

**PENINSULA REGIONAL SUPPORT NETWORK  
Utilization Management Plan  
FY 2012**

The Peninsula Regional Support Network (PRSN) Utilization Management (UM) Plan summarizes the processes, procedures, standards and monitoring mechanisms that govern the utilization management program. The PRSN UM functions attempt to strike a balance between promoting a recovery based service delivery system and effectively managing resources.

The PRSN UM Plan is designed to comply with the contractual requirements outlined in the Agreement with the Washington State Department of Social and Health Services.

PRSN Mission

*The Peninsula Regional Support Network (PRSN) is dedicated to ensuring and continually improving the delivery of quality mental health care so that the individuals we serve may better manage their illness, achieve their personal goals, and live, work and participate in their community.*

The PRSN is committed to creating and supporting a mental health treatment system that focuses on supporting consumers and encouraging recovery and resiliency. We understand and promote the understanding that mental health is an essential element of overall health and mental illnesses are conditions from which people can and do recover.

The PRSN UM program strives to assist every individual in receiving quality care through utilization of adequate resources in the most cost effective manner. The PRSN believes a managed care structure allows for the delivery of the highest possible quality care, in a coordinated and cost effective manner.

Introduction

The PRSN provides a full range of mental health services to individuals within the service delivery geographical area, providing the required covered services for the Medicaid and state only revenue contracts. The PRSN provides comprehensive and medically necessary services in a variety of settings including, but not limited to outpatient, inpatient, residential, and intensive outpatient programs. The PRSN delivers timely, appropriate, and quality mental health services through an effective and carefully monitored network of mental health providers. All services requested, authorized, and provided for individuals using PRSN funding are subject to utilization review.

- *State funded services are provided according to the state defined priority services and additional outpatient services are provided based upon available resources.*

**Service Delivery Structure:** The PRSN has an extensive and fully licensed network of mental health providers that delivers comprehensive, quality care. The PRSN sub-capitates the Medicaid service funding with the core network providers, thereby ensuring full participation in implementing cost effective utilization management strategies.

**Standard Authorization Structure:** The PRSN has contracted with Community Network for Behavioral Healthcare, Inc. (CommCare) to authorize PRSN services requests from the provider network. CommCare is accredited by the Utilization Review Accreditation Commission (URAC) and is required to maintain the accreditation per contract. CommCare is responsible for providing service authorization determinations for services the PRSN has identified as requiring prior authorization, on behalf of the PRSN, for Medicaid and non-Medicaid individuals seeking mental health services.

**PRSN Oversight Committee:** The PRSN operates a UM committee to provide network oversight of the UM Plan activities, identify UM program and plan improvements, and review the Plan at least annually. The PRSN UM committee is responsible for prioritizing the UM Plan activities, targeting areas needing improvement, identifying benchmarks, and maintaining threshold capacity. The UM Committee members are listed in attachment 1.

### Utilization Program Goals

The goal of the PRSN UM program is to provide a process that systematically monitors and evaluates service delivery to ensure individuals have access and are receiving timely and appropriate mental health services to meet their needs. In addition, the UM activities provide a continuous framework for network evaluation of the appropriate use and amount of current resources within the network. The process focuses on monitoring contract requirements and developing cost-effective strategies within the service delivery structure.

### Utilization Management Program Objectives

The PRSN UM program strives to ensure easy and timely access to appropriate treatment; work collaboratively with each network provider in delivering quality care; address the needs of special populations; and make appropriate clinical decisions at the level closest to the individual. The UM program attempts to integrate with the network providers UM activities and internal quality management strategies where possible. The PRSN UM program emphasizes the principles of recovery, reintegration, rehabilitation, and resiliency which include involvement of individuals, and their families, in the direction their treatment.

### Utilization Management Program Structure

The UM program operates in a clearly defined organizational structure (see attachment 1). The PRSN UM program is supported by adequate clinical staff from multiple levels within the service structure, including staff from CommCare, the PRSN staff, and the network provider's senior management and clinical staff. The PRSN Quality Improvement Committee (QUIC) is responsible for the overarching oversight of the UM program, prioritizing monitoring activities and reviewing UM committee functions.

CommCare, the PRSN utilization management contractor, is required to adhere to Utilization Review Accreditation Commission (URAC) standards. CommCare is contracted to review authorization requests for outpatient, inpatient, and residential care.

