The Georgia Collaborative ASO

GAC000461

Behavioral Health Quality Review
Final Assessment Report
Georgia Pines Community Service Board

Location of Review: 1102 Smith Avenue, Thomasville, GA 31792	
Names of Quality Assessors: Jerald Carter, MPA; Kelly Brown, LCSW; Natalee Fritsch, LPC; Sydney Arthur, LPC; Timeka Howard, LCSW, RPT; Dorian Milam, RN,CPHQ; Edna Childs, MSN, RN; Helen Rohrich, RN	
Individuals Interviewed: 5	**Staff Interviewed:** 5
Records Reviewed: 45	**Date Range of Review:** 12/3/2018 - 12/6/2018

The ASO Collaborative in partnership with the Department of Behavioral Health and Developmental Disabilities (DBHDD) believes in easy access to high-quality care that leads to a life of recovery and independence for the people we serve. The Quality Division is dedicated to ensuring services provided are person-centered and include a commitment to wellness and recovery.

Individual Interviews Conducted: 5	**Staff Interviews Conducted:** 5
	
The Individual Interview is not calculated into the overall score.	The Staff Interview is not calculated into the overall score.

	Individual Interviews			Staff Interviews		
Focused Outcome Area	**Yes**	**No**	**NA**	**Yes**	**No**	**NA**
Whole Health	52	3	5	41	2	7
Safety	26	2	2	48	1	1
Rights	40	3	2	17	0	3
Choice	20	0	5	23	0	2
Person Centered Practices	33	0	2	45	1	9
Community	22	0	8	24	1	5

Individual Interview:

Five individuals were interviewed during this Behavioral Health Quality Review (BHQR). All indicated that:

- they had seen a primary care physician (PCP) and dentist within the past 12 months;
- they had been provided with education/resources and tools to prepare for safety issues;
- they had been educated on the provider's complaint and grievance procedure;
- they were offered a choice of when services occur (i.e appointment times, days, etc.); and
- they were involved in the development of the their Individual Recovery/Resiliency Plans (IRPs).

The following comments were made by the individuals related to their experiences with this provider:

- *"She's [the physician] awesome. I started one medicine and I told her I did not like the way it made me feel, and she immediately changed it. She is a great doctor."*
- *"The services here are pretty good."*
- *"I like that the programs gives you options to deal with peer pressure. They help individuals to find jobs that they qualify for. They help with anger management and keep us orderly. The physicians see us whenever we need them."*
- *"This place is convenient and it's a resource."*
- *"I like the services and my Case Manager."*

Staff Interview:

Five staff were interviewed during this review. All indicated that:

- they were aware of how the individual was managing their personal health and could describe how the whole health of the individual was addressed in services;
- they were able to identify the individual's warning signs and triggers prior to a crisis to promote early intervention;
- they were aware that individuals have the right to refuse treatment, services, or supports without retaliation;
- they provide choice related to services according to the individual's/family's schedules and preferences; and
- they were aware of the individuals' interests in community activities and could describe how the individuals participate in those activities of choice.

The following comments were made by the staff interviewed:

- *"Our program emphasizes whole health and wellness. We work well with our psychiatrists to come up with a great treatment plan. Our staff works well as a team to help individuals."*
- *"Co-workers are wonderful. I love the team I am part of. Each day is something new. I never know what is walking through the door. Each day is a new challenge I get to figure out."*
- *"I talk to him about taking his medications and going to his peer support group."*
- *"We brainstorm to present ideas to overcome barriers because there are a lot of transportation issues."*
- *"We started a clothing closet for people that may need it."*

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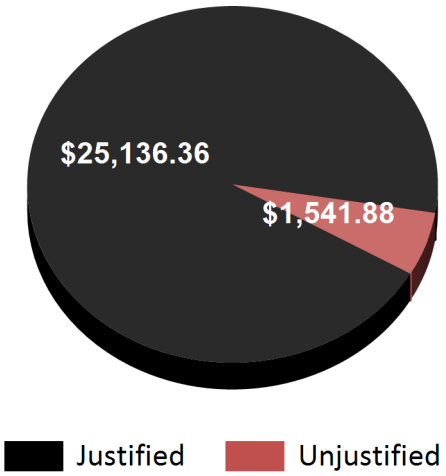
	Overall Score	Billing Validation	Focused Outcome Areas	Assessment & Planning	Service Guidelines
Review Date: 01/29/2018	88%	96%	88%	82%	85%
Review Date: 01/09/2017	82%	94%	83%	70%	82%
FY18 Statewide Average	88%	85%	92%	84%	90%

The overall score is calculated by averaging the four areas: Billing Validation, Focused Outcome Areas, Assessment and Planning, Compliance with Service Guidelines. Each area accounts for twenty-five percent (25%) of the overall score. Review questions are based on DBHDD Provider Manual and Medicaid Requirements.

