The Georgia Collaborative ASO

# Douglas Community Service Board

| Behavioral Health Quality Review Final Assessment | |
|---|---|
| **Address:** Remote Quality Review: 5905 Stewart Parkway Douglasville, GA 30135 | |
| **Assessors:** John Dury, LPC, LMFT, MAC; Kristen Ponce, MFT; Sydney Arthur, LPC; Amanda Hawes, LCSW | |
| **Records Reviewed:** 30 | **Date Range of Review:** 2/22/2021 - 2/25/2021 |

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 as an opportunity 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: 03/03/2020 | 66% | 57% | 80% | 70% | 79% |
| Review Date: 03/04/2019 | 70% | 53% | 76% | 70% | 80% |
| FY20 Statewide Average | 84%* | 76% | 93% | 88% | 90% |

*For reviews conducted July 1, 2019 through June 30, 2020, Quality Risk Items (where identified) were deducted from the Overall Score. Additionally, in response to the COVID-19 pandemic, Quality Reviews were postponed between March 16 through June 30, 2020. Therefore, caution should be made when comparing scores to this time period.

# Summary of Significant Review Findings

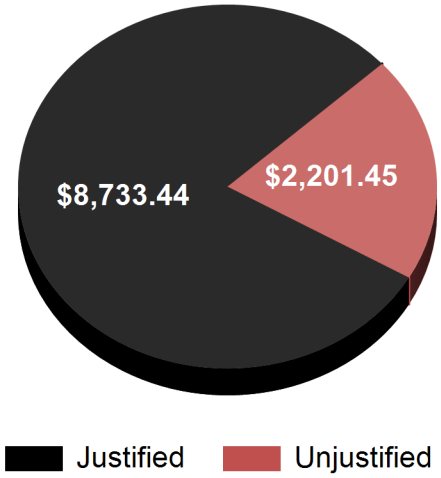
**Strengths and Improvements:**

- Due to the COVID-19 pandemic, this review was conducted remotely instead of on-site.
- The provider's policy entitled "Douglas County Health and Safety Training Program" highlights the importance of personal protective equipment (PPE) and its proper use during the pandemic.
- The provider's Overall Score improved from 66% in the last Behavioral Health Quality Review (BHQR) held in March of 2020 to 88% for this review.
- The provider has a documented Quality Assurance Plan that includes the monitoring of the quality of services for individuals who are at risk for suicide, which is an improvement over the previous BHQR in which the required policy was missing.

**Opportunities for Improvement:**

- Please see Focused Outcomes Area section for more information on the following:
  - Almost all (29 of 30) records did not contain documentation of medication consent.
  - There was no evidence of ongoing assessment when an individual was assessed to be at risk for suicide in eight of nine applicable records.
    - Additionally, seven of these records did not reflect that clinically-appropriate actions or steps that were taken and linkages or referrals were made based upon the findings/outcome of suicide risk assessments.
  - Eleven of 24 applicable records did not contain lab work when required for specific medications or Abnormal Involuntary Movement Scales (AIMS) when the individual was prescribed medications known to have substantial or undesirable side effects.
- Please see the Billing Validation section for more information on the following:
  - Claims for Psychiatric Treatment were billed with incorrect code based on time in/out documented on corresponding notes.
  - One record did not have a current IRP.
  - There were three progress notes not filed within the required seven-day timeframe.
- Please see the Compliance with Service Guidelines section for more information on the following:
  - Monthly minimum contacts were not met in records with Case Management (CM) and Psychosocial Rehabilitation-Individual (PSR-I) services.

# Billing Validation




| | Medicaid | State Funded Services | Total |
|---|---|---|---|
| Justified | $4,187.72 | $4,545.72 | $8,733.44 |
| Unjustified | $1,281.84 | $919.61 | $2,201.45 |
| Total | $5,469.56 | $5,465.33 | $10,934.89 |

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 | # of Discrepancies |
|---|---|---|
| Eligibility Standards | Missing/incomplete service order | 3 |
| Performance Standards | Content does not support code billed | 6 |
| | Intervention unrelated to IRP w/o clinical justification | 5 |
| | Minimum contacts not met per DBHDD Service Guidelines | 5 |
| | Content does not support units billed | 2 |
| | Mutually exclusive services billed | 1 |
| Quantitative Standards | Progress note not filed within seven calendar days | 3 |

# Billing Validation: 80%

## Strengths and Improvements:

- The provider's Billing Validation score improved from 57% in the previous Behavioral Health Quality Review (BHQR) in March 2020 to 80% for this review.
- All progress notes included the specific out-of-clinic location as required which is an improvement over the previous BHQR.
- Fewer records contained expired IRPs, which is an improvement over the previous review. For example, only one record with five claims (see billing details below) were impacted by this issue for this review, whereas sixteen (16) claims were impacted by this issue in the previous BHQR.

## Opportunities for Improvement:

### Eligibility Standards

- Three (3) claims were unjustified due to lacking an order for service on or before the date the service was provided. In this case, the record contained an IRP that was not signed by a qualified practitioner until 11/23/2020, and the stand-alone order for service (OFS) was not signed until 11/30/2020, yet the services began on 10/20/2020.

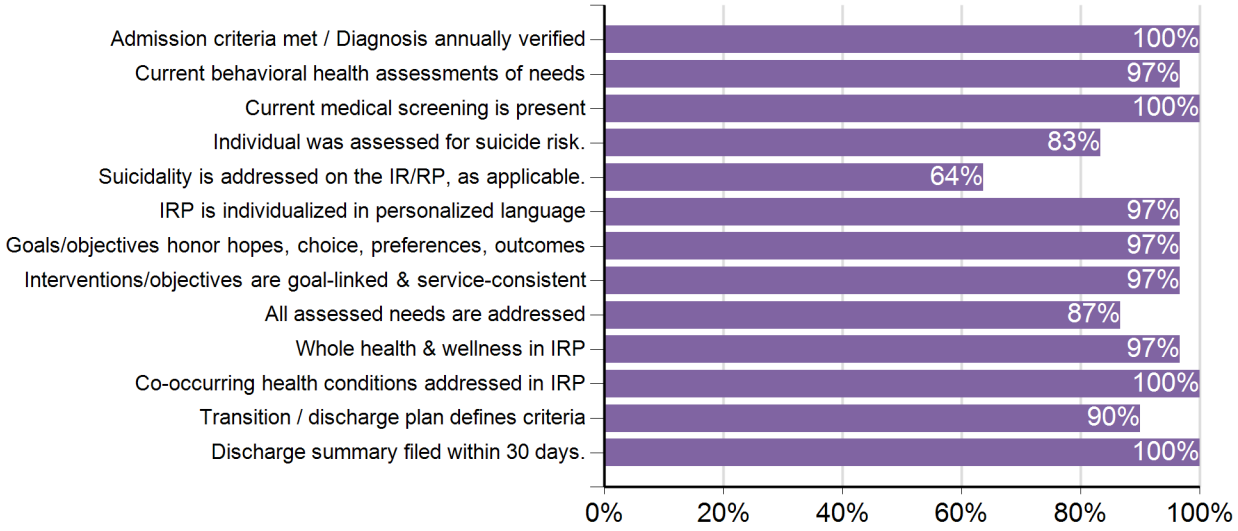
### Performance Standards

- Six (6) progress notes had content that did not support the code billed. Claims for psychiatric services were billed with codes that did not correspond with documented time in/out on note or services for telehealth were billed as out-of-clinic.
- Five (5) progress notes contained interventions that were unrelated to the IRP without clinical justification. In this case, the record was missing a current IRP. The previous IRP had expired on 12/19/2019 and had claims beyond the expiration date. This is a recurring issue from the previous review.
- Five (5) progress notes were unjustified due to missing the minimum number of contacts required per the DBHDD Service Guidelines. For example, in one record the provider billed the code H2017HEU4U7 on 10/30/2020, and there were no other documented PSR-I contacts in the month of October 2020, as required to meet the minimum standard of two contacts per month. This is also a recurring issue.
- Two (2) progress notes had content that did not support the units billed. In one case, the provider billed the code 99213GTU2 and provided a refill for medication, but the content of the note did not justify the 20-29 minutes billed. The documentation indicated that the individual was not available for an appointment and needed to be rescheduled.
- One claim was unjustified for Nursing Assessment & Health Services due to mutually exclusive services that were billed. In this case, the provider billed both Nursing Assessment and Medication Administration on the same day, which are mutually exclusive services.

### Quantitative Standards

- Three (3) progress notes were not filed within the required seven-day time frame. For example, one note for PSR-I dated 10/16/2020 was not signed until 10/25/2020, nine days after the date of service.

# Assessment & Planning




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

## Assessment & Planning: 94%

### Strengths and Improvements:

- The provider's Assessment and Planning score improved from 83% in the previous BHQR to 90% for this review.
- All thirty records reviewed contained an annually-updated verified diagnosis by a qualified practitioner and an updated medical screening. This remains a strength for the provider.
- IRPs were consistently individualized and written in personalized language. For example, one IRP for a 57-year-old diagnosed with Posttraumatic Stress Disorder and Alcohol Use Disorder indicated, "I hope to have some sense of normal, where I don't get depressed anymore and can come to terms with my son's loss. I want to complete Drug Court and get off Probation. I want to stay sober."

### Opportunities for Improvement:

- Four (36%) of the eleven applicable IRPs reviewed did not include goals, objectives, and/or interventions to address suicide when the individual was considered to be at risk. For example, an individual who reported two previous suicide attempts was missing goals or objectives to address his suicide risk. In another case, an individual reported two previous attempts and indicated that she had tried to overdose on "a bunch of lithium" and then also attempted to cut her wrist on 6/28/2019, yet the issue was not addressed on her IRP, as required.

# Focused Outcome Areas

# Focused Outcome Areas: 84%

## Strengths and Improvements:

- The provider's Focused Outcome Areas score improved from 80% in the previous BHQR to 84% for this review.
- All (100%) thirty records reviewed contained documentation that the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules (as outlined in 45 {Code of Federal Regulations} CFR Parts 160 and 164) were reviewed with the individual as required. This remains a strength for the provider.
- There was documentation that the individual/guardian had signed formal acknowledgement of rights and responsibilities at the onset of services in 96% of applicable records.
- All (100%) twenty-nine applicable records contained a psychiatric or other advanced directive or documentation that the individual has either denied the existence of a directive or declined to have it in their record.

## Opportunities for Improvement:

**Whole Health**

- Eleven (58%) of 19 applicable records were missing documentation of communication with external referral sources and providers to obtain results of testing, treatment, and follow-up as clinically indicated. For example, an individual who suffered from congestive heart failure was missing documentation of any referrals to an external health care professional. Another example includes an individual who was discharged from a Crisis Stabilization Unit (CSU) prior to their intake appointment with the provider, and there was no documentation to support that a request for or discharge information/paperwork was initiated. This is a recurring issue for the provider from the previous review.
- Eleven (46%) of 24 applicable records were missing documentation of safeguards utilized for medications known to have substantial risk or undesirable effects (lab work, assessments, AIMS, etc.). For example, in one record there were no lab results for an individual prescribed Depakote. In other records, individuals prescribed medications such as Abilify and Invega Sustenna did not have documentation of an AIMS assessment (a minimum every three months for children and adolescents, and every six months for adults). This is also a recurring issue for the provider.

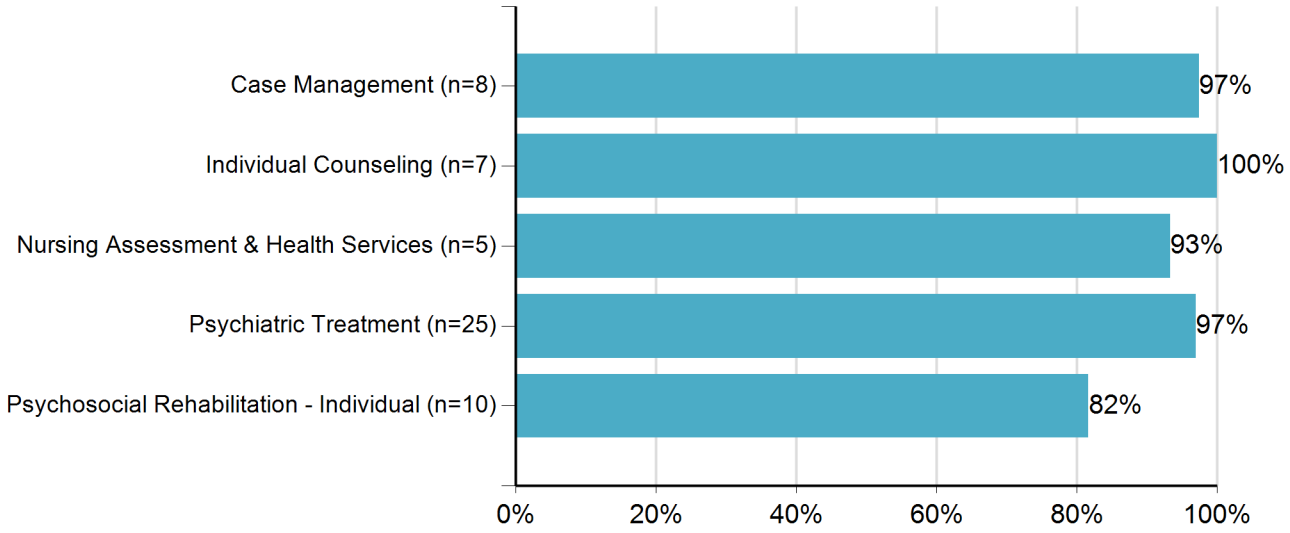
**Safety**

- Seven (78%) of the nine applicable records did not contain documentation of the clinically-appropriate actions or steps that were taken and linkages or referrals that were made based upon the findings/outcome of suicide risk assessments. For example, the record of an individual who was assessed to be at a moderate to high risk for suicide with a history of ideation and attempts was missing clinically-appropriate actions to address her suicide risk. The documentation reflected that the staff were not addressing the potential risk of suicide in the ongoing array of services.
- Eight (89%) of the nine applicable records were missing documentation to support that when an individual has been assessed to be at risk for suicide, there is evidence of ongoing assessment. For example, an individual who was recommended for supportive psychotherapy by the psychiatrist and verbalized her suicidal ideation stating that "life is no longer worth it", was missing evidence that she had received any individual counseling or was engaged with another service or external provider for counseling. In this record, the documentation was missing evidence that one of the required ongoing risk assessments (C-SSRS Since Last Visit, Collaborative Assessment and Management of Suicidality {CAMS}, or Structured Follow-Up and Monitoring Procedure) was conducted for this individual who was at moderate to high risk for suicide.
- Twenty-nine (97%) of the thirty records reviewed were missing documentation that the individual (or legal representative, guardian/parent of a minor), had been educated on the risk/benefits of all prescribed medications. Medications such as Wellbutrin, Invega Sustenna, Paxil, and Klonopin were missing the corresponding medication consents that reflected the discussion of risks and benefits were conducted as required. This is a recurring issue from the previous review.

**Community Life**

- Six (26%) of the 23 applicable records were missing documentation that indicated that services consisted of resource coordination to assist the individuals in gaining access to necessary services to promote recovery/resiliency. For example, an individual who was homeless and living out of her car was missing documentation that supported that she had received any resource coordination for her identified needs of housing, employment, referral to a primary care physician (PCP), and/or an application for Supplemental Security Income (SSI).

# Service Guidelines



# Service Guidelines: 94%

## Strengths and Improvements:

- The provider's Compliance with Service Guidelines score improved from 79% in the previous review to 94% for this review.
- All (100%) eight applicable Case Management records contained joint development of a crisis plan to include the provider and individual, with the provider listed as primarily responsible.
- All (100%) of the Case Management (CM) records contained documented evidence that individuals were assisted in the development of natural supports, as applicable. This is an improvement over the previous BHQR in which all CM records reviewed were missing documentation of the development of natural supports as required.
- All (100%) eight records in CM reflected that the provider had documented needed referrals and linkages to services and resources identified on the IRP. Examples included linking individuals to Medicaid extensions for physician appointments, rental assistance to prevent evictions, securing glasses and dentures, assistance with employment, applications for colleges/financial aid, and contacting Supplemental Security Income (SSI) to inquire if the individual is a candidate for benefits.

## Opportunities for Improvement:

**Case Management**

- Two (25%) of the eight applicable records were missing the minimum number of two (2) contacts per month, as required. Examples include one record in which there were no contacts in August or September of 2020; and another record with only one contact in December 2020, and one contact in January 2021. This is a recurring issue for the provider.

**Psychosocial Rehabilitation-Individual**

- Eight (80%) of the ten applicable records were missing the minimum number of two (2) contacts per month, as required. Examples include one record in which there were no documented PSR-I contacts in August, September, or October of 2020. In another record, only one contact was found for January 2021.

**Nursing Assessment & Health Services**

- Two (40%) of the five records in which this service was provided were missing goals and objectives that were individualized and addressed health issues to include (but not limited to) medical, physical, nutritional, and behavioral needs. For example, in one record the provider documented the service with a generic intervention addressing non-specific "health issues" but did not address the individual's assessed needs related to high cholesterol, diabetes, and asthma.

# 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, Quality Improvement Recommendations are made based on 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 |
| | **# Yes** | **# No** | **# N/A** | **SCORE*** |
| | **5** | **0** | **1** | **100%** |

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

## Additional Comments on Practices

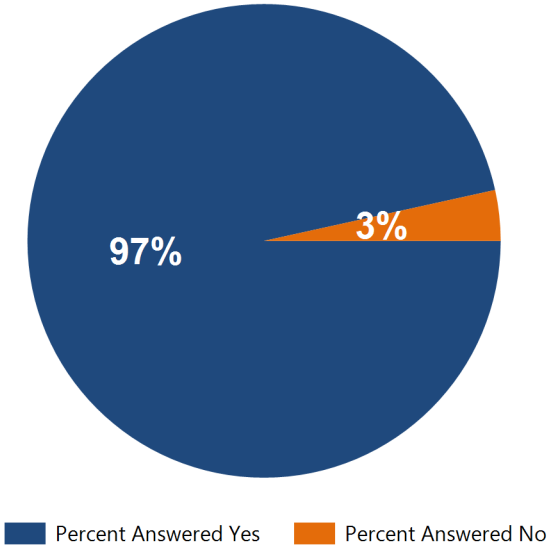
Additional strengths and concerns beyond the general scope of the review were discovered by reviewers. Additional issues/practice concerns may have the potential to impact service delivery, quality of care, or may represent a risk to the provider.

- It was noted that within some records, the provider was relying exclusively upon paraprofessionals (U4 and U5 practitioners) to conduct the entire assessment of needs for individuals and billing Behavioral Health Assessment (H0031) for this service. Per DBHDD Provider Manual: "Practitioner scope of practice is often defined in law and/or regulation. As such, while U4 and U5 practitioners are supporting partners in the assessment process, certain aspects of assessment must be completed by practitioners licensed or certified to do so."
- Although Quality Risk Items (QRI) no longer represent a point deduction from the Overall Score, the following QRIs were noted during this review: Minimum contact requirements were not met in ten records including two records reviewed for Case Management and eight records reviewed for Psychosocial Rehabilitation–Individual.

# Individual Interviews

## Individual Interviews Conducted: 3

*Individual Interviews are not calculated into the Overall Score*




All three individuals interviewed expressed satisfaction regarding the accessibility of appointments, connecting with provider staff, and other supports. A comment included:

- "I have never had any difficulty getting an appointment with my counselor. She has been very responsive to me whenever I call."

All three individuals expressed that they felt supported by Douglas County CSB in moving toward achieving their goals and dreams. A comment included:

- "One of my goals was to learn how to handle my anxiety. I am now able to talk to someone and to keep my mind occupied, instead of worrying excessively."

Regarding what keeps the individuals "coming back" to this provider, comments included:

- "My therapist, I'm very comfortable with her. She gives me a different perspective to look at. She's the best counselor I've ever had."
- "My therapist has been so helpful to me. I appreciate having someone to talk to and how to handle difficult situations that I have faced. She has been wonderful to me."
- "What keeps me coming back is the kindness, the respect, the warm smiles, and just the way that I feel like family and at home when I am there (at Douglas CSB)."

One suggestion for improvement was made:

- "I do feel like I have options for services and think they are what I need. However, since the pandemic started, I haven't received group services, and I really miss them. I felt they were really helpful, and I haven't heard any information on when they plan to resume those."

## Quality Improvement Recommendations

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 recommendations below.

| Recommendations: Current and Prior Review |
|---|
| Billing Validation - Quantitative<br>• Ensure all Quantitative Standards are met in documentation. |
| Billing Validation - Performance Standards<br>• Ensure all Performance Standards are met in documentation. |
| Focused Outcome Areas - Whole Health<br>• Ensure there is documented communication with external referrals and resources to determine the results of testing, treatment, and referral.<br>• Ensure there are documented safeguards utilized for medications known to have substantial risk or undesirable effects. |
| Focused Outcome Areas - Safety<br>• Ensure that individuals (or parent/guardian) have been educated on the risks and benefits of all prescribed medications. |
| Compliance With Service Guidelines - All<br>• Ensure the minimum required contacts are met for all services (as required). |

| Recommendations: Current Review |
|---|
| Billing Validation - Eligibility<br>• Ensure documentation supports that all Eligibility Standards are met. |
| Assessment and Planning<br>• Ensure suicidality is addressed on the IR/RP when the individual is assessed as having any suicide risk. |
| Focused Outcome Areas - Safety<br>• Ensure there is documented evidence of ongoing assessment when an individual has been assessed to be at risk for suicide.<br>• Ensure documentation supports that clinically-appropriate actions or steps were taken and linkages or referrals were made based upon the findings/outcome of suicide risk assessment. |
| Focused Outcome Areas - Community Life<br>• Ensure documentation supports that services consist of resource coordination activities that assist the individual, youth and parent/responsible caregiver in gaining access to necessary services to promote resiliency. |