

**AMH Integrated Services and Supports Rule (ISSR)
Regional Training: April and May 2010
Question and Answer Follow Up**

Assessment:

1. Is screening for Problem Gambling required for adolescents?

Screening for Problem Gambling is a requirement in all assessments, except when the provider can document that it is not clinically indicated.

2. Currently we are not completing a provisional assessment for Alcohol and Other Drug treatment. Can we do this now?

Yes, a provisional assessment can be done in Alcohol and Other Drug Treatment programs and Problem Gambling Treatment programs as well as Mental Health programs. When a provisional assessment is done in Alcohol and Other Drug Treatment programs, the ASAM PPC-2R dimensions must be included.

3. Can practicum students conduct assessments under the supervision of clinical staff?

Practicum students can assist in collecting the information for an assessment, although the assessment must be written by a QMHP.

4. What can a Qualified Mental Health Associate (QMHA) do in a provisional assessment and what does “under the supervision of a Qualified Mental Health Professional (QMHP)” mean in regard to crisis services?

A QMHA can gather the information for the assessment. When crisis services are provided, a QMHP must be available to approve the information in the assessment and the diagnosis either in person or by phone. To bill Medicaid for the assessment, a QMHP must be available in person.

5. Could there be a full assessment with a provisional Individual Service and Support Plan (ISSP)?

Yes, but there must be documented rationale and a time line for completion of a full ISSP.

6. Does assessment include a Mental Status Exam and a clinical formulation?

A Mental Status Exam is not required, but can be included if it is clinically appropriate to complete the needed biopsychosocial information in the assessment.

7. What is the criteria for using a provisional assessment and ISSP? Can this be done only in a crisis situation?

There is not specific criteria. If it is necessary to begin services with a provisional assessment or provisional ISSP, the provider must document the reason and the time line for completion of a full assessment or ISSP.

8. For Problem Gambling Services, if an individual receives concurrent Alcohol and Other Drug Treatment services, can the gambling assessment be used for entry?

Yes, if the Problem Gambling assessment includes all of the information that is required in an Alcohol and Other Drug Treatment assessment including all of the ASAM PPC-2R information.

9. If a provider does a screening and identifies problem gambling do they have to follow up?

Problem Gambling is included in the required screening. Any issue that arises as a result of the required screening (i.e. Alcohol and Other Drug, MH, Problem Gambling, Chronic Physical Conditions and/or symptoms from psychological trauma) requires referral and follow up to assist the individual in accessing needed services.

Note: Every county receives funding for Problem Gambling Treatment. A referral can be facilitated through the state-wide Help Line by calling 1-877-695-4648 or at www.1877mylimit.org.

10. When an individual changes programs can the assessment follow them?

Yes, but the receiving provider must document that a qualified person had reviewed and agreed with the information in the assessment.

ISSP:

1. What are the Licensed Healthcare Professional (LHP) or Licensed Medical Practitioner (LMP) signature requirements when there is a change made to the ISSP?

Any changes made to the services provided require LHP approval and signature. If the change is to the intended outcome, or other detail in the ISSP, no signature is required.

2. Does the ISSP have to be an all inclusive document or could the behavior support plan or crisis plan be a separate document?

Each component of the ISSP must be developed as part of the larger ISSP, although the physical location or presentation of the information is at the provider's discretion.

3. Can a LMP sign an initial ISSP instead of a LHP?

Yes.

4. By what date must the annual LMP signature be obtained for assessment and ISSP reviews and updates?

The LMP signature must be obtained by the anniversary date, which is 365 days from the date of entry to the program.

5. Does the LHP signature on an ISSP have to be obtained within five business days or five calendar days?

Five business days

6. Is there a minimum the ISSP should be updated? At least annually?

The ISSP must be updated consistent with the time lines indicated for the individual. ISSPs must be updated no less than annually in Mental Health programs.

7. Can an ISSP be developed as a collaborative effort among providers and shared?

No, each provider must have their own ISSP for each individual served, however, collaboration and coordination are encouraged where appropriate.

8. Do the intended outcomes of the ISSP include outcomes for other service agencies like child welfare, SPD, OYA, etc?

No, the intended outcomes are those that are applicable to the services provided only.