CommCare's utilization management system improves the functioning and quality of life of individual served by the PRSN by applying a clinically sound, consumer-oriented, and cost-effective authorization process to the regional system of care.

CommCare's Care Managers are behavioral health clinicians who are trained to address not only the psychological needs of the individual and their families, but also their medical and social needs. Each member of the clinical staff averages over four (4) years of experience in the case management of Medicaid populations. The Care Managers are supervised by the Director of Utilization Management. The CommCare Medical Director is a board-certified psychiatrist who oversees all of CommCare's clinical activities. (see attachment 2)

The PRSN Adult Clinical Review Manager, Resource Development Manager, and Quality Assurance Manager, and Childrens Mental Health Services Coordinator participate in the PRSN UM program. The Clinical Review Manager conducts clinical chart reviews, monitors internal network adherence to authorized care, and facilitates the network Clinical Directors meetings. The PRSN Resource Development Manager is responsible for this plan and activities monitoring for network sufficiency, facilitates the monthly UM meetings, and maintains the PRSN Level of Care criteria. The PRSN Quality Assurance Manager is responsible for providing the linkages between the UM Plan to the PRSN Quality Management (QA) Plan, including plan activities and committees. The PRSN Childrens Mental Health Services Coordinator is responsible for oversight of the continuum of care for Childrens services.

The Utilization Management Committee (UMC) is a working sub-committee of the QUIC that is compiled of PRSN staff, network provider senior clinical management staff, information services staff, and CommCare's Clinical Director. The network agency representative have been oriented and trained on PRSN clinical criteria, case management philosophy and procedures, and treatment resources available. Each network agency and CommCare provide at least one representative that routinely attends the monthly meetings. This meeting rotates between face-to-face and phone conference call meeting formats.

The UMC is responsible for:

- Monitoring of the service authorization process; ensuring access to care meets standards.
- Establish, and on-going review of the PRSN criteria for each level of care.
- Monitoring of authorization movement through and across levels of care (including authorization of intensity levels of care, such as inpatient treatment).
- Monitoring the process of re-authorizing or extended service outpatient authorization.
- Tracking service denials (including the process of appeal).
- Monitoring inpatient utilization trends.
- Established regional benchmarks and thresholds of authorization procedures.
- Evaluating current network sufficiency and recommending changes to the governing boards and other PRSN committees, as necessary.
- Recommends Corrective Action Plans for concerning trends, such as exceeding authorized services hours and/or duration of time.
- Assists in the development of UM Policies and Procedures (including Levels of Care criteria), and annually reviews UM Plan.
- Reviews and makes recommendations for updates to the authorization forms (PRAT for outpatient services, PARS for residential services, certification for inpatient services, and other relevant authorization documents).

- Operationalizes state-directed inpatient authorization requirements/ modifications, such as the Community Psychiatric Instructions.

The PRSN ensures that utilization management activities are not structured in such a way as to provide incentives to any individual or entity to deny, limit, or discontinue medically necessary mental health services to any enrollee as evidenced in the PRSN policy: Authorization of Services: Independence from Financial Incentives.

### Service Authorization for Routine Care, Medicaid and non-Medicaid

The PRSN utilization management contractor, CommCare, uses the medical necessity criteria, Levels of Care standards, and *resources available* when making authorization determinations. The PRSN requires prior authorization for all routine outpatient service levels. These standards are reviewed at least annually to incorporate the evidence based and best practice industry standards in the behavioral health field.

The PRSN adopts Levels of Care Standards that:

- a. Include the Department's Access to Care Standards.
- b. Promote individual progress towards the highest possible level of health and self sufficiency.
- c. Can be reasonably expected to benefit the individual's mental health.
- d. Are medically necessary and appropriate to the individual's condition.
- e. Are designed to assist individuals in managing their illness to the greatest extent possible in order to live, learn, and work in their own communities.
- f. *For non-Medicaid services, are provided based upon available resources*

### Service Authorization Principles

1. The service authorization process is intended to meet all applicable requirements of the Centers for Medicare and Medicaid Services (CMS) and the Washington State Department of Social and Human Services, Division of Behavioral Health and Rehabilitation.
2. The service authorization process is designed to allow for rapid approval, with a minimum of steps to promote timely access to services. All service authorizations provide an expedited review process for urgent and emergent situations, as well as a standard review process.
  - Corrective Action plans will be required for late PRATs, exceeding 15% of the monthly total.
3. Medicaid recipients/enrollees will be authorized and receive all medically necessary mental health services defined in the Medicaid state plan.
4. Individuals not enrolled in Medicaid will be authorized and receive medically necessary outpatient mental health services subject to availability of resources.

