The Georgia Collaborative ASO

Fulton County Department of BH & DD

Behavioral Health Quality Review Final Assessment

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Individual Records Reviewed: **30**	Current Review Frequency: **Semi-Annual**
Staff Records Reviewed: **3**	Date Range of Review: **1/6/2026 - 1/9/2026**

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.

This is the provider's first Behavioral Health Quality Review.

	Overall Score	Billing Validation	Focused Outcome Areas	Assessment & Planning	Service Guidelines
FY25 Statewide Average	89%	79%	94%	90%	94%

Note: The FY25 Statewide Averages represent the mean of scores for all reviewed providers.

Summary of Significant Review Findings

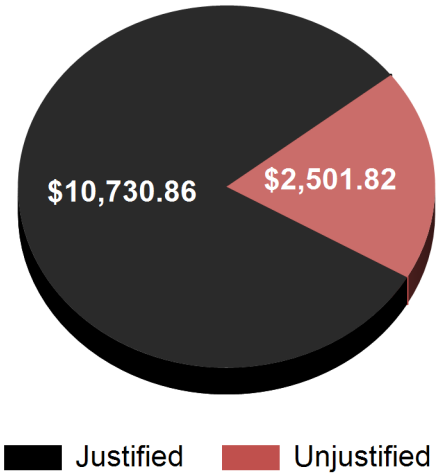
Strengths and Improvements:

- Fulton County Department of Behavioral Health and Development Disabilities (BHDD) contracts services through four independent providers: CHRIS 180, Georgia HOPE, Grady Memorial Health Systems, and River Edge Behavioral Health Center. This was Fulton BHDD's first Behavioral Health Quality Review (BHQR) with the Georgia Collaborative Administrative Services Organization (ASO). Individuals referred to Fulton BHDD are matched with the nearest contracted provider who is able to fulfill their needs.
- One hundred percent of records reviewed documented a current behavioral health assessment of needs, a medical screening, and a suicide screening. Additionally, suicidality was addressed on all applicable individualized recovery plans (IRPs).
- All applicable records reviewed contained a high or moderate suicide risk flag.
- Strengths were noted within the various medical records of the contractors but these were generally unique to the contractor and their electronic medical record (EMR):
    - A treatment plan update note captured the individual's involvement in reviewing and updating (if necessary) the IRP.
    - Assessments included information about the individual's most recent medical, physical, dental, and vision appointments. The contracted provider also completed a separate assessment for the "Social Drivers of Health" that captured the status of the individual's housing, employment, social involvement, etc.
    - One EMR contained a summary tab that was comprehensive and informative for the staff when entering the record.
    - Individual and Family Counseling progress notes documented specific and individualized interventions, responses, plans, and progress, which provided a detailed description of each session as well as an overall snapshot of the individual's services and progress.
    - The Columbia Suicide Severity Rating Scale (C-SSRS) Since Last Visit was embedded in all progress notes of one contractor, ensuring all individuals were monitored for suicide, regardless of risk level.

Opportunities for Improvement:

- Four records lacked a complete and valid service order.
- Twelve progress notes reviewed did not support the units billed.
- One supervisee/trainee (S/T) staff did not meet all credentialing requirements.
- Fourteen transition/discharge plans lacked one or more of the required components.
- None of the applicable records contained a "suicide attempt history" flag.
- The required minimum monthly contacts were not met for Case Management (CM) and Psychosocial Rehabilitation-Individual (PSR-I) services.

Billing Validation



	Medicaid	State Funded Services	Total
Justified	$2,464.85	$8,266.01	$10,730.86
Unjustified	$278.71	$2,223.11	$2,501.82
Total	$2,743.56	$10,489.12	$13,232.68

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	11
Performance Standards	Content does not support units billed	12
	Content of note does not match service definition	7
	Intervention unrelated to the IRP	4
	Multiple services billed at same time	4
	Content of documentation is not unique	3
	Minimum contacts not met per DBHDD Service Guidelines	3
	Intervention provided is outside the scope of practice for staff	2
	No overall progress documented	1
Quantitative Standards	Staff credential not supported by documentation	6
	Progress note not filed within seven calendar days	1

Billing Validation: 81%

Strengths and Improvements:

- All records reviewed contained a valid, verified diagnosis at the time of service delivery.

