The Georgia Collaborative ASO

DeKalb Community Service Board

Behavioral Health Quality Review Final Assessment

Address: **445 Winn Way, 4th Floor, Decatur, GA 30030**	
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Individual Records Reviewed: **30**	Current Review Frequency: **Semi-Annual**
Staff Records Reviewed: **5**	Date Range of Review: **1/6/2025 - 1/9/2025**

The Georgia Collaborative ASO, in partnership with the Department of Behavioral Health and Developmental Disabilities (DBHDD), believes in accessible, high-quality care that leads to a life of recovery and independence. The provider should note any recommendations and reminders of DBHDD requirements as opportunities for quality improvement activities. The review is intended to measure the quality of your organization's systems and practices in adherence to DBHDD policies and standards. The Overall Score is calculated by averaging the categories below.

	Overall Score	Billing Validation	Focused Outcome Areas	Assessment & Planning	Service Guidelines
Review Date: 07/15/2024	93%	79%	98%	96%	97%
Review Date: 01/22/2024	93%	86%	97%	92%	97%
FY24 Statewide Average	87%	75%	93%	89%	92%

Note: The FY24 Statewide Averages represent the mean of scores for all reviewed providers.

Summary of Significant Review Findings

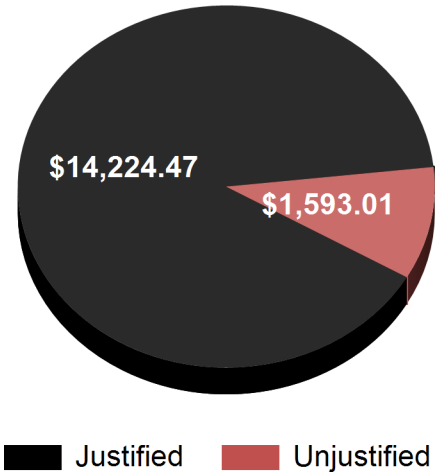
Strengths and Improvements:

- Individual recovery/resiliency plans (IRPs) contained a variety of evidenced-based treatment modalities including cognitive behavioral therapy (CBT), dialectical behavior therapy (DBT), motivational interviewing (MI), supportive therapy, insight oriented, psychoeducation, solution-focused therapy, and mindfulness techniques.
- Assessments listed a variety of health approaches to inform individuals of alternatives (i.e., probiotics, prebiotics, yoga, meditation, mindfulness, tai chi, progressive muscle relaxation, art/music/dance therapy, palates, reiki, homeopathy).
- Crisis and safety plans provided individuals with a wealth of resources including the Georgia Peer Support Warm Line; Georgia Crisis and Access Line; 988 and 988lifeline.org for English, Spanish, and deaf/hard-of-hearing/American Sign Language (ASL); myGCAL (Georgia Crisis and Access Line) application; and the Text Crisis Line.

Opportunities for Improvement:

- The following are recurring issues noted in prior Behavioral Health Quality Reviews (BHQRs) in 7/2024 and 1/2024:
  - The transition/discharge plans in 14 records lacked one or more of the three required components.
  - The records of eight individuals assessed to be at high or moderate risk for suicide lacked evidence of ongoing assessment and follow-up, as required by DBHDD policy.
  - Minimum monthly contacts of at least two per month were not met per DBHDD guidelines for services where this is required.
- Whole health and wellness goals, objectives, and interventions were duplicated across records.

Billing Validation



	Medicaid	State Funded Services	Total
Justified	$3,421.08	$10,803.39	$14,224.47
Unjustified	$140.34	$1,452.67	$1,593.01
Total	$3,561.42	$12,256.06	$15,817.48

The Billing Validation Score is the percentage of justified billed units vs. paid/billed units for the reviewed claims. Paid dollars are calculated based on payer: Medicaid is the sum of paid claims; State Funded Services are Fee for Service and State Funded Encounters combined (State Funded Encounters is the estimated sum of the value of accepted encounters).