5. All individuals residing within the PRSN have access to state funded crisis services.
6. Family member involvement is valued by the PRSN. Families will be encouraged to be involved in the assessment, service planning and treatment process whenever possible. Family non-involvement will not result in denial of service.
7. Authorized services will be provided in the most clinically effective, cost effective and least restrictive setting.

#### Outpatient Service Authorization Process

1. Following the Intake Assessment, service admission authorization requests typically are made by the PRSN network provider mental health professional that conducted the intake assessment. Requests are made using the Peninsula Regional Assessment Tool (PRAT).
2. The admission PRAT for outpatient services requires the following information:
  - Medicaid recipient/enrollee or Non-Medicaid assigned funding.
  - Multi-axial diagnosis, including if there is a covered A or B diagnosis and the required additional criteria for B diagnosis.
  - Access to Care standards, including medical necessity criteria questions and GAF/CGAS score information.
  - Requested Level of Care.
  - For Level 2 services, additional risk assessment criteria.
  - (optional) If entrance criteria is not met, referral provided.
  - For admission authorization beyond 14 days from the intake assessment, a request for an extension is required.
4. The PRSN network provider submits a PRAT (for outpatient episode of care authorization) requesting service authorization to CommCare. CommCare may review additional documentation, such as the Intake Assessment in Profiler and other relevant information available in the electronic medical record in making an authorization determination according to the PRSN standards.
5. CommCare will make an authorization determination; document the determination on the PRAT and transmits an on-line authorization determination back to the network provider. The network provider is responsible for providing and verbally notifying individuals of their authorized outpatient services.
  - The PRSN directly notifies individuals in writing when outpatient services are authorized. The PRSN Handbook accompanies the notification letter.
6. If the requested service is denied, individuals are found to not qualify for outpatient services, or there are not sufficient resources to provide services- CommCare will issue a service denial notification, on behalf of the PRSN, to the Medicaid and non-Medicaid individual.

- A copy of the notification letter is mailed directly to the individual and a copy is mailed to the PRSN office.
  - CommCare will conduct the Notice of Action Appeals for authorization decisions and service denials they issue for Medicaid individuals. Reference PRSN policy: Notice of Action Requirements.
7. The PRSN staff conduct retrospective reviews of a sample of authorized charts, as a part of the quality management plan and annual Administrative Reviews of network contractors and subcontractors.

The individual service plan (ISP) is reviewed as a part of the retrospective reviews to ensure it:

- Meets the needs of the individual.
  - Is consistent with the requested LOC and adopted PRSN Clinical Practice guidelines.
  - Includes consumer participation in the treatment planning process.
  - Involved family members, when appropriate, in the evaluation and service planning processes.
  - Includes input from other formal service systems and is consistent with privacy requirements.
8. The PRSN staff conduct targeted chart reviews in cases in which a complaint or grievance regarding the authorization determination is raised, when a network provider staff requests a review, when there has been an adverse incident or potential for negative media occurs, or when determined necessary due to repeated and uncorrected errors identified in retrospective reviews.
9. If a network provider performs below expected standards during any of the reviews, listed above, a Corrective Action will be required for PRSN approval.

#### Authorization for Inpatient Services, Medicaid and Non-Medicaid

The PRSN utilization management contractor, CommCare, uses the Department of Social and Health Services statewide Community Psychiatric Inpatient Instructions Per Diem (implemented August 1, 2007), medical necessity criteria and PRSN Levels of Care standards when making inpatient authorization determinations. The PRSN requires prior authorization for all inpatient services. The PRSN provides an expedited review process for urgent and emergent inpatient authorizations.

Involuntary placements into an acute psychiatric hospital or evaluation and treatment center must be automatically authorized and in accordance with the notification process outlined in the, DSHS Community Psychiatric Inpatient Instructions Per Diem.