Opportunities for Improvement:

Eligibility Standards

- Four records lacked an appropriately signed service order, resulting in 11 billing discrepancies. Three orders were not signed by a qualified practitioner to order medical services, and one order did not include CM services.

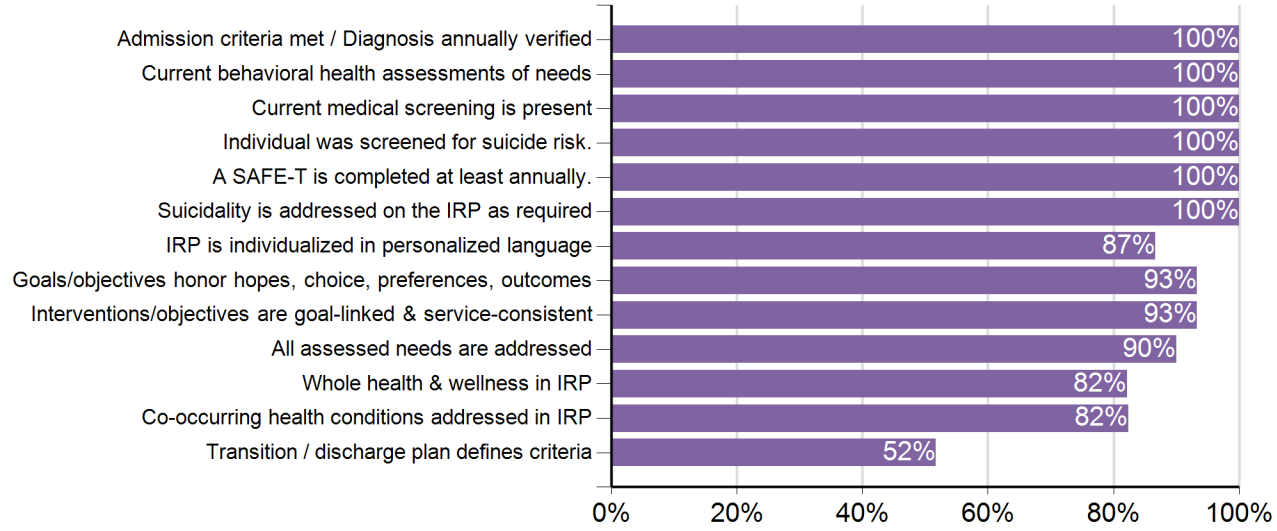
Performance Standards

- The content of 12 progress notes did not support the units billed. Examples included:
  - CM notes were duplicated from day-to-day or only documented check-ins with the individual and without interventions to support the time billed.
  - Group Skills Training notes were also duplicated from day-to-day.
  - One Mental Health (MH) Peer Support - Individual note lacked interventions and responses to justify one hour of service billed.
- The content of seven progress notes did not match the definition for CM. Medical services such as obtaining vitals and completing medical screenings or providing counseling interventions were documented.
- The intervention was unrelated to the IRP in four progress notes due to CM not being listed on two IRPs as a service to be provided.
- Multiple services were billed at the same time, resulting in four discrepancies. Examples included:
  - A progress note for Behavioral Health Assessment (H0031) documented a time in/out as 8:45am to 9:30am on 09/02/2025, and a psychiatric assessment documented a time in/out as 9:20am to 9:40am on the same day.
  - A Service Plan Development (SPD) note noted time in/out as 10:13am to 11:00am on 09/25/2025, while a CM note documented the time in/out as 10:50am to 11:00am on the same day.
- Three CM progress notes contained documentation that was not unique to the individual and session.
- The minimum monthly contacts for CM services were not met in two records, resulting in three discrepancies.
- Due to a certified peer specialist-mental health (CPS-MH) documenting obtaining vital signs, two progress notes were cited for the intervention being out of the scope of practice for peer staff.
- One MH Peer Support - Individual note lacked documentation of overall progress for the individual, as the only information documented was "reviewing the rules of the program."

