The Georgia Collaborative ASO

Fulton County Department of BH and DD

Crisis Stabilization Unit Quality Review Final Assessment		
Address: **2805 Metropolitan Parkway, SW, Building A, Atlanta, GA 30315**		
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Review Date Range: **1/6/2026 - 1/9/2026**	CSU Type: **BHCC**	CSU Beds: **24**
Individual Records Reviewed: **20**	Temp Obs Beds: **16**	Transitional Beds: **0**
Staff Records Reviewed: **5**	Current Review Frequency: **Semi-Annual**	

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.

This is the provider's first CSU Quality Review.

	Overall Score	IRR	Service Guidelines	FOA
FY25 Statewide Average	89%	89%	82%	95%

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

Summary of Significant Review Findings

Strengths and Improvements:

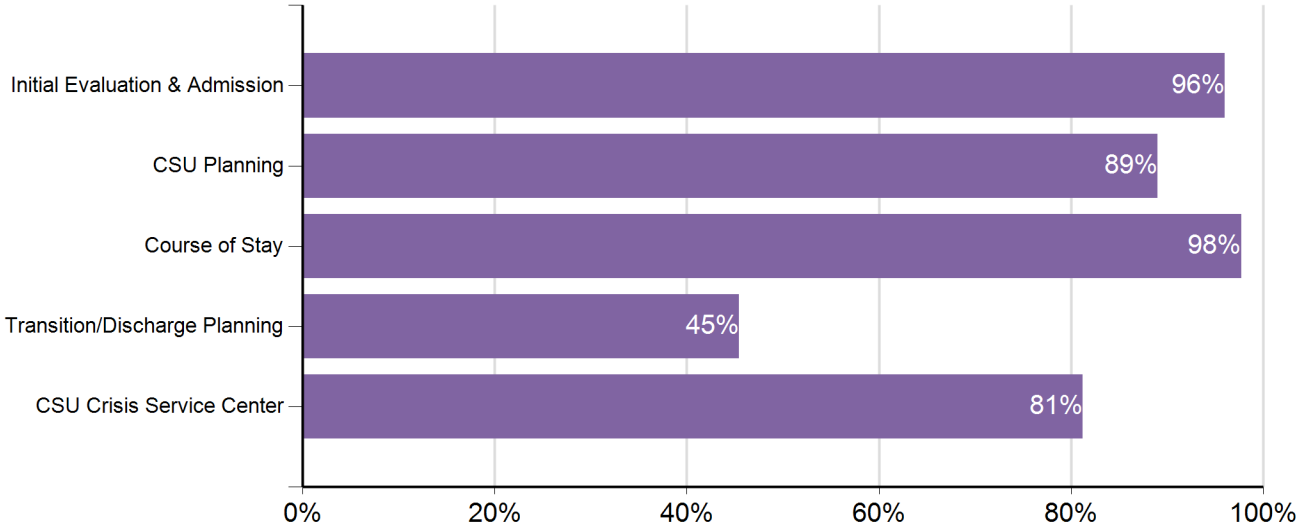
This is the provider's first Crisis Stabilization Unit Quality Review.

- The electronic medical record (EMR) contained useful alerts for staff; for example, "Proceed with caution as patient is sexually inappropriately with female staff" and "This patient poses a violence risk".
- The EMR also included social drivers that list needs of the individuals such as food insecurity ("worried about running out of food within the last year"), homelessness in the past year, tobacco use, transportation, whether individuals have a cell phone, etc.
- Staff, primarily physicians, documented attestations that detailed dispositions related to admission, discharge, risk to harm self/others, treatment recommendations, etc. For example, one record detailed a physician attesting that an individual was not a suicide risk following a review of record and face-to-face discussion with the individual as compared to the assessment that indicated active suicidal ideation. Another example was a detailed internal staffing note between a nurse practitioner and a medical doctor regarding discussion/agreement with a medication protocol.
- Across multiple records documentation by staff demonstrated comprehensive communication with both the individuals and external resources. For example, an individual desired to be discharged back to a personal care home (PCH) he had previously resided. The Crisis Stabilization Unit (CSU) staff contacted the PCH and arranged for the individual to be discharged back to where he previous resided. Staff provided clear evidence within documentation that housing stability was confirmed and the individual was not at risk of homelessness following discharge.
- Throughout records it was evident that risk assessments were thorough and included all required components of the Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) Protocol with a Columbia Suicide Severity Screener (C-SSRS), consistent with Department of Behavioral Health and Developmental Disabilities (DBHDD) new suicide prevention policy, effective 11/1/2025.
- Discharge instructions included clearly-defined "red flags" for post-discharge risk, along with specific guidance for accessing crisis services, including the Georgia Crisis Hotline, demonstrating appropriate safety planning and patient education.
- The provider's EMR utilized a "care timeline" that documented timely completion of required clinical interventions, including diagnostic assessment, suicide risk assessment, crisis intervention, service plan development, and discharge, demonstrating appropriate sequencing of care prior to discharge.