All service denials of requested inpatient care are made by CommCare's board certified psychiatrist or consulting physician.

#### A. Service Authorization Process for Inpatient

The PRSN inpatient authorization process follows the Community Psychiatric Inpatient Instructions Per Diem, implemented August 1, 2007.

1. The request for inpatient services is sent to CommCare to authorize. CommCare is required to use the medical necessity and PRSN Levels of Care.
3. A PRSN Crisis Response Team conducts a crisis face to face evaluation within 2 hours of a request and determine the level of acuity. For out of region requests, the request is verbally assessed within 2 hours of the request.
4. The PRSN Crisis Response Team submits the request for inpatient services, providing the necessary documentation, to make an inpatient authorization determination. The determination to authorize inpatient care shall be completed within 12 (twelve) hours from the initial request for authorization. The determination is entered into Provider 1 for community inpatient facilities and Profiler for the local Evaluation and Treatment Centers.
5. The PRSN staff conducts retrospective reviews of a sample of inpatient authorized charts, as a part of the quality management plan and annual administrative reviews of network contractors and subcontractors.
6. The PRSN staff conducts targeted chart reviews in cases in which a complaint or grievance regarding the authorization determination is raised, when a network provider staff requests a review, when there has been an adverse incident or potential for negative media occurs, or when determined necessary due to repeated and uncorrected errors identified in retrospective reviews.
7. If a network provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for PRSN approval.
8. The inpatient facility is responsible for requesting extension/continuing stay requests and retro-certifications, 24 (twenty-four) hours prior to the expiration of an episode.
  - CommCare makes authorization determinations for extension, continuing stay requests and retro-certifications

#### B. Discharge Planning for voluntary hospitalizations

The PRSN expects the network provider to coordinate the discharge planning for individuals voluntarily hospitalized.

The discharge planning process must begin within 3 days of admission and include:

- Purposeful use of the individual's/family's strengths
- Identification of what caused the individual to need hospital or out of home placement
- What the individual and his/her family need to be successful in the community
- Identified solutions to getting those needs met
- Offered Outpatient appointment (within 7 days of inpatient discharge)

An individual, and their family, must be an integral part of the treatment and discharge planning, with a voice in the discharge placement decisions. Discharge planning is integral to the authorization, retrospective certifications, and re-authorization process.

### Authorization for Intensive Residential Services (adults), Medicaid and Non-Medicaid

The PRSN utilization management contractor, CommCare, uses the medical necessity criteria and Levels of Care standards developed and adopted by the PRSN when making intensive residential service authorization determinations. The PRSN requires prior authorization for intensive brief and long-term residential service for adults. *Authorization of residential services for non-Medicaid individuals will be based upon available resources.*

#### A. Service Authorization Process for Intensive Residential Services

1. The PRSN network provider submits a Peninsula Assessment for Residential Services (PARS) request (for intensive residential services authorization) service authorization to CommCare. CommCare may review additional documentation, such as the Intake Assessment, Crisis Prevention Plan, Individual Service Plan (ISP) and other relevant information in making an authorization determination according to the PRSN standards.
2. CommCare will make an authorization determination; document the determination on the PARS form and transmits an on-line authorization determination back to the network provider. The network provider is responsible for providing and verbally notifying individuals of their authorized residential services.
3. If the requested service is denied, CommCare will issue a service denial notification, on behalf of the PRSN, to the Medicaid and Non-Medicaid individual.
  - A copy of all residential authorization determinations are forwarded to the PRSN office.
4. The PRSN staff conduct retrospective reviews of a sample of charts authorized for residential services, as a part of the quality management plan and annual Residential Reviews of network contractors and subcontractors.
5. The PRSN staff conduct targeted chart reviews in cases in which a complaint or grievance regarding the authorization determination is raised, when a network provider staff requests a review, when there has been an adverse incident or potential for negative media occurs, or when determined necessary due to repeated and uncorrected errors identified in retrospective reviews.
6. If a network provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for PRSN approval.

### Continuing Stay and Service Re-Authorization

The PRSN network providers use the LOC developed and adopted by the PRSN when making re-authorization determinations.

- The PRSN requires prior re-authorization for *all* continuing stay inpatient services.