Standard	Reason	# Discrepancies
Eligibility Standards	Missing/incomplete service order	1
Performance Standards	Multiple services billed at same time	3
	Mutually exclusive services billed	3
	Content does not support units billed	2
	Content does not support code billed	1
	Content of documentation is not unique	1
	Minimum contacts not met per DBHDD Service Guidelines	1
	No overall progress documented	1
	Non-billable activity billed	1
Quantitative Standards	Staff credential not supported by documentation	12
	Billing code is missing or different from code billed	3

Billing Validation: 90%

Strengths and Improvements:

- All individuals had a valid, verified diagnosis on the date services were provided.

Opportunities for Improvement:

Eligibility Standards

- Within one record, the order for service (OFS) expired on 10/2/2024. Psychiatric Treatment was provided on 11/12/2024 without an OFS. This is a reoccurring issue from the previous BHQR in 7/2024.

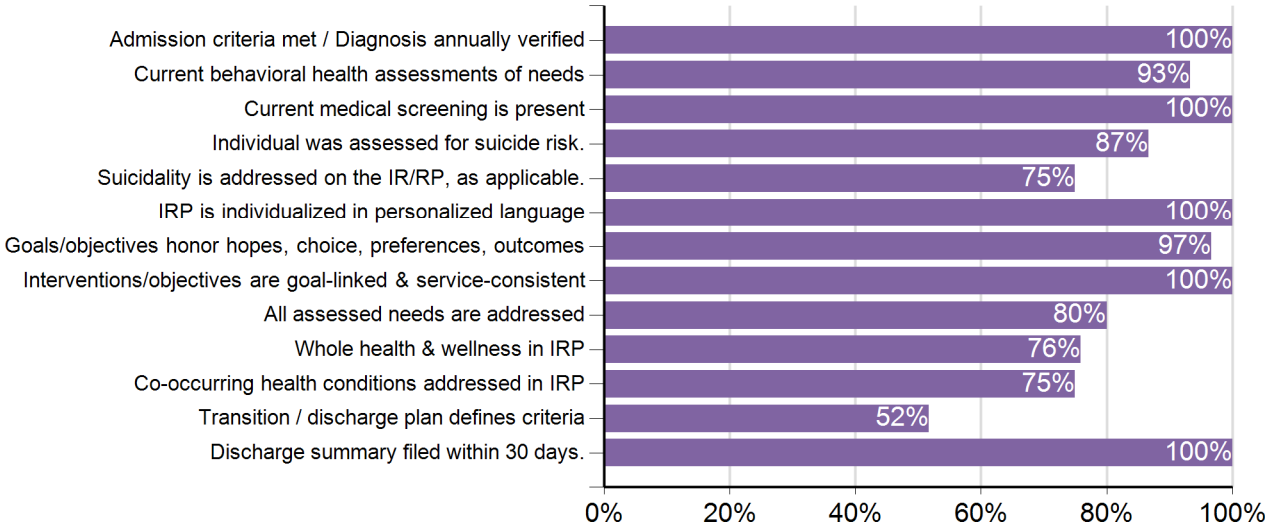
Performance Standards

- Within one record, multiple services were billed at the same time. Documentation evidenced that the individual attended the Mental Health (MH) Peer Support Program from 9:00 am-2:30 pm on 11/14/24; however, Case Management (CM) was billed from 12:00 pm-12:10 pm (out-of-clinic) and Psychosocial Rehabilitation-Individual (PSR-I) was billed (out-of-clinic) from 12:10-12:45 pm on the same day.
- Within three records, Medication Administration and Nursing Assessment and Health Services were billed for the same date of service, which is a service exclusion.
- The content of two Group Skills Training progress notes did not support the units billed. This is a recurring issue noted in the prior three BHQRs (7/2024, 1/2024, 7/2023).
    - The content of one note specified that the group took place from 1:45 to 2:30 pm; however, four units were billed. If services were provided the full time, only three units would be possible or justified.
    - Documentation within another progress note specified that the group took place from 11:00 am-12:00 pm; however, eight units were billed. Given the one-hour documented, only four of the billed eight units would have been possible. Additionally, no overall progress was documented within the note.
- Overall progress toward goals and objectives was not documented for CM within one individual's record.
- The content in one CM progress note reviewed did not support the code billed. This is a recurring issue noted in the prior three BHQRs (7/2024, 1/2024, 7/2023). The UK (ancillary contact) modifier was utilized for a face-to-face session with the individual.
- The content of documentation was not unique in one MH Peer Program progress note reviewed. The progress note was written for another individual (referencing a male individual throughout the note) when the identified individual was female.
- One claim for CM was not justified because the minimum contacts were not met per DBHDD Service Guidelines. This is a recurring issue noted in the prior three BHQRs (7/2024, 1/2024, 7/2023).
- A non-billable activity (attempting to contact the individual) was billed for one Individual Counseling progress note reviewed. This is a recurring issue noted in the prior three BHQRs (7/2024, 1/2024, 7/2023).

Quantitative Standards

- Twelve claims were not justified because the staff credential was not supported by documentation. This is a recurring issue noted in the prior four BHQRs (7/2024, 1/2024, 7/2023, 1/2023). A staff member was lacking the following minimum standard training requirements:
    - Pharmacology/Medication Self Administration (two hours required); however, .5 hours were not completed.
    - Safety/Crisis De-escalation (four hours required): however, one hour was not completed.
