

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	
<b>Imminent Risk</b>				
<p>During the review was the individual's health and/or safety identified to be at imminent risk? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, follow protocol in Reviewer Guidelines.</p> <p>Describe issue and action taken:</p>				
<b>General Summary</b>				
Briefly describe the person and their current situation.				
<b>Cross System Crisis Plan (CSCP)</b>				
REVIEWER(S)			CURRENT PLAN DATE	PREVIOUS PLAN DATE
YES	NO	N/A		
<input type="checkbox"/>	<input type="checkbox"/>		Is a CSCP in use?	
<input type="checkbox"/>	<input type="checkbox"/>		Is a CSCP required by DDA Policy 5.18?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Was the CSCP discontinued?	
			If yes, date discontinued:                      Reason discontinued:	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Was team consulted per policy?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has the plan been reviewed in the last year as required by DDA Policy 5.18?	

COMPONENTS PRESENT		
YES	NO	INCOMPLETE
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Contact information
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Diagnoses current
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Communication
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Preferred language
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Challenges
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Contact for updated medications
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Current medications attached to form
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Risk issues
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Symptoms / Behaviors description
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Response (intervention strategies)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> CSCP consistent with PBSP
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> CSCP reflects team participation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 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
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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
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**Residential Supports**

REVIEWER \_\_\_\_\_

LIVING SITUATION TYPE

<input type="checkbox"/> AFH	<input type="checkbox"/> Community Protection	<input type="checkbox"/> Supported Living (specify hours/month): _____
<input type="checkbox"/> Alternative Living	<input type="checkbox"/> Companion Home	<input type="checkbox"/> Supported Living 24/7
<input type="checkbox"/> ARC	<input type="checkbox"/> Group Home	<input type="checkbox"/> RHC
<input type="checkbox"/> Assisted Living	<input type="checkbox"/> Family Residence	<input type="checkbox"/> SOLA
<input type="checkbox"/> Community ICF/IID	<input type="checkbox"/> Independent Living	<input type="checkbox"/> 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 _____
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BHO / MENTAL HEALTH REVIEW (Specify sources, include completion dates)

REVIEWER _____	DATE OF REVIEW _____
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Residential Site Visit	
REVIEWER(S)	DATE OF VISIT
<p>YES NO NA</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Presentation and interaction by staff is friendly and appropriate</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Home environment is clean and free of debris or odor</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Home environment appears to be in good repair</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Home environment reflects the interests and choice of the individual</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> There is adequate supply of food items in the home</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Home has access to community transportation</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Accommodations to the home meet the needs of the individual</p>	
<p>PRESENTATION OF INDIVIDUAL</p> <p>YES NO NA</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Individual's appearance was clean</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Individual expressed satisfaction with the environment</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Individual expressed satisfaction with support staff</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Individual expressed satisfaction with the overall support being received.</p>	
<p>RESIDENTIAL PROVIDER RECORDS INCLUDE CURRENT</p> <p>YES NO NA</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> CSCP</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> ISP</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> FA</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> PBSP</p>	
<p>GENERAL OBSERVATIONS (Include description of the home environment and presentation of the individual)</p>          	
FINDINGS	CORRECTIVE ACTION REQUIRED
<p>DDA QUALIFY COMPLIANCE REVIEW (Specify sources, include completion dates)</p>          	
REVIEWER	DATE OF REVIEW



BHO / MENTAL HEALTH REVIEW (Specify sources, include completion dates)	
REVIEWER	DATE OF REVIEW
<b>Incident Reports (IR) (previous one year)</b>	
<b>If individual did NOT receive incident reports within the past one year, check this box <input type="checkbox"/> and skip to next section.</b>	
REVIEWER	
<p>COMPONENTS PRESENT</p> <p>YES NO NA</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> IRs include description of services used to facilitate resolution (diversion, crisis services)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> IR follow-up section is complete and up to date</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> DDA IRs were completed on all Central Office reportable incidents as required by DDA Policy 12.01</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Evidence that PBSP was implemented, if appropriate</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> CSCP and other treatment plans (e.g., PBSP) were updated following significant incident</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> During review, was information discovered that should have triggered an IR?</p> <p style="margin-left: 40px;">If yes, specify date and incident type:</p>	
<p>IMMINENT RISK</p> <p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> During review, was individual identified as having been at imminent risk to his/her health or safety at anytime within the past year?</p> <p style="margin-left: 40px;">If yes, please describe circumstances and resolution:</p>	
<p>DOCUMENTS REVIEWED</p> <p>YES NO NA</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Provider IRs</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> DDA Central Office IRs</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Service Episode Records</p>	
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)