- The PRSN requires re-authorization for outpatient service episodes when a previously authorized benefit period expires.
- The PRSN does not require a re-authorization within a current authorized benefit period. The PRSN network providers may close and re-open a clinical episode within an authorized administrative benefit period.

The PRSN Levels of Care for outpatient and inpatient care outline the re-authorization criteria must be met, documentation provided to support criteria, and information reviewed when re-authorizing a service episode.

Service re-authorizations for Non-Medicaid individuals must meet the LOC additional requirements to serve the individuals. *There must be available resources to provide the services.*

The PRSN requires a review of the individual service plan (ISP) as part of the continuing stay service authorization process to ensure it:

- Meets the needs of the individual.
- Is consistent with the requested LOC and adopted PRSN Clinical Practice guidelines.
- Includes consumer participation in the treatment planning process.
- Involved family members, when appropriate, in the evaluation and service planning processes.
- Includes input from other formal service systems and is consistent with privacy requirements.

#### Consistency of Authorization Determination and Service Requests

The PRSN has formally adopted the *Authorization of Outpatient Services Based on Medical Necessity* policy and Levels of Care to ensure the PRSN, network providers, and CommCare share a common definition and standardized process to determine the medical necessity of requested and authorized mental health services provided by the PRSN.

The PRSN expects the utilization management contractor, CommCare, to consistently apply and authorize the most appropriate Level of Care and service modalities, based upon the request and clinical documentation provided for determining medical necessity.

The PRSN expects the network providers to provide clear and consistent assessments, request clinically appropriate services, and adhere and deliver services within the scope of authorized mental health services.

#### Limitations on the Provision of Covered Services, Medicaid and Non-Medicaid

The PRSN contracts with CommCare to make all the service authorization decisions on behalf of the PRSN.

- A. There are several ways that CommCare can limit the provision of Medicaid covered services. These include:
- Determining that an enrollee does not meet Access to Care standards.

- Denying authorization for a requested covered service: Denials of a requested service will be addressed through the PRSN service denial and notification policy and procedures.
- Determining to reduce, suspend or terminate a previously authorized service.
- Pend an authorization request, awaiting additional information

B. There are several ways that CommCare can limit the provision of services to Non-Medicaid individuals. These include all the above, a reduction of resources, as well as the additional criteria for Non-Medicaid individuals.

C. When one of the above actions occurs, CommCare through the notification process informs an individual in writing. Medicaid recipients receive a Notice of Action for all actions and Non-Medicaid individuals receive a PRSN Letter of Ineligibility.

When services are reduced as a result of reduced state funding, a notification letter is mailed to the individual. The PRSN maintains a list of individuals that have been mailed this notice.

- CommCare will conduct the NOA appeal, if requested.
- PRSN will conduct a Grievance investigation, if requested.
- DSHS will conduct a Fair Hearing, if requested.

### Ensuring Client Rights Are Provided

The PRSN places a high priority on informing individuals seeking services of their rights. The PRSN ensures individuals are provided this information through the DSHS booklet, the PRSN Handbook and brochures, and reviews the provision of information through monthly on-site chart reviews, and annual Administrative Reviews. A clinical chart must evidence that individuals were given the client rights information prior to the completion of the intake assessment. The PRSN developed and distributes the informational PRSN Handbook and brochures, and a standardized outpatient client rights form to network providers to be given to each individual seeking services. The PRSN also distributes the informational material to subcontractors, such as the local Ombuds office, BRIDGES to Parent Voice program, and NAMI advocacy groups.

Individuals with sensory impairments, or who speak a language other than English, are provided equal access to this information through:

- Provision of material in Braille.
- Use of a DSHS TDD language or TTY line.
- Access to certified sign and language interpreters.
- PRSN contracted hearing impaired consultant.
- Client rights are posted in common areas of the network agencies in the seven DSHS identified languages.

Clients are informed that mental health professional and primary mental health care providers, acting within the lawful scope of mental health practice, are not prohibited or restricted from advising or advocating on behalf of them with respect to their mental health status. Reference the PRSN policies: General Information and Requirements, Enrollee Rights, and Mental Health Care Professional Advocacy policies.

Clients are informed of their second opinion rights, how and when to request a second opinion, and payment of costs associated with providing a second opinion in the published and distributed documents, as well as on the Notice of Action and PRSN Letter of Ineligibility.