Billing Validation



	Medicaid	State Funded Services	Total
Justified	$15,793.95	$9,342.41	$25,136.36
Unjustified	$773.78	$768.10	$1,541.88
Total	$16,567.73	$10,110.51	$26,678.24

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	1
Performance Standards	Content of note does not match service definition	4
	Content does not support code billed	2
	Content does not support units billed	3
Quantitative Standards	Location missing	5
	Billing code is missing or different from code billed	4

Billing Validation: 94%

Strengths and Improvements:

The following improvements were noted from the provider's previous BHQR in January 2018:

- All individuals reviewed met admission criteria for services.
- All progress notes had content that was unique to the individual.
- There were no non-billable activities documented within the progress notes reviewed.

Opportunities for Improvement:

Eligibility

- One claim did not have a corresponding Order for Service (OFS); specifically, the OFS form in one record was missing an endorsement for Individual Counseling.

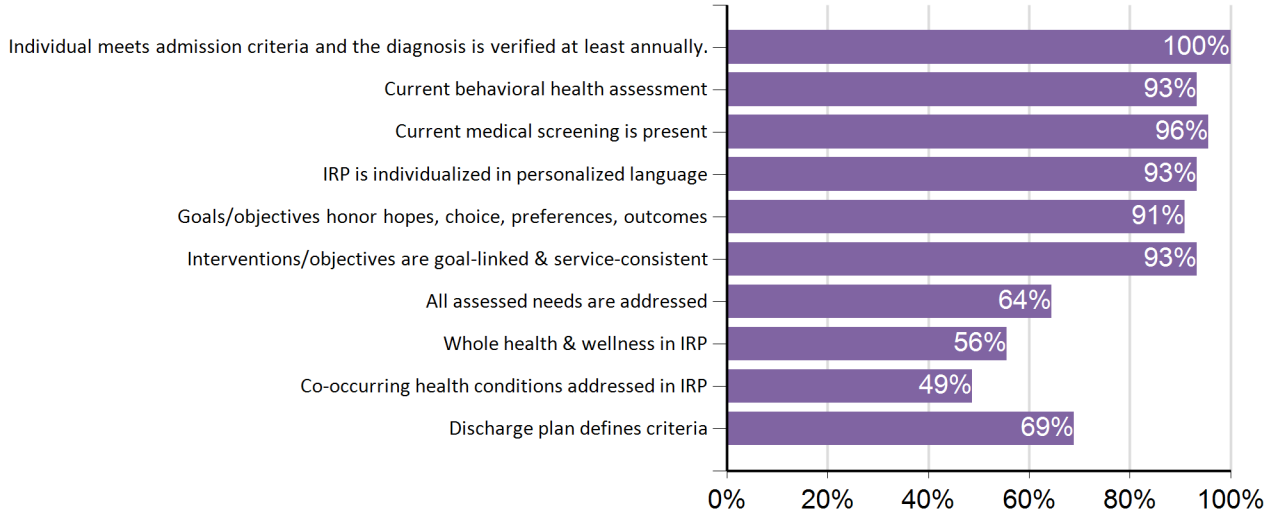
Performance Standards

- Four progress notes did not match the service definition of the service billed. Two Community Transition Planning (CTP) progress notes contained documentation that only documented checking in the with the individual who was in the Behavioral Health Crisis Center (BHCC) with no evidence of transition planning. Two other Psychosocial Rehabilitation Individual (PSR-I) progress notes had content that documented Case Management (CM) activities instead of PSR-I.
- Two progress notes had content that did not match the code billed. A CTP progress note was billed for services in the state hospital, but the session was held at the BHCC/Crisis Stabilization Unit (CSU), which requires the ZC modifier.
- Three progress notes had content that did not support the units billed. Three Assertive Community Treatment (ACT) progress notes were check-ins with the individual and lacked clinical interventions to justify the units billed.

Quantitative Standards

- Five progress notes were missing the out-of-clinic locations.
- Four Diagnostic Assessments were missing the required billing codes.

Assessment & Planning



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

Assessment & Planning: 81%

Strengths and Improvements:

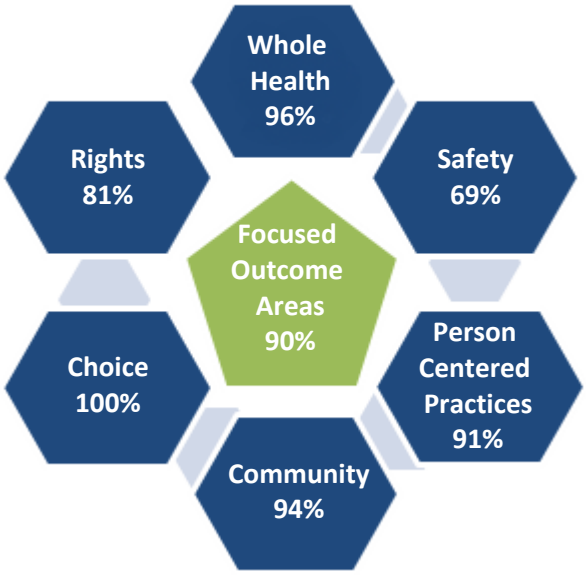
