in the past 5 years?
☐	☐	If yes, was the initial mental health intake assessment completed by a Developmental Disability Specialist (MH- DDS) or in consultation with a MH-DDS?
☐	☐	Is the individual currently receiving RSN funded mental health services?
☐	☐	If yes, is the current mental health provider a MH-DDS or are services being provided with MH-DDS consultation?

BREAKOUT BY SERVICE TYPE

Check all that apply.	DATE (Most recent)	BY (List provider type and/or credential)
☐ Brief intervention treatment		
☐ Crisis services		
☐ Day support		
☐ Evaluation and treatment facility		
☐ Group treatment		
☐ High Intensity treatment		
☐ Individual treatment/case management		
☐ Inpatient hospitalization		
☐ Intake evaluation (most recent)		
☐ Medication management		
☐ Medication monitoring		
☐ MH services in residential setting		
☐ Special population evaluation		
☐ Stabilization services		
☐ Other (specify):		

List only current diagnoses from RSN funded mental health provider. If these diagnoses are inconsistent with other diagnoses documents by other treating clinicians (e.g., psychiatrist / nurse practitioner), comment in General Observations section below.

YES NO NA

- ☐ ☐ Is this diagnostic formulation consistent with the current clinical presentation? If no, explain below.
- ☐ ☐ ☐ Rule out diagnoses are actively being addressed
- ☐ ☐ Mental health records reflect appropriate interventions related to diagnosis
- ☐ ☐ ☐ Does the mental health record include hospital discharge documents?
- ☐ ☐ ☐ Were treatment team recommendations from recent (past two years) hospital admissions consistent with the current treatment recommended actions?
  If no, explain:

- ☐ ☐ ☐ If a reduction in mental health services has occurred, was the DDA Case Resource Manager notified?

MENTAL HEALTH TREATMENT PLANNING

Participants in development of mental health treatment plan (check all that apply):

- ☐ Consumer
- ☐ Family
- ☐ State Hospital liaison
- ☐ DDA Case Resource Manager
- ☐ MH care provider
- ☐ Other (specify):

YES NO

- ☐ ☐ Does the current mental health treatment plan meet the needs of the participant? If no, explain:

YES NO

- ☐ ☐ Were BHO/Medicaid funded mental health services ever discontinued?
- ☐ ☐ Was the individual referred to another provider when BHO/Medicaid funded mental health services were discontinued?
- ☐ ☐ Was the DDA Case Resource Manager consulted prior to the discontinuation of mental health services?

GENERAL OBSERVATIONS

FINDINGS	CORRECTIVE ACTION REQUIRED

BHO / MENTAL HEALTH REVIEW (Specify sources, include completion dates)

REVIEWER	DATE OF REVIEW

DDA Funded Behavioral Health (BH) Services

If individual did not receive DDA funded BH services within the past one year, check this box ☐ and skip to next section.

REVIEWER

BREAKOUT BY SERVICE TYPE

Check all that apply.	DATE (Most recent)	BY (List provider type and/or credential)
☐ Sexual deviancy therapy (SOTP)		
☐ Counseling/psychotherapy		
☐ Behavior support services		
☐ Dialectical behavior therapy (DBT)		
☐ Chemical Dependency		
☐ Psychoactive medication services		
☐ Other (specify):		

YES	NO	NA	
☐	☐	☐	Records reflect appropriate interventions
☐	☐	☐	Individualized Treatment Plan(s) available for review
☐	☐	☐	Provider Progress Reports available for review

GENERAL OBSERVATIONS (Include brief description of services and frequency)

FINDINGS	CORRECTIVE ACTION REQUIRED

DDA QUALITY COMPLIANCE REVIEW (Specify sources, include completion dates)

REVIEWER	DATE OF REVIEW

Psychoactive Medication

If individual is not currently on psychoactive medications, check this box ☐ and skip to next section.

REVIEWER

Type of provider prescribing psychoactive medications (e.g., ARNP, Primary Care Physician, Psychiatrist, etc.):

_____ Date last seen: _____

YES	NO	NA	
☐	☐		Medication management records available
			If no, please record comments on any available records in General Observations
☐	☐		Are current psychoactive medications consistent with prescriber's current diagnostic impressions?
☐	☐		Is there evidence of intraclass polypharmacy?
☐	☐		If yes, does documentation support current treatment?
☐	☐		Is there a plan to taper or discontinue any psychoactive medications?
☐	☐		If no, does documentation support current treatment?
☐	☐		Does documentation include evidence of **a**ppropriate clinical evaluation and laboratory testing for potential psychoactive medication side effects?
☐	☐		General side effect monitoring used (e.g., Tools: MOSES, AIMS or DISCUS, or documentation in record)
			Date last done: Specific tool used:
☐	☐		Medication side effects assessments were done on a routine and regular basis
☐	☐	☐	If side effects were noted, is there a plan to address them in the individual's record?

GENERAL OBSERVATIONS

FINDINGS	CORRECTIVE ACTION REQUIRED

BHO / MENTAL HEALTH REVIEW (Specify sources, include completion dates)

REVIEWER	DATE OF REVIEW

Crisis Stabilization Services (previous one year) (MH or DDA funded)

If individual did not access crisis stabilization services in the past one year, check this box ☐ and skip to next section.