    - Agency-based Safety/Crisis De-escalation training hours were not completed.
    - First Aid certification was not completed.
    - Cardiopulmonary resuscitation (CPR) certification expired on 9/1/2024.
    - Additionally, the date of hire was 9/12/2022; however the criminal background check was not completed until 10/27/2023.
- Within one record, the billing code for Individual Counseling was not documented on three progress note in the sample.

Assessment and Planning



When all responses to a question are "Not Applicable", no percentage is displayed.

Assessment and Planning: 87%

Indicators scoring below 80%

	Yes	No	NA	%
Suicidality is addressed on the IR/RP, as applicable.	15	5	10	75%
Whole health & wellness in IRP	22	7	1	76%
Co-occurring health conditions addressed in IRP	15	5	10	75%
Transition / discharge plan defines criteria	15	14	1	52%

Assessment and Planning

Strengths and Improvements:

- IRP goals were individualized in personalized language. This was a continued strength for the provider. Examples included,
  - "I want to stop using Percocet."
  - "I want to be able to pass all the requirements to get off probation."
  - "I want to eat healthy and exercise."
- IRPs contained detailed perceptions of what individuals identified as their strengths, needs, abilities, and preferences (SNAPS). Examples included,
  - "I am very artsy, friendly, and courteous. I am an empath."
  - "I want to get back to where I was financially and mentally before I came to treatment."
  - "I'm a good communicator. I was very reliable at my previous jobs."
  - "I want to have medication management and therapy."

Opportunities for Improvement:

- Five of 20 applicable records did not address suicidality on the individual's IRP. Examples included,
  - One individual's suicide attempt and hospitalization occurring in 9/2024 was not addressed on the updated IRP in 10/2024.
  - An individual's Columbia Suicide Severity Rating Scale (C-SSRS) dated 10/7/2024, endorsed a history of suicidal ideation (SI) within the past month; however, this was not addressed on the individual's IRP.
  - Another individual, who was receiving Community Transition Planning (CTP) while incarcerated, was not assessed for suicide risk using the appropriate version of the C-SSRS.
- Whole health and wellness goals, objectives, and interventions were duplicated across seven of 29 records. An example included, *"Goal: Client will identify two health/wellness goals and implement at least one. Objective: Client will identify and practice at least three lifestyle changes to support recovery including diet, exercise and meditation. Intervention: CBT, MI and psychoeducation on lifestyle changes to support recovery and wellness."* Documentation did not support how these goals/objectives, and interventions were specific/unique to the individuals' needs.
- Co-occurring health conditions were not addressed within five IRPs. Medical issues such as chronic asthma, chronic back pain, hydrocephalus, and myasthenia gravis disorder were not addressed.
- The transition/discharge plan lacked one or more of the three required components in 14 records. This is a recurring issue noted in the prior three BHQRs (7/2024, 1/2024, 7/2023). Examples included:
  - *"[Individual] will transition to 'Non-intensive Outpatient Services (NIOP)' when client has maintained/reported improvement in mood and behaviors for 6 out of 12 months."* (Lacks a clinical benchmark)
  - *"Will transition to NIOP when client has gained confidence and resilience for 4 out of 7 days."* (Lacks a clinical benchmark, target date, and service)
  - *"[Individual] will transition to PSR-I services when client has maintained stability in symptoms of schizoaffective disorder for 12 consecutive months."* (Lacks a clinical benchmark)