Opportunities for Improvement:

- Treatment team notes must document multidisciplinary team participation.
- Discharge plans must include specific step-down service/activity/supports and clinical benchmarks to meet individualized needs.
- Discharge summaries must be entered into the ASO's Provider/Connect system within 48 hours of discharge.
- Documentation must include consideration of psychiatric medications, the individual's ability to access and afford medication post-discharge, how the medication will be obtained after the five-day post-discharge supply is exhausted, and how any associated lab work will be accessed and funded.
- A Need of Supportive Housing (NSH) survey should be completed, and a referral made, for necessary residential supports for all individuals identified as homeless.
- CSU staff must collaborate care with the aftercare provider.
- Crisis Service Center (CSC) must have an order for admission.

Individual Record Review



The individual category scores are an average of questions within the category and are for the agency's reference only.

Individual Record Review: 78%	*Indicators scoring below 80%*			
CSU Planning - 89%	**Yes**	**No**	**NA**	**%**
Plan of Care discussed every 72 hours.	8	5	2	62%
Transition/Discharge Planning - 45%	**Yes**	**No**	**NA**	**%**
The discharge plan includes specific step-down service/activity/supports and clinical benchmarks to meet individualized needs.	0	15	0	0%
There is documentation of consideration of psychiatric medications, the individual's ability to access and afford medication post-discharge, how the medication will be obtained after seven-day supply is exhausted, and how any associated lab work will be accessed and funded.	0	15	0	0%
A discharge summary was entered into the ASO's ProviderConnect/ batch system within the required time following the individual's discharge.	0	15	0	0%
If individual was discharged to a homeless shelter, documentation reflects alternatives were explored.	3	1	11	75%
Individuals who are identified as homeless, a Need of Supportive Housing (NSH) survey is completed and referral for necessary residential supports.	0	3	12	0%
Is there evidence in the medical record of follow-up with the individual within 5 to 7 days post discharge.	5	8	2	38%
Individuals discharging from a crisis admission who were treated for suicidal behaviors, CSU crisis staff monitor for suicide risk within seventy-two (72) hours of discharge, and then weekly (documenting any action taken) until the individual is linked to ongoing care	0	1	14	0%
For individuals with a current moderate or high risk of suicide/suicide risk behaviors, the CSU communicates by phone and in clinical documentation that corresponding risk for suicide exists when an individual is transitioning to another level of care or another provider.	0	1	14	0%
High risk for suicide: Documentation supports that CSU staff have documented collaboration with the aftercare provider to include: individual/youth's safety plan, who will follow-up with individual/youth, parent/responsible caregiver and when it will occur.	0	3	12	0%
The medical record is flagged high or moderate risk for suicide, as applicable. If the individual/youth was hospitalized or in a CSU for suicidal ideation/behavior, their record has been flagged for high risk of suicide for three months following discharge.	4	3	8	57%
CSU Crisis Service Center - 81%	**Yes**	**No**	**NA**	**%**
All orders were completed and signed within 24 hours.	0	5	0	0%

Individual Record Review

Strengths and Improvements

- There was evidence in records demonstrating the provider began implementing SAFE-T suicide risk screenings prior to the DBHDD implementation date of 11/01/2025.
- All individuals admitted to the CSC were screened for suicide risk.
- There was evidence of discharge planning initiated at admission. The agency utilized a form titled "Discharge and Initial Assessment" which documented individuals' supports, and needs prior to discharge, along with staff clearly documenting communication with individuals' support systems.