### PRSN Oversight and Sampling Methodology

The PRSN utilizes random sampling to select charts for clinical and targeted reviews. The PRSN conducts a minimum of 500 chart reviews annually, sufficient to meet CMS and the Department requirements for reviews. Additional reviews may occur to address performance issues, concerning trends, or to accomplish utilization management or quality management activities.

The PRSN conducts annual Administrative Reviews of each network provider, the ASO, and the local Ombuds office. During the network provider administrative reviews, the PRSN randomly identifies 10% of the direct service staff to interview face to face. The interview questions include purpose of the local Ombuds office, two client right questions (one specifically about outpatient second opinion rights), advocating for clients authorization of services, and procedures for access a certified interpreter to ensure the integrity of the network system. If there is an area of interview questions that are vague or consistently answered incorrectly, the PRSN requests a corrective action plan typically related to training/supervision.

### Over and Under Utilization Project

The PRSN monitors and detects for consistent application of requested, authorized, and provided services through an over and under utilization project that meets federal requirements. Both of these projects are monitored through regional quality assurance activities. Both projects are explained in the PRSN Quality Management Plan.

High Utilizers: The PRSN monitors for high inpatient utilization through chart reviews, with a targeted data pull and with specific items on the crisis chart review tool.

Under Utilizers: The PRSN monitors for outpatient under utilization through a data report and/or chart reviews.

### Examination of Network Sufficiency

The PRSN UM program uses a variety of measures as indicators of network sufficiency and resources sufficiency. These indicators include:

- Historical use of resources.
- Current use of resources.
- Projections for future use and need of resources.
- Funding shifts- expenses and revenue reports.
- Quarterly Provider Performance Reports
- Census information for Medicaid and general population growth, by age, ethnicity, and gender.
- Monitoring of outpatient and inpatient utilization through the Authorization and Utilization Management Report submitted monthly.

The PRSN has polices and procedures for collecting the service data, demographic, and census data, as evidenced in the Using the Information System for Utilization and Resource Management policy.

### Integration of Utilization Management Data

Utilization management data is an integral part of the PRSN overall quality improvement strategy. The PRSN UM Plan defines areas of focus, establishes thresholds and benchmarks against which performance is measured, and defines special utilization management studies to be conducted.

The PRSN utilizes a regional database (MIS) system to collect the required service data for individuals receiving PRSN funded services:

- Client Demographic Information.
- Social Security Number.
- Health Insurance Information (plan, group number, subscriber name).
- Attending Physician/Practitioner Information/Primary Mental Health Care Provider assigned.
- Client Diagnosis/Treatment Information.
- Inpatient/Residential Facility Information.

Unique situations may require for additional information prior to making an authorization determination. Clinical and demographic information may be shared within the PRSN service network to avoid multiple requests for information from patients and providers.

Information from utilization management activities is aggregated, trended and analyzed to establish validity for completeness, accuracy, and timeliness. The PRSN staff and UMC evaluate the data using comparative statistical methods to identify variance from expected performance and reviews progress over time for trends or patterns. They report their findings to the PRSN QUIC.

The PRSN staff, UMC, and QUIC monitor performance against the benchmarks established in the Quality Management Plan. Should required activities not result in attainment of established benchmarks, the QUIC can impose corrective actions or implement concurrent reviews, as required to achieve benchmarks.

When analysis of available data suggests a deficiency in the sufficiency of the network, the UMC and/or the QUIC presents the issue for discussion and decision making to the PRSN governing boards.

### Annual Evaluation of the PRSN UM Program

The PRSN Utilization Management Program is reviewed, evaluated and revised annually. The plan evaluation includes an assessment of the UM plan activities, and the extent to which compliance was achieved with the specified performance standards and outcomes.