Focused Outcome Areas

Focused Outcome Areas: 95%				*Indicators scoring below 80%*
Safety - 89%	**Yes**	**No**	**NA**	**%**
When an individual has been assessed to be at high or moderate risk for suicide (within the past six months), there is documented evidence of ongoing assessment, as required by DBHDD policy.	5	8	17	38%
Documentation supports that clinically-appropriate actions or steps were taken and linkages/referrals were made if the individual has been assessed to be at risk for suicide (within the past six months).	11	3	16	79%

Focused Outcome Areas

Strengths and Improvements:

- The following are continued strengths from the previous review in 7/2024:
  - Records contained documentation of communication with external referral sources and providers to obtain results of testing, treatment, and follow-up.
  - Safety/crisis plans that directed, in advance, the individual's desires/wishes/plans/objectives in the event of a crisis were developed in all records reviewed.
  - When barriers were identified, documentation demonstrated that alternatives were explored. Examples included:
    - A staff member tailored their approach to ensure an individual with autism and mild intellectual disability understood the interventions being utilized.
    - Another individual wanting to acquire their own transportation was assisted in obtaining a driver's license.

Opportunities for Improvement:

Safety

- In eight applicable records, the individual was assessed to be at high or moderate risk for suicide (within the past six months) yet there was no documented evidence of ongoing assessment, as required by DBHDD policy. This is a recurring issue noted in the prior three BHQRs (7/2024, 1/2024, 7/2023).
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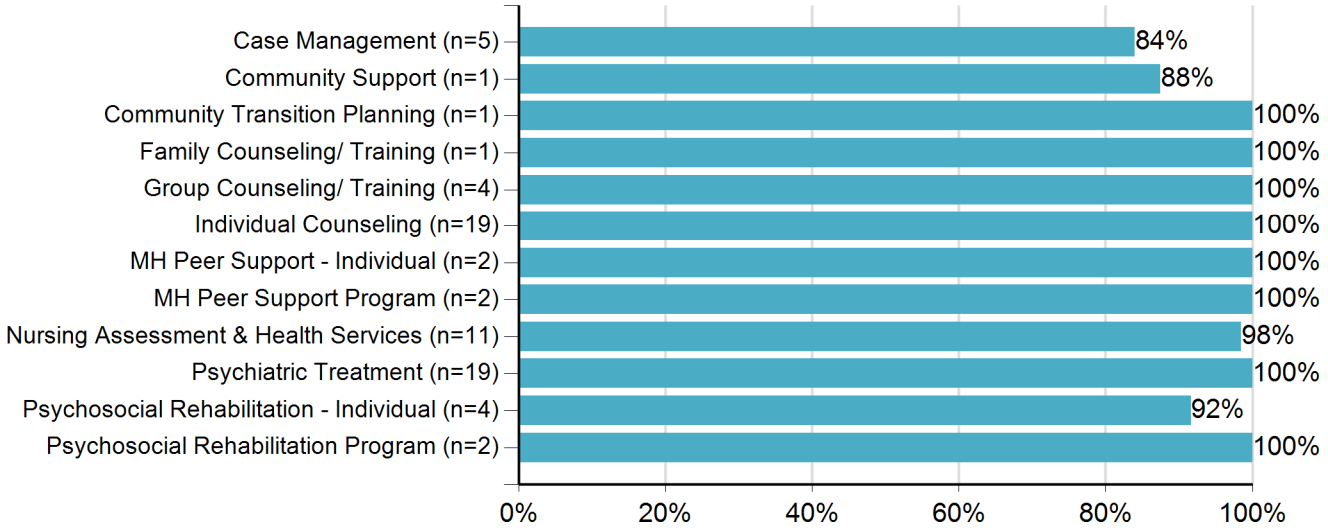
  - A C-SSRS was completed with an individual on 10/9/2024 who endorsed SI in their lifetime and in the past month with *"general thoughts of not wanting to be here 1-2xs per week - thinking of killing self, but without intent or plan."* Additionally, a Psychiatric Treatment progress note from 10/24/2024 noted that the individual had passive SI last week (without a plan or intent), but lasted all evening. There was no evidence of monitoring for SI on the two dates of service following the C-SSRS assessment and Psychiatric Treatment encounter (10/17/2024, 10/24/2024).
  - An individual who was hospitalized for reporting SI (7/2024) and had attempted overdose was not re-assessed at each visit, as required by DBHDD policy.
  - Another individual had an extensive history of SI and multiple suicide attempts. While C-SSRS Since Last Visit (SLV) assessments were completed at most contacts, they were not completed at every contact (per policy). The individual was seen by their counselor; however, a C-SSRS SLV was not completed during the sessions dated: 8/16/2024, 9/3/2024, 9/9/2024, 11/15/2024, and 12/9/2024.