Opportunities for Growth

CSU Planning

- Treatment team was not held every 72 hours in five records. In all instances, treatment team documentation within records did not identify the multidisciplinary staff members who participated in treatment team meetings. The Plan of Care documentation was written and signed solely by the social worker assistant, with no evidence of multidisciplinary team participation, in addition to the meetings not occurring every 72 hours.

Transition/Discharge Planning

- In all 15 records, the discharge plan did not include specific step-down service/activity/supports and clinical benchmarks to meet individualized needs. Transition planning must begin at the onset of service delivery to include clinical benchmarks the individual must meet in order to be discharged and the anticipated step down service (individual counseling, Assertive Community Treatment, etc.)
- There was no evidence of consideration of psychiatric medications, the individual's ability to access and afford medication post-discharge, how the medication will be obtained after seven day supply is exhausted, and how any associated lab work will be accessed and funded in all 15 records.
- Discharge summaries were not entered into the ASO's Provider/Connect system within 48 hours following the individual's discharge. In all 15 records; discharges summaries were missing entirely.
- There was no evidence of housing alternatives being explored prior to an individual being discharged to a homeless shelter. The individual was discharged to Gateway homeless shelter without any indication in progress notes if this was the individual's choice and/or housing preference.
- A Need of Supportive Housing (NSH) survey was not completed in three applicable individuals who were identified as homeless. When an individual presents at the CSU with housing insecurity, the CSU staff must initiate the NSH survey. Please refer to DBHDD policy 01.120 Georgia Housing Voucher Program and Need for Supportive Housing Survey.
- Eight records did not evidence that a follow-up telephone call to individuals occurred five to seven days post discharge.
- One individual was admitted voicing suicidal ideation with a plan; however, documentation was not found to support that required suicide risk monitoring occurred within seventy-two (72) hours post discharge, and then weekly until the individual was linked to ongoing care.
- For the same individual, documentation within the record also did not support that attempts were made to communicate the corresponding suicide risk by phone with the aftercare provider as required.
- Documentation did not support that CSU staff documented collaboration with the aftercare provider to include: individual’s safety plan, who will follow-up with individual and when it will occur, and that the individual’s chart was flagged for high suicide risk upon discharge within three applicable records. One example involved an individual who presented with suicidal ideation and a plan to overdose; however, documentation did not reflect collaboration or communication of the individual's suicide risk level occurred with the aftercare provider.
- Three of seven applicable individuals assessed to have recent suicidal ideation did not have their record flagged for high risk of suicide. For example, an individual's suicide screening indicated a plan to walk into traffic and identified the need for a high-risk suicide flag; however, the flag was not present in the individual's medical record.

Crisis Service Center (CSC)

- All five records reviewed lacked an order for CSC admission.

Focused Outcome Areas

Focused Outcome Areas: 92%				*Indicators scoring below 80%*
Safety - 90%	**Yes**	**No**	**NA**	**%**
The records of all individuals who have a history of suicide attempts at any time in their lifetime are flagged with "suicide attempt history"	1	2	12	33%

Focused Outcome Areas

Strengths and Improvements

- Documentation supported that all individuals reviewed were referred to case management and other health services when the need was indicated. All individuals were linked to appropriate outpatient services, including Assertive Community Treatment (ACT), personal care homes, and non-intensive outpatient programs.
- Documentation demonstrated that when barriers to discharge were identified, alternatives were explored. In one instance, an individual was unable to return home at the time of discharge, and arrangements were made to postpone discharge to ensure appropriate placement and continuity of care.

Opportunities for Growth

Safety

- Two of three applicable records of individuals with a history of suicide attempts at any time in their lifetime were not flagged with "suicide attempt history". An example included an individual who had a nursing note in their record stating *"History of SI with attempts per chart review",* but the record was not flagged with suicide attempt history as required by DBHDD policy, effective November 1, 2025.
    - According to DBHDD Policy Stat, 01-118, Suicide Prevention, Screening, Brief Intervention and Monitoring, E, 5: "All individuals with a history of suicide attempts at any time in their lifetime, have a chart alert with "suicide attempt history" in addition to their current risk level."