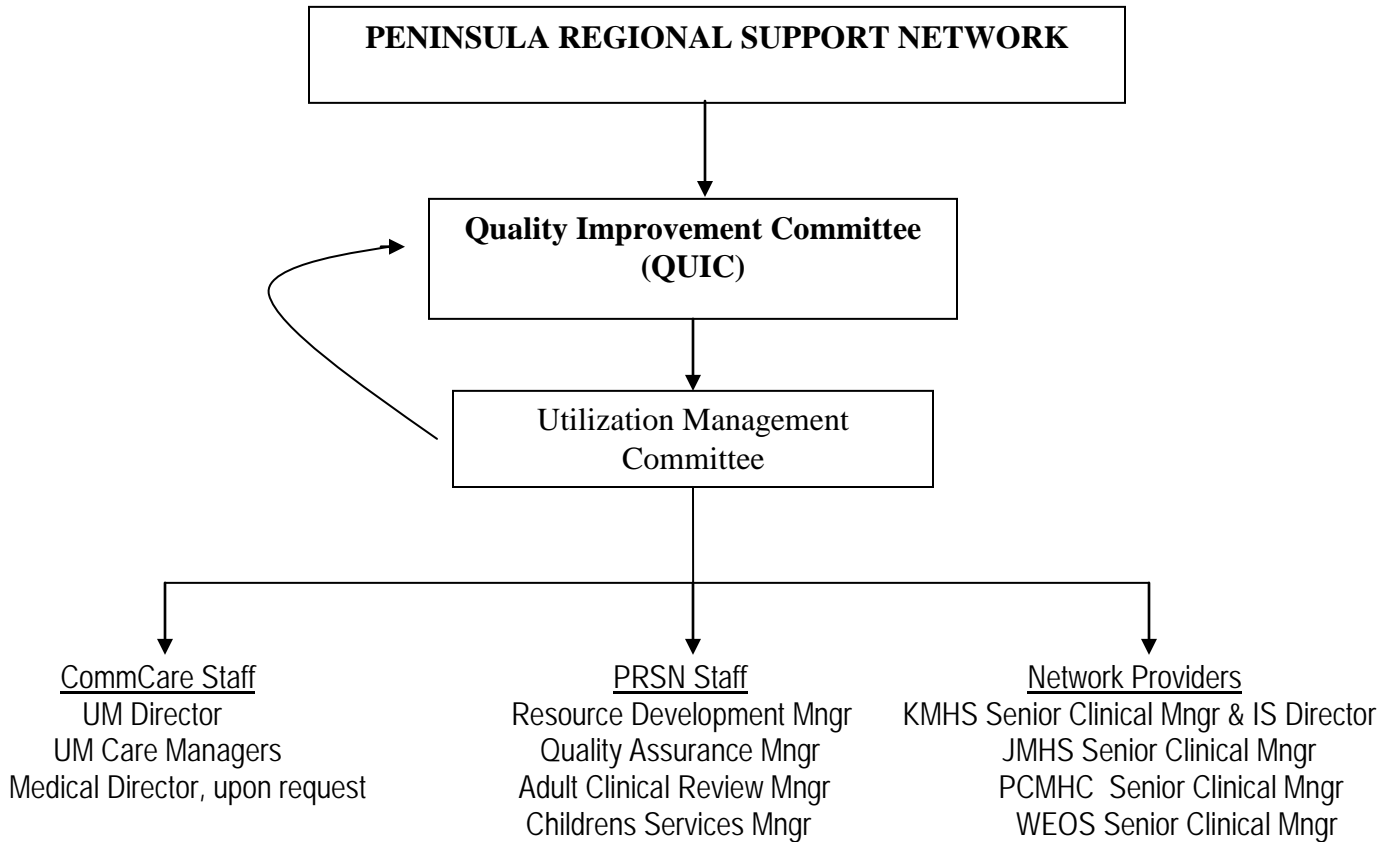
The plan evaluation includes:

1. Identification of activities to be included in the subsequent year's Utilization Management Program.
2. Identification of any barriers to implementing the Utilization Management Program.
3. Recommended changes or additions to the criteria for monitoring over or under utilization project.
4. Recommended changes in the PRSN infrastructure, as needed, to accomplish the goals of the UM Plan.
5. Identification of opportunities for improvement through the provision of on-site technical assistance or training.
6. Updating information within the plan that accurately reflect the monitoring and oversight activities.