- Documentation in three records did not support that clinically appropriate actions or steps were taken and linkages/referrals were made based on the individual's assessed risk for suicide. For all three individuals, documentation did not reflect discussion around safety planning, SI thoughts, deterrents, etc. For example, one individual, with a long history of behavioral health services (to include multiple inpatient hospitalizations), was assessed to be at high risk for suicide yet there was a lack of documented attempts at engagement in services, follow-up when the individual failed appointments, outreach, or referral to services appropriate to meet her significant needs and risks. When the individual notified the provider that she would be moving to another city in the state, there was no evidence in the record of referral to or service coordination with the provider(s) in that area.

Service Guidelines



n = the sample size (records) reviewed specific to the service

Service Guidelines: 97%				*Indicators scoring below 80%*
Case Management - 84%	**Yes**	**No**	**NA**	**%**
There are a minimum of two (2) contacts per month, with at least one (1) face-to-face in a non-clinic setting. (Review authorization period.)	3	2	0	60%
If the individual has been incarcerated, hospitalized, or experienced an episode of homelessness, the Case Manager is involved with the transition/discharge. (Review authorization period. Answer N/A if not applicable.)	0	1	4	0%
Community Support - 88%	**Yes**	**No**	**NA**	**%**
Staff are meeting the monthly minimum requirement of two (2) contacts per month. (Review authorization period.)	0	1	0	0%
Psychosocial Rehabilitation - Individual - 92%	**Yes**	**No**	**NA**	**%**
There is a minimum of two (2) contacts each month and one (1) is face-to-face. (Review authorization period.)	2	2	0	50%

Service Guidelines

Strengths and Improvements:

- Individual Counseling progress notes evidenced that the provider addressed specific goals defined by the individual and specified in the treatment plan. Examples included:
  - A counselor explored an individual's feelings on how to manage stressors such as, being in trouble at work, physical health issues, and the relationship with their child's father.
  - One record evidenced an individual counselor utilizing "Seeking Safety", an evidenced-based curriculum to address the individual's trauma and substance use.
- Documentation within the one record reviewed for Community Support evidenced service and resource coordination. This was a continued strength for the provider. Services included collaboration with outside providers, as well as the parent, to assist with completing an application to a residential program for the individual.