REVIEWER

YES	NO	NA	
☐	☐	☐	Was an emergency meeting convened when the individual exhibited deterioration or increased risk?
☐	☐	☐	Was referral made to a diversion bed, respite bed, or other diversion services prior to hospital admission(s)?
☐	☐	☐	Did the individual use diversion services?
☐	☐	☐	Were the crisis stabilization services effective in averting hospitalization?
☐	☐		Was the individual admitted to an inpatient unit or facility for psychiatric services within the past year?
			If yes, state number of times:

GENERAL OBSERVATIONS

FINDINGS	CORRECTIVE ACTION REQUIRED

DDA QUALITY COMPLIANCE REVIEW (Specify sources, include completion dates)

REVIEWER	DATE OF REVIEW

BHO / MENTAL HEALTH REVIEW (Specify sources, include completion dates)

REVIEWER	DATE OF REVIEW

Cross System Collaboration

REVIEWERS

YES	NO	NA	
☐	☐	☐	Evidence that DDA and MH systems are communicating on treatment approach
☐	☐	☐	Evidence of DDA and community MH participation during hospitalization
☐	☐	☐	After the last state hospital discharge (civil commitment), were discharge summary (and HMH, if available) recommendations followed in the community?
☐	☐	☐	If no, is rationale in the individual record?
☐	☐	☐	Do the records clearly reflect collaboration with others, key community support agencies (e.g., DOC, law enforcement, healthcare providers, etc.)?

GENERAL OBSERVATIONS

FINDINGS	CORRECTIVE ACTION REQUIRED

DDA QUALITY COMPLIANCE REVIEW (Specify sources, include completion dates)

REVIEWER	DATE OF REVIEW

BHO / MENTAL HEALTH REVIEW (Specify sources, include completion dates)

REVIEWER	DATE OF REVIEW

INSTRUCTIONS

Timeframes:

TASKS	1ST QUARTER REVIEW	2ND QUARTER REVIEW	3RD QUARTER REVIEW	4TH QUARTER REVIEW
Identify participant	December 1	March 1	June 1	September 1
RRT conducts review	January	April	July	October
RRT members submit required sections to DDA RRT Lead	February 15	May 15	August 15	November 15
RRT Leads send out review tool to appropriate staff for completion of corrective actions	February 28	May 31	August 15	November 10
Last day for completion of corrective actions or plan for completion	March 31	June 30	September 30	December 31
QCC and BHO / Mental Health compliance review	April	July	October	January
Last day to send final review to DDA and DBHR Program Managers	April 30	July 31	October 31	January 31

Conducting the review:

- Each RRT member completes their assigned sections of the review tool and sends it to the RRT leads. **For sections in which more than one reviewer is involved, it is critical that those individuals review and coordinate with each other to summarize observations, findings, and corrective actions. This will eliminate inconsistencies and contradictions in the final report.**
- The RRT leads compile the information (i.e., general observations, findings, and corrective actions); review for consistency; correct grammar and spelling; and finalize the report.
- The DDA RRT lead sends the completed report to the:
  - Assigned Case Resource Manager (CRM) and their supervisor for facilitation of the required corrective actions;
  - DDA Quality Compliance Coordinator (QCC);
  - DDA Field Services Administrator; and
  - DDA Regional Administrator.
- The BHO / Mental Health RRT lead sends the completed report to the applicable mental health provider for facilitation of corrective actions.
- The compliance review of the required corrective actions will be documented on the review tool in the applicable section and will include the following information:
  - Sources of information (e.g., SER notes, verbal report from CRM, specific documents that were reviewed, etc.); be sure to include dates;
  - Date corrective action(s) were completed;
  - Status of corrective action(s) (i.e., completed, partially completed, incomplete, etc.);
  - Date QCC review was completed; and
  - Other information as necessary.
- The completed review tool will then be submitted to the following individuals:
  - For DDA corrective actions:
    - DDA Mental Health Program Manger
    - DDA Field Services Administrator;
    - DDA Regional Administrator
  - For Mental Health corrective actions:
    - DBHR Program Administrator

Reviewer assignments:

SECTION	RRT TEAM MEMBER
Imminent Risk	Full RRT
Cross System Crisis Plan (CSCP)	DDA Quality Assurance (QA) and Regional Support Network (RSN) QA staff
Functional Assessment (FA) and Positive Behavior Support Plan (PBSP)	Psychologist
Residential Supports	DDA QA or BHO / Mental Health QA
Residential Site Visit	DDA QA
Employment or Day Program	DDA QA or BHO / Mental Health QA
Incident Reports (IR)	DDA QA or Psychologist
BHO/Medicaid Funded MH Services	BHO/Mental Health QA and Psychiatrist/ARNP
DDA Funded Behavioral Health Services	Psychologist and Psychiatrist/ARNP
Psychoactive Medication	Psychiatrist/ARNP
Crisis Stabilization Services	DDA QA and BHO/Mental Health QA
Cross System Collaboration	DDA QA and BHO/Mental Health QA