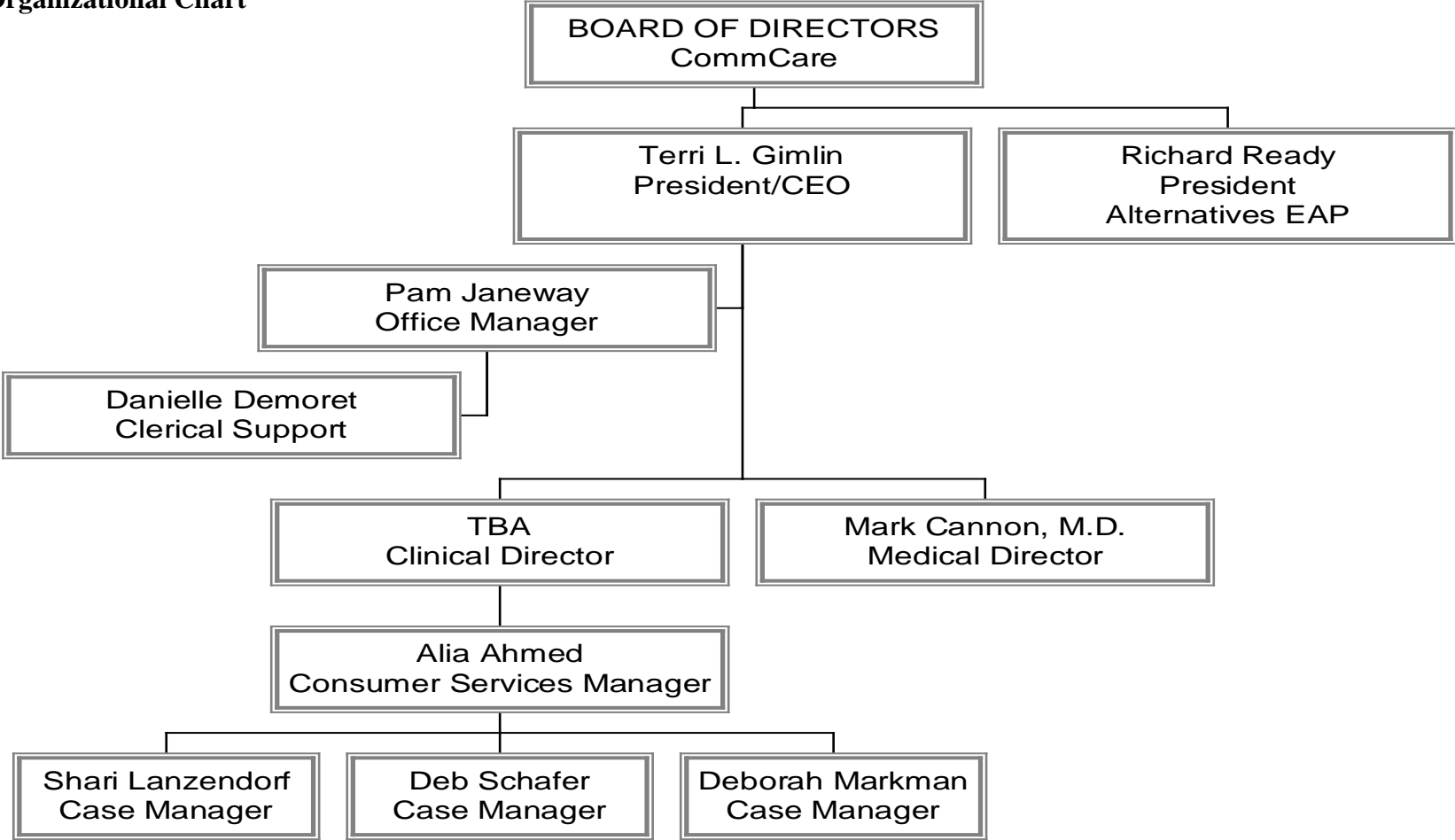
The written summary of the evaluation is prepared by the PRSN staff, in conjunction with UM Committee, and presented to the QUIC for review and approval.

The annual UM Program evaluation is the basis for the development and focus of the upcoming fiscal year's established priorities.

# PRSN Utilization Management & Clinical Directors Committee Organizational Chart



**PENINSULA REGIONAL SUPPORT NETWORK  
Contracted Authorization and Utilization Management  
CommCare Organizational Chart**



Credentials for CommCare Staff

- TBA – Clinical Director
- Alia Ahmed, LSCSW
- Shari Lanzendorf, LCSW
- Deb Schafer, LCSW
- Deborah Markman, RN