Service Guidelines

1	Adult CSU Staffing Requirements Met	No
2	The Crisis Service Center staffing requirements met.	No
3	C&A staff requirements met.	N/A
4	The CSU has policies and procedures for identifying and managing individuals at high risk of suicide or intentional self-harm.	Yes

5	Program offerings for the CSU is designed to meet the biopsychosocial stabilization needs of each individual, and a medical and clinical leadership team annually approves the therapeutic content of the program (group therapy/training, individual therapy/training, education support, etc.) This annual review is documented by signature and date of review and by participating leadership.			No
6	Adherence to Medication Notification Policy			Yes
7	Protocols for Handling Licit and Illicit Drugs present			Yes
8	Adherence to Safe Storage of Medication Policy			No
9	Infection Control Plan Adherence			Yes
10	Seclusion & Restraint Policy Adherence			Yes
11	Therapeutic Blood Level Monitoring			Yes
12	Physician Availability for 3.7-WM			Yes
13	All staff credentialing criteria are met.			No
14	Psychiatrist Available for Consultation			Yes
	# Yes	**# No**	**# NA**	**SCORE**
	8	**5**	**1**	**62%**

Service Guidelines: 62%

Strengths and Improvements

- Medication Administration Records (MARs) were present in all records and adhered to the agency's Medication Notification Policy.
- The CSU was fully staffed, with a multidisciplinary team that included four full-time certified peer specialists (CPS) and seven senior licensed mental health clinicians, supporting consistent clinical and peer-based services for individuals during hospitalizations.

Opportunities for Growth

Adult CSU Staffing Requirements

- While the CSU did have four certified CPS on staff, they did not have CPS staff scheduled seven days a week between the hours of 8:00 AM to 10:00 PM, seven (7) days per week, for the months of October, November and December 2025. As a result, 43 hours were not covered during this period.
    - Per the DBHDD Provider Manual, "A CSU that functions as a component of a Behavioral Health Crisis Center (BHCC) must employ a full-time peer specialist (MH, CPS-AD) during the hours of 8:00 AM to 10:00 PM seven (7) days per week."

The Crisis Service Center Staffing Requirements

- The Behavioral Health Crisis Center (BHCC) did not have a fully licensed clinician on staff at all times during the months of October, November and December 2025. As a result, 190 hours were not covered during this period.
    - Per the DBHDD Provider Manual, "A fully licensed Behavioral Health Clinician must be on site at all times."

Program Offerings

- The therapeutic content annual review document contained only one signature, which was illegible, and did not include the required signatures from the medical and clinical leadership team. Additionally, the last date of review was August 13, 2024.
    - DBHDD Policy Stat, CSU: Program Description, 01-329, A, 17, "Program offerings for the CSU are designed to meet the biopsychosocial stabilization needs of each individual, and the therapeutic content of the program (group therapy/training, individual therapy/training, education support, etc.) are annually approved by a medical and clinical leadership team. This annual review is documented by signature and date of review and by participating leadership."

Adherence to Safe Storage of Medication Policy

- The medication refrigerator in the CSU was not double locked. Though the refrigerator was in the locked medication room, the refrigerator itself was not locked. Additionally, one patient-specific bottle of reconstituted liquid amoxicillin stored in the medication room refrigerator lacked a documented date opened, and staff initials. Although an expiration date was present, the absence of a date opened and initials limit staff's ability to verify medication integrity and appropriate beyond-use dating.

Staffing Credentialing

- Four of five staff reviewed met all standard training requirements (STRs). One staff member, a registered nurse (RN), was hired on 05/06/2024; however, the staff member was lacking a background check in their personnel file.

Crisis Stabilization Unit Site Visit Observations

Crisis Service Center

- Upon entry, a metal detector was used for added security, and two security guards were present on site at all times.
- The common area was well lit and furnished appropriately, including comfortable seating and an enclosed television.
- Individuals who presented voluntarily to the CSC, but did not meet criteria for admission to the CSU, were offered the facility's "Living Room Service." This service provided additional support by a CPS and/or a licensed therapist, as well as linkage to community resources that may benefit the individual. While in the "living room", individuals are offered snacks, water, coffee, and a shower, if needed.