Individual Service Notes:

1. Can individual service notes be documented on checklists that indicate what is available to the individual with check marks next to services provided?

No, each individual service note must be recorded each time a service is provided, including specific service, duration of service, date, location, dated signature of provider with credentials, and any significant event or change.

2. What must be included in a periodic review and who is responsible for conducting it, signing it and making changes to the assessment and ISSP as a result?

The periodic review must document progress toward intended outcomes. The review and any changes to the assessment and/or ISSP resulting from the review must be done by a QMHP in Mental Health

programs and a qualified treatment staff in Alcohol and Other Drug Treatment programs.

Service Conclusion and Transfer:

1. Is a service conclusion summary required for one service and not the other when you are providing co-occurring services and one type of service has ended?

Yes.

2. When an individual concludes treatment to participate in another service or setting and the intent is for that individual to return, do the assessment and ISSP have to be re-created when he/she returns?

No, but there must be documentation to indicate that both the assessment and the ISSP have been reviewed and updated by qualified staff.

3. If an ISSR certified program provides assessment and brief crisis intervention services at a hospital and the individual does not begin further services, is a service conclusion summary required?

Yes, but the summary can be documented on an individual service note.

Clinical Supervision:

1. Who is required to have two hours of clinical supervision per month?

All staff providing services to individuals must receive two hours per month of clinical supervision. The only exceptions to this requirement are for the clinical supervisor or anyone who is a Licensed Medical Practitioner (LMP) as defined.

2. What is meant by a proportional amount of supervision for part-time staff?

The personnel policy must address how this will be documented and allocated in instances when someone works less than full time. If someone works half time for the agency, he/she must receive one hour per month of clinical supervision.

3. Which agency is responsible for clinical supervision when someone contracts with more than one agency?

Each agency is responsible for clinical supervision proportional to the amount of time the staff person is employed with that agency.

4. What education level does the supervisor of a QMHA require? Can an experienced “A” supervisor supervise other “A’s” when that person is supervised by a QMHP?

Only a qualified clinical supervisor (see definitions 309-032-1505) can provide clinical supervision.

5. Please clarify what is required as “documentation” for clinical supervision. Is it enough to have the clinical supervisor list what they do for clinical supervision?

The documentation must be adequate to verify that clinical supervision has been provided to each staff, as required, for the purpose of “ongoing evaluation and improvement of the effectiveness of services and supports.”

6. Can a personnel file be contained in an electronic system or must it be printed and physically filed for the purpose of documenting clinical supervision?

Yes, the file can be contained in an electronic system as long as it is accessible to reviewers.

7. Does an agency staff meeting qualify as “group supervision?”

Yes, as long as the documentation of the supervision indicates that the staff meeting focused on “ongoing evaluation and improvement of the effectiveness of services and supports.”

8. Can clinical supervision documentation be kept in a file other than the personnel file or must it be in each personnel file?

Yes, the documentation can be kept in a separate file as long as it is accessible to reviewers.

Medicaid Billing:

1. Is a Children's Emergency Safety Intervention Specialist (CESIS) considered a LHP?

No.

2. If a group is being conducted by both a Certified Alcohol and Drug Counselor (CADC) and a QMHP, co-facilitating, can both Alcohol and Other Drug and Mental Health be billed?

No, you cannot bill for both services if they occur at the same time.

3. If the LHP recommends changes to the ISSP, do they have to be documented and approved within the five-day period?

Yes, the ISSP would have to be changed and approved by the LHP within the five-day period.

4. What types of case management are billable and which are not?

Services that meet the definition of the case management code are billable.

5. Can agencies bill for an intern providing services?

Yes, if the intern meets the qualifications to provide the services.

6. Is more than one assessment per year reimbursable under this rule?

Yes, as per the ISSR, but providers should check with their MHO for additional information or limitations as applicable.

7. If a provider completes a provisional assessment first and then a full assessment, how does the billing work?

DHS reimburses providers on a per occurrence basis for assessments, regardless of the number of visits it takes to complete. When a provider chooses to complete a provisional assessment and then conducts future visits to complete a full assessment, the provider has completed one assessment. In this case, the provider is appropriately entitled to reimbursement for one assessment.