Opportunities for Improvement:

Case Management (CM)

- Two records lacked a minimum of two contacts per month. This is a recurring issue note in the previous three BHQRs (7/2024, 1/2024, 7/2023).
- Documentation did not support that the case manager was involved with the transition/discharge of an individual who was hospitalized. The individual was hospitalized in 9/2024 for a suicide attempt via overdose; however, there was no evidence of the case manager being involved in the individual's discharge from the hospital or an adjustment of her services to support her in the community. Further, her assessed trauma was not planned to be addressed.

Community Support (CS)

- The one record reviewed lacked a minimum of two contacts per month. There were no contacts documented during the month of June 2024.

Psychosocial Rehabilitation-Individual (PSR-I)

- Two records lacked a minimum of two contacts per month. This is a recurring issue note in the previous three BHQRs (7/2024, 1/2024, 7/2023).

Overall Programmatic

The Programmatic standards below, relevant to services reviewed during this BHQR, are not currently calculated into any scored area of the review; however, the provider will be reminded of the requirements and recommendations will be made based upon the findings.

Provider-Level Indicators				
1	Where applicable, all services are provided at approved Medicaid sites.			Yes
2	On-site nurse is present 10 hours/week.			Yes
3	Staff safety and protection policies/procedures are present.			Yes
4	Quality Assurance Plan includes assuring/monitoring quality of services for individuals at risk for suicide.			Yes
5	The provider employs an ASL-fluent practitioner.			N/A
6	The provider has policies and procedures for providing reasonable accommodations to individuals who are deaf/hard of hearing.			Yes
7	The provider had obtained the appropriate DBHDD-approved criminal records background check on all reviewed staff members by their hire date.			No
	# Yes	**# No**	**# N/A**	**SCORE***
	5	**1**	**1**	**83%**

** Overall Programmatic Score is not calculated into the Overall score at this time.*

Additional Comments on Practices

Additional strengths and concerns beyond the general scope of the review were discovered by reviewers. Additional issues/practice concerns may have the potential to impact service delivery, quality of care, or may represent a risk to the provider.

- There was no documentation in one record to support a verified diagnosis. A document was scanned into the electronic medical record (EMR) late in the afternoon on the first day of the review which was past the timeframe for submission of records. The provider was reminded that medical records must be uploaded within the specified two-hour timeframe, as outlined on page 49 of the Quality Management chapter of the Georgia Collaborative ASO Provider Handbook.
- One 23-year-old adult individual's IRP listed "youth peer" objectives and interventions and "Youth Peer Support - Individual" listed in the services on her IRP. The rest of her planned services were appropriate to her age. It was difficult to determine what information contained within assessments, interpretive summaries, and C-SSRS tools was historical versus current when dates were not specified.
- Psychiatric Treatment progress notes contained documentation that the practitioner spoke to an individual about drug use during pregnancy (individual was a cisgender male). In addition, it was documented that the individual was educated on the risk of death from opioid use, but the individual had no documented history of substance use. The staff member seemed to have been using a template. Similar documentation was seen across records, but appeared to be staff specific.
- While the goals regarding suicidality were slightly different, the objectives and interventions were duplicated across records. While interventions regarding assessment and monitoring may be similar, it is expected that there would be differences within objectives, such as personalized actions the individual could take, how they experience suicidal ideation, how their particular support system could be involved, etc.
- The files of five staff members were reviewed for credentialing requirements. Four of the five staff members did not have criminal history background checks from DBHDD on or prior to their date of hire. This issue was noted in the two previous reviews (7/2024, 1/2024).

Individual Interviews

Each individual is asked a standard set of questions; a sampling of responses is listed below. Individual interviews are not calculated into the Overall score. For a complete list of questions, please refer to the Georgia Collaborative's website.