Temporary Observation

- The unit included 16 weighted, padded chaise loungers.
- At the time of the site visit, the census was zero.
- The area contained three enclosed large-screen televisions.
- The unit did not have a designated seclusion or restraint room; however, a "Quiet Room" was available. The Quiet Room included a short, corded telephone that allows individuals to make private phone calls.
- A separate nurses' states and medication room are also present.

Crisis Stabilization Unit

- A sally port was utilized for involuntary admissions. Housed within the sally port was a metal detector and large bedbug scanner.
- Weapons and drug paraphernalia are placed in a lock box within the sally port area, assuring they do not enter the CSU. Law enforcement later disposes of contraband.
- Two examination rooms were available for intake assessments to be completed prior to individuals being transferred to the unit. Individuals were first evaluated by nursing staff, followed by the provider and clinician.
- The CSU had a 24 bed capacity. Rooms were single occupancy and halls were divided by male and female. At the time of the CSU tour, the census was 20.
- Emergency food and water supplies were available and adequate.
- Meals are sourced externally. The cafeteria was observed to be clean and welcoming, with weighted furniture. Skylights above the windows allowed for natural light and views of the sky.
- The unit also included a small group room equipped with weighted furniture and a television. A therapy room was available and used for individual, one-on-one therapy sessions. Two full bathrooms were located on the CSU.

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.

- A note for discharge on 9/15/25 was written and signed 9/12/25.
- All staff must utilize DBHDD-approved credentials. During this review, it was noted the credential of Social Worker Assistant was utilized, which is not an approved credential.
- During this quality review, several documents were inaccessible to assessors within the EMR (Abnormal Involuntary Movement Scales (AIMS), releases of information, social determinants of health). These documents were securely emailed to the lead assessor during the review. During the next quality review, these sections of the EMR must be available for review.

Individual Interviews

Individual Interviews Conducted: 3

Three individuals were interviewed during this review: All reported:

- being offered with supports and services
- being supported in moving toward desired goals/dreams
- Some examples included,
  - *"The services are exceptional here."*
  - *"The peer specialists are the best and have been the most helpful for me."*
  - *"The social worker is awesome, and the doctor really listened to me."*
- When asked, *"What are some things this agency does exceptionally well?"* they shared,
  - *"When I first got here, I wasn't really sure what to expect, but now I know this is where I needed to be and they have really helped me."*
  - *"Even though I don't feel like I need to be here or didn't want to take medication, they have been respectful and didn't push me much."*
  - *"The environment here is like family."*

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. Please refer to the comments documented in each section above for specific information pertaining to the requirements below.

Requirements: Current Review

Individual Record Review - CSU Planning

- Each individual's NCP/IRP must be discussed a minimum of once every 72 hours with the treatment team.

Individual Record Review - Transition/Discharge Planning

- Transition/discharge plans must define criteria for discharge to include clinical benchmark(s), planned discharge date, and specific services for ongoing support.
- Documentation must include consideration of psychiatric medications, the individual's ability to access and afford medication post-discharge, how the medication will be obtained after the five-day post-discharge supply is exhausted, and how any associated lab work will be accessed and funded.
- Discharge summaries must be entered into the ASO's ProviderConnect/batch system within 48 hours of discharge.
- Alternatives must be explored (and documented) when an individual is discharged to a homeless shelter.
- A Need of Supportive Housing (NSH) survey should be completed, and a referral made, for necessary residential supports for all individuals identified as homeless.
- The medical record must reflect follow-up and connection with the individual within 5 to 7 days post discharge.
- Records must be flagged for high risk of suicide for individuals assessed to have recent suicidal ideation.
- CSU staff must collaborate care with the aftercare provider.

Compliance w/Service Guidelines - Crisis Stabilization Services

- The adult Crisis Stabilization Unit must meet all staffing requirements.
- The Crisis Service Center must meet all staffing requirements.
- Program offerings for the CSU must be designed to meet the biopsychosocial stabilization needs of each individual and a medical and clinical leadership team must annually approve the therapeutic content of the program (group therapy/training, individual therapy/training, education support, etc.) This annual review must be documented and signed by participating leadership and dated.
- The Crisis Stabilization Program must adhere to its current policy and procedure for the safe storage of medications.
- All staff credentialing criteria/requirements must be met.

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/