Children’s Intensive Treatment Services (ITS) and Intensive Community-based Treatment and Support Services (ICTS)
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1. Can the service coordination plan be done separately and then referred to as an addendum in the ISSP?

Yes, but the service coordination plan must be completed as part of the ISSP by a QMHP.

2. Can a PMHNP, under the supervision of a board certified child psychiatrist, provide ICTS services and sign an annual ISSP?

Only a person meeting the definition of a Licensed Medical Practitioner (LMP) can approve and sign an annual ISSP.

3. Why is “identification of strengths and needs” only required in an ICTS ISSP?

All assessments are required to identify the strengths and needs of the individual, which must be reflected in the intended outcomes of the ISSP. For ICTS programs, the ISSP must list the specific strengths and needs that are to be considered in the coordination of all services received by the child and family.

4. What is currently on the list of AMH approved evidence-based practices for behavior support services?

Collaborative Problem Solving

5. What is a time-out?

As defined in 309-032-1505, time out means the restriction of a child for a period of time to a designated area from which he or she is not physically prevented from leaving, for the purpose of providing him or her an opportunity to regain self-control. When time out is documented as a behavior support strategy in the ISSP, it must be tracked for effectiveness in increasing positive behavior.

6. Are LMPs still required to be involved with the ICTS teams?

The ISSR does not specify that a LMP must be a member of the child and family team.

7. Are restraints allowed and/or regulated in community-based ICTS programs?

Restraints and/or seclusion are allowed only as emergency safety interventions in approved programs providing Intensive Treatment Services (ITS).

8. What is meant by “tracking data” to insure that behavior support strategies are effective?

Each strategy listed in the behavior support plan is designed to minimize or eliminate undesired behavior. The tracking data should include pertinent information about the use of the strategy to allow the provider to assess its effectiveness.

Other:

1. What is AMH requiring regarding the use of new terminology in policies, forms, documentation, etc.?

AMH encourages the use of new terminology to promote outcome and recovery based services. There will not be certification findings with required corrective action when the terminology is not used.

2. What is a provider required to do if a staff person tested for TB is found to be positive?

This information can be found at:

http://arcweb.sos.state.or.us/rules/OARs_300/OAR_333/333_071.html

3. Can a person who has received services, but is currently on staff, fill the requirement for consumer representation on a Quality Assessment and Performance Improvement committee?

No. To prevent any potential conflict of interest, the consumer must be someone who is not contracted with, or employed by, the agency.

4. For Alcohol and Other Drug treatment programs providing services in institutions, how do these rules apply when some requirements conflict with institution rules?

AMH developed institution-specific administrative rules with the Department of Corrections (DOC) over the past year. These rules are designed to be consistent with DOC policies. There may be cases where services are delivered in other institutions (local jails, juvenile facilities, OYA) pursuant to the ISSR and the program identifies inconsistencies between institution rules and the ISSR. In these cases, the program should consult with the AMH Regional Coordinator about the need for variance or other strategies.

5. If an agency is funded by both the Community Mental Health Program (CMHP) and AMH, who would they submit their grievances to?

The grievance can be submitted to either the CMHP or AMH.

6. Does a consent form need to be signed each time a new medication is prescribed?

A parent or guardian must sign a new consent form each time a new medication is prescribed for a child.

7. Can a provider get a variance to use Washington licensed staff to meet the LHP signature requirement when the program is rural and has only access to Washington licensed staff?

The provider can request a variance and it will be considered as per 309-032-1565.

8. Is a person with current peer specialist training recognized as a Peer Support Specialist in the ISSR?

Yes, as long as the training is, or has been, approved by AMH.

9. Clarify the issue of Primary Language for the orientation packet. What about an individual who can read and understand English but it is not their primary language?

The individual must be given the option of receiving the information and/or documentation in his or her primary language. This procedure should be addressed in the provider's entry and orientation policy.

10. What is the responsibility of the provider if an individual does not have a Primary Care Physician (PCP)?

The provider must document that the individual does not have a PCP and document a referral and attempts to coordinate services with a PCP.