Quantitative Standards

- One supervisee/trainee (S/T) record lacked required documentation to support their credential, resulting in six discrepancies. The attestation form was missing the following:
  - Supervisee signature
  - Anticipated licensure or exam date
  - Graduation date from the master's program
  - Type of licensure being sought
- One Diagnostic Assessment was filed on 11/25/2025, twelve days after the date of service on 11/13/2025.

Assessment and Planning



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

Assessment and Planning: 90%

Indicators scoring below 80%

	Yes	No	NA	%
Transition / discharge plan defines criteria	15	14	1	52%

Assessment and Planning

Strengths and Improvements:

- The Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) document was embedded in the Carelogic EMR, and already being utilized for some individuals.
- The majority of IRPs were individualized and written in personalized language. Examples included:
  - *"I want to stop using marijuana and alcohol all together."*
  - *"I want to continue learning about my triggers."*
  - *"I need to learn better ways to think when I'm stressed. I have to be here for my son."*
  - *"I would like to continue with my MH medication because when taken consistently I am able to stay balanced."*

Opportunities for Improvement:

- Fourteen records lacked transition/discharge plans that defined all required criteria. Transition plans were not present in the record, did not document specific step-down services, lacked specific clinical benchmarks, and/or were duplicated across records. Examples included:
  - *"[Individual] is new to services . . . Readiness for discharge will be measured by successfully meeting all goals on the treatment plan."*
  - *"When the current level of treatment concludes, it is anticipated that the client will: transition to other services, will be ready for discharge when he is able to communicate feeling or frustration and anger, will learn to cope and deal with health issues and decrease anxiety that he feels when it comes to day to day life, will learn to adjust with accommodations and deal with things that he is able to control."*

Focused Outcome Areas

Focused Outcome Areas: 94%				*Indicators scoring below 80%*
Safety - 87%	**Yes**	**No**	**NA**	**%**
If individual is currently identified as having moderate or high risk for suicide, the safety plan is reviewed & updated (as needed) at every one-to-one service provided by a clinician (Individual Counseling, Psychiatric Treatment, etc.).	4	2	24	67%
The records of all individuals who have a history of suicide attempts at any time in their lifetime are flagged with "suicide attempt history."	0	7	23	0%
Person Centered Practices - 95%	**Yes**	**No**	**NA**	**%**
Documentation demonstrates the plan is reassessed based upon any changing needs, circumstances and/or response by the individual.	12	4	14	75%
Community Life - 89%	**Yes**	**No**	**NA**	**%**
Services consist of resource coordination to assist individual in gaining access to necessary services to promote recovery/resiliency.	13	8	9	62%

Focused Outcome Areas

Strengths and Improvements:

- All records reviewed contained documentation of safeguards for medications known to have substantial risk or undesirable side effects.
- One hundred percent of records reviewed contained documentation of the staff completing with individuals either the Stanley-Brown Safety Plan or an internal safety plan that contained all the required components.
- When barriers were identified, documentation demonstrated that alternatives were explored with the individual in all records reviewed. For example:
  - Staff completed a referral for Supported Employment for one individual who lost her job due to their child's mental health crisis. Multiple attempts to engage the individual in Supported Employment services were also documented in the record.
  - Staff explored methods, readiness, and barriers with one individual who wanted to become their own payee.

Opportunities for Improvement:

Safety

- Two of six applicable records of individuals assessed to be at high or moderate risk of suicide lacked evidence that the safety plan was reviewed at every one-to-one service provided by a clinician after 11/1/2025. Reviewing the safety plan was not documented in all individual services such as Individual Counseling.
- None of the records reviewed contained a "suicide attempt history" flag for individuals who had a history of suicide attempts in their lifetime.