Individual Interviews Conducted: 5

- Individuals/guardians indicated options for supports and services were offered. Comments included:
  - "The program offers a variety of recovery related services. I feel like I am getting all that I need from the program."
  - "Right now they are helping me find a job. I was referred to supportive employment."
- Individuals/guardians shared they have been supported in moving toward their personal goals and dreams. Individuals stated:
  - "My daughter is doing a lot better."
  - "I see a difference since being prescribed medications."
- Individuals felt supported to achieve their desired level of involvement in the community. One individual shared:
  - "I was homeless at one point and their program has gotten me back on the right path."
  - "They helped me get my food stamps back after they got cut off."
- When asked, "What about this agency makes you keep coming back?", individuals shared:
  - "They involve your peers in your progress, and it has helped me become confident in what I need to do."
  - "My daughter has had a lot of anxiety and she has made so much progress. There was a time when she would not get out of the car to go into school and now she has no problem going in."
  - "There is a lot of skill practice to move you ahead and prepare you for when you leave."
  - "They really help prepare you for a lifestyle to get a handle on your addiction. "
  - "The support, the consistency, help, and hope. They find me resources to help me out. I don't have the luxury of having friends and family I can ask for help."
- Two individuals expressed a concern about an issue with accessing appointments, provider staff, and other agency supports in a timely manner.
  - "They don't answer the phone when I call so it's hard to get an appointment when I call."
  - "I have been trying to get in touch with them to reschedule a doctor's appointment and haven't heard from anyone yet."

Quality Improvement Requirements

Providers are reminded of the responsibility to maintain internal processes which ensure immediate and permanent corrective actions on issues identified during the quality review process. DBHDD may request corrective action plans (CAPs) as quality review findings warrant as well as review agencies' internal documentation regarding corrective actions and ongoing quality assurance and quality improvement. Please refer to the comments documented in each section above for specific information pertaining to the requirements below.

Requirements: Current and Prior Review

Provider Level - Overall Programmatic

- DBHDD-approved criminal record background checks must be obtained on all employees, members of staff, and/or contractors prior to their having any contact with individuals served.
- Paraprofessional (PP) and supervisee/trainee (S/T) staff members must complete the Standard Training Requirements (STR) within their first 90 days of employment (or prior to further contact with individuals when this standard has not been met).

Billing Validation

- Eligibility standards must be met for all submitted claims.
- Quantitative documentation standards must be met for all submitted claims.
- Performance documentation standards must be met for all submitted claims.

Assessment and Planning

- Transition/discharge plans must define criteria for discharge to include clinical benchmark(s), planned discharge date, and specific services for ongoing support.

Focused Outcome Areas - Safety

- There must be documented evidence of ongoing assessment when an individual has been assessed to be at risk for suicide.

Compliance with Service Guidelines - All Services

- Minimum required contacts must be met for all services (as required).

Requirements: Current Review

Provider Level - Overall Programmatic

- All employees and/or contractors must receive First Aid training and certification within their first 90 days of employment (or prior to further contact with individuals when this standard has not been met).
- All employees and/or contractors must have, and maintain, current certification in cardiopulmonary resuscitation (CPR).

Assessment and Planning

- Suicidality must be addressed on the IR/RP when the individual is assessed as having any suicide risk.
- Treatment/recovery/service plans must contain goals, objectives, and interventions that promote whole health and wellness of the individual.
- Treatment/recovery/service plans must address co-occurring health conditions and concerns.

Focused Outcome Areas - Safety

- Documentation must support that clinically-appropriate actions or steps were taken and linkages or referrals were made based upon the findings/outcome of suicide risk assessment.

Compliance with Service Guidelines - Additional Requirements

- Individuals that have been incarcerated, hospitalized, or experienced an episode of homelessness, the case manager must be involved with the transition/discharge.

Providers have the opportunity to appeal review findings for up to ten (10) business days following notification that their written Final Assessment has been saved to the Collaborative's website. For appeals procedures and submission requirements, access the Georgia Collaborative's website to review the appeals process in the Quality Management section of the Provider Handbook and for a current version of the Review Appeal Form at this link: https://www.georgiacollaborative.com/providers/behavioral-health-providers/