- |   |       |       |
|---|-------|-------|
| <input type="checkbox"/> Brief intervention treatment         | _____ | _____ |
| <input type="checkbox"/> Crisis services                      | _____ | _____ |
| <input type="checkbox"/> Day support                          | _____ | _____ |
| <input type="checkbox"/> Evaluation and treatment facility    | _____ | _____ |
| <input type="checkbox"/> Group treatment                      | _____ | _____ |
| <input type="checkbox"/> High Intensity treatment             | _____ | _____ |
| <input type="checkbox"/> Individual treatment/case management | _____ | _____ |
| <input type="checkbox"/> Inpatient hospitalization            | _____ | _____ |
| <input type="checkbox"/> Intake evaluation (most recent)      | _____ | _____ |
| <input type="checkbox"/> Medication management                | _____ | _____ |
| <input type="checkbox"/> Medication monitoring                | _____ | _____ |
| <input type="checkbox"/> MH services in residential setting   | _____ | _____ |
| <input type="checkbox"/> Special population evaluation        | _____ | _____ |
| <input type="checkbox"/> Stabilization services               | _____ | _____ |
| <input type="checkbox"/> 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	
<input type="checkbox"/>	<input type="checkbox"/>		Is this diagnostic formulation consistent with the current clinical presentation? If no, explain below.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rule out diagnoses are actively being addressed
<input type="checkbox"/>	<input type="checkbox"/>		Mental health records reflect appropriate interventions related to diagnosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does the mental health record include hospital discharge documents?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Were treatment team recommendations from recent (past two years) hospital admissions consistent with the current treatment recommended actions? If no, explain:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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):

<input type="checkbox"/> Consumer	<input type="checkbox"/> DDA Case Resource Manager
<input type="checkbox"/> Family	<input type="checkbox"/> MH care provider
<input type="checkbox"/> State Hospital liaison	<input type="checkbox"/> 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
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**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)
<input type="checkbox"/> Sexual deviancy therapy (SOTP)	_____	_____
<input type="checkbox"/> Counseling/psychotherapy	_____	_____
<input type="checkbox"/> Behavior support services	_____	_____
<input type="checkbox"/> Dialectical behavior therapy (DBT)	_____	_____
<input type="checkbox"/> Chemical Dependency	_____	_____
<input type="checkbox"/> Psychoactive medication services	_____	_____
<input type="checkbox"/> Other (specify):	_____	_____

YES	NO	NA	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Records reflect appropriate interventions
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Individualized Treatment Plan(s) available for review
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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 appropriate 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																									
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">YES</td> <td style="width: 5%; text-align: center;">NO</td> <td style="width: 5%; text-align: center;">NA</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Was an emergency meeting convened when the individual exhibited deterioration or increased risk?</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Was referral made to a diversion bed, respite bed, or other diversion services prior to hospital admission(s)?</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Did the individual use diversion services?</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Were the crisis stabilization services effective in averting hospitalization?</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> <td>Was the individual admitted to an inpatient unit or facility for psychiatric services within the past year? If yes, state number of times:</td> </tr> </table>		YES	NO	NA		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Was an emergency meeting convened when the individual exhibited deterioration or increased risk?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Was referral made to a diversion bed, respite bed, or other diversion services prior to hospital admission(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Did the individual use diversion services?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Were the crisis stabilization services effective in averting hospitalization?	<input type="checkbox"/>	<input type="checkbox"/>		Was the individual admitted to an inpatient unit or facility for psychiatric services within the past year? If yes, state number of times:
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BHO / MENTAL HEALTH REVIEW (Specify sources, include completion dates)																									
REVIEWER	DATE OF REVIEW																								
<b>Cross System Collaboration</b>																									
REVIEWERS																									

YES	NO	NA	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Evidence that DDA and MH systems are communicating on treatment approach
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Evidence of DDA and community MH participation during hospitalization
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	After the last state hospital discharge (civil commitment), were discharge summary (and HMH, if available) recommendations followed in the community?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If no, is rationale in the individual record?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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
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BHO / MENTAL HEALTH REVIEW (Specify sources, include completion dates)

REVIEWER	DATE OF REVIEW
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## INSTRUCTIONS

### Timeframes:

TASKS	1 <sup>ST</sup> QUARTER REVIEW	2 <sup>ND</sup> QUARTER REVIEW	3 <sup>RD</sup> QUARTER REVIEW	4 <sup>TH</sup> 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