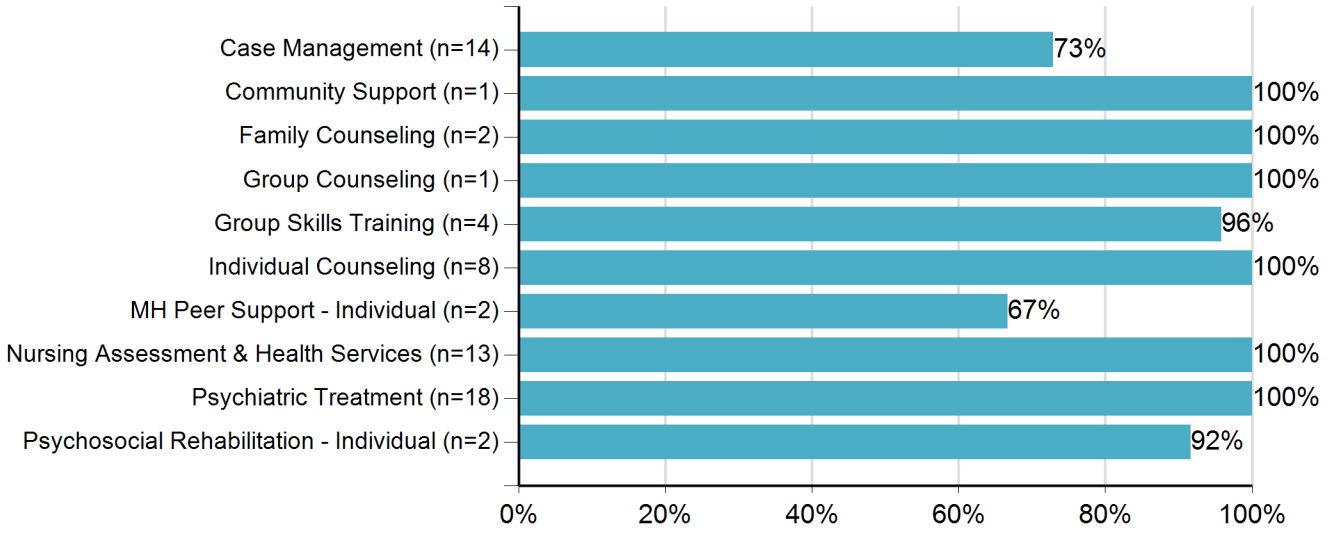
Person-Centered Practices

- Four applicable records lacked documentation that the plan was reassessed based upon any changing needs, circumstances, and/or response by the individual. Examples included:
  - One IRP had been duplicated since February 2023.
  - Three records contained documentation of issues arising while in services, such as grief, legal problems, housing instability, family conflict, employment, and trauma; however, the IRPs of these individuals were not updated to reflect these new problems.

Community Life

- Documentation of coordination and linkage for resource and service needs, such as employment, substance abuse, medical problems, and housing, was not located in eight applicable records.

Service Guidelines



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

Service Guidelines: 90%				*Indicators scoring below 80%*
Case Management - 73%	**Yes**	**No**	**NA**	**%**
Documentation reflects referral and linkage to services and resources identified on the Individual Recovery Plan (IRP) including housing, social supports, family/natural supports, and entitlements. (1 x authorization)	6	6	2	50%
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	9	2	25%
At least 50% of CM service units are delivered face-to-face, and the majority of all face-to-face service units are delivered in non-clinic settings. (Review authorization period.)	3	8	3	27%
Documentation supports interventions that assist the individual in developing natural supports to promote community integration.	7	6	1	54%
Group Skills Training - 96%	**Yes**	**No**	**NA**	**%**
Progress notes contain documentation of the individual's progress (or lack of) toward specific goals/objectives on the treatment plan.	3	1	0	75%
MH Peer Support - Individual - 67%	**Yes**	**No**	**NA**	**%**
Documentation supports interventions that promote socialization, recovery, wellness, self-advocacy, development of natural supports, and maintenance of community living skills.	1	1	0	50%
Progress notes contain documentation of the individual's progress (or lack of) toward specific goals/objectives on the treatment plan.	1	1	0	50%
The staff interventions reflected in the progress notes are related to the staff interventions listed on the treatment plan.	1	1	0	50%
Service is provided as planned within the IRP	1	1	0	50%
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.)	1	1	0	50%

Service Guidelines

Strengths and Improvements:

- In all records reviewed, Individual Counseling progress notes described multiple therapeutic techniques utilized with individuals, such as cognitive behavioral therapy (CBT), motivational interviewing (MI), psychoeducation, and person-centered therapy (PCT).

Opportunities for Improvement:

Case Management (CM)

- Six applicable records lacked documentation of referral and linkage to services and interventions that assisted the individual in developing natural supports due to CM progress notes only documenting obtaining vital signs and completing safety check-ins.
- Nine records did not document a minimum of two contacts per month. Many records lacked at least two contacts per month for multiple months.
- The majority of all CM services were delivered in clinic or via telephone in eight records.

Group Skills Training

- Due to duplicated progress statements in notes, one record lacked documentation of overall progress.

Mental Health (MH) Peer Support - Individual

- One record contained only one MH Peer Support - Individual note that documented "reviewing rules and guidelines" with the individual; therefore, the following indicators were scored negatively:
  - Documentation supports interventions that promote socialization, recovery, wellness, self advocacy, development of natural supports, and maintenance of community living skills.
  - Progress notes contain documentation of the individual's progress (or lack of) toward specific goals/objectives on the treatment plan.
  - The staff interventions reflected in the progress notes are related to the staff interventions listed on the treatment plan.
  - Service is provided as planned within the IRP.

Psychosocial Rehabilitation - Individual (PSR-I)

- One record lacked PSR-I contacts for October. Additionally, many of the memo-to-chart and no-show notes did not identify the intended service of the missed contact.

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	Policy: Provider has a comprehensive Quality Assurance Plan. Tier 3 providers (other than CSUs) are excluded.	Yes
5	Policy: Provider has a comprehensive Suicide Prevention Planning Strategy that describes staff training related to suicide prevention and assuring/monitoring quality of services for individuals at risk for suicide. Tier 3 providers (other than CSUs) are excluded.	Yes
6	The provider employs an ASL-fluent practitioner.	N/A
7	The provider has policies and procedures for providing reasonable accommodations to individuals who are deaf/hard of hearing.	Yes
8	The provider had obtained the appropriate DBHDD-approved criminal records background check on all reviewed staff members by their hire date.	Yes

	# Yes	# No	# N/A	SCORE*
	7	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.

Documentation issues varied by contractor.

- The goal, objective, and intervention for suicidality was duplicated across records.
- Services such as CM and PSR-I were documented as being completed via phone and telehealth; however, the documentation lacked the appropriate modifiers for those service locations (UK for phone, GT for telehealth).
- Most interventions for CM within one record were more aligned with skills training. For example, on 09/24/2025, the documented interventions included reviewing the crisis/safety plan, developing a daily routine, discussing/identifying coping skills. The only intervention that matched the service definition of CM was exploring treatment needs. Additionally, within this same record, several sections of CM progress notes were duplicated from note to note: treatment plan goal and intervention used, assessment, and interventions. Documentation must be unique to each individual and session.
- "His/her" and "he/she" were documented throughout IRPs in multiple records, instead of the individual's specific pronouns.
- In one record reviewed, the most recent C-SSRS Lifetime/Recent was incongruent with individual's presentation. Assessments identified a history of suicidal ideation without attempts, but the C-SSRS Lifetime/Recent dated 10/16/2024 was scored all "no". There was no documentation to justify/explain the discrepancy.
- In another record, the C-SSRS completed by a registered nurse (RN) on 09/02/2025 did not match the C-SSRS completed by an licensed master social worker (LMSW) on the same date. The C-SSRS by the LMSW identified suicidal thoughts in the last four days triggered by argument with a family member, but the C-SSRS by the RN was all scored "no".
    - In this same record, while suicidality was addressed on the IRP, it was only mentioned in some of the interventions (Psychiatric Treatment, Behavioral Health Assessment (BHA)) that staff will "monitor SI risk." This individual had recently experienced suicidal thoughts and was known to have a history of attempts. A more individualized and in-depth goal/objective/intervention addressing her suicidality was needed.
- It was noted in one record that some attempted phone contacts (outside the billing sample) were documented as being billed for one or two units. Attempted contacts are not billable.
- The section within the Psychiatric Treatment progress note template does not completely fulfill the requirements within PolicyStat 01-118 that the safety plan be reviewed by a clinician at each contact with an individual assessed to be at moderate or high risk for suicide. The template captured a brief assessment for suicidal ideations and identified a plan was present. Documentation must clearly capture the review and update (if needed) of the Stanley-Brown Safety Plan.
- One record contained a flag on their record that stated "low risk (sx hx [suicide history]) rather than a "suicide attempt history" flag, as required by DBHDD policy.
- There was incongruence in the time documented at the top of the note and within the body of the note within Group Skills Training progress notes within one record reviewed. The top of the note had a time in/out as 10am-12pm with 20 nonbillable minutes, but the narrative of the note had time in/out as 10am-1pm with 20 nonbillable minutes, and breaks were timed at 10:50am-11am and 11:50am-12pm.
- In one record, CM, PSR-I, and Group Skills Training notes had duplicated content within the intervention sections. Additionally, the CM and PSR-I notes had similar individual responses. Group Skills Training, CM, and PSR-I are distinct services and when provided in tandem, should reflect unique interventions and responses reflective of the service definition so there is no duplication in effort or documentation.

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: 4

Four individuals were interviewed during this review.

- They reported being able to access appointments, provider staff, and other agency supports in a timely manner.
  - One individual reported, "*They are very accommodating with my schedule."*
- They felt supported in moving towards their goals/dreams, achieving their desired level of community involvement, and were treated with respect and dignity.
  - One individual stated, *"They get me out of the house."*
  - Another individual stated, "*I love my therapist I have right now*."
- When asked, "What about this agency keeps you coming back?", they reported:
  - *"They have been very helpful to me. They make sure I have something to eat and my medications. I am very satisfied with them."*
  - *"[My therapist] helps me maintain that hopeful outlook, and she takes good notes. The psychiatrist really advocates for me and the medications I should be on, especially when there is conflict with the accountability court. The nurse I've been seeing lately is great. She always remembers the small talk we have."*
  - *"It's very good. I am so comfortable with them and very grateful for them."*
  - *"It's the kindness of the staff, and I feel like I am heard and not judged at this agency. I went a year waiting on a therapist, but she does a great job."*

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 Review
Provider Level - Overall Programmatic • All supervisee/trainee (S/T) attestations must be complete (address all required elements) and updated annually. • Documentation within or among individuals' records must be unique to the individual and the session.
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 - Person-Centered • Individuals must be assessed and re-assessed for their changing needs and circumstances and plans are updated to reflect current assessments of need.
Focused Outcome Areas - Community Life • Services should consist of resource coordination activities that assist the individual, youth, and parent/responsible caregiver in gaining access to necessary services to promote resiliency.
Focused Outcome Areas - Additional Requirements • There must be documented evidence of the safety plan being reviewed and updated (as needed) at every one-to-one service provided by a clinical (Individual Counseling, Psychiatric Treatment, etc.) when an individual has been assessed to be at high or moderate risk for suicide. • The record must be flagged with "suicide attempt history" when an individual has had any suicidal attempts in their lifetime.
Compliance with Service Guidelines - All Services • Progress note documentation must address the individual's progress toward specific goals and objectives on their plan. • Progress note documentation must be related to the goals and objectives on the plan. • Services must be provided as planned. • Minimum required contacts must be met for all services (as required).
Compliance with Service Guidelines - Case Management • Case Management services must include referral and linkage to services identified in each individual's plan. • Individuals receiving Case Management services must have, as part of their plan, referral and linkage to community services that meet their unique assessed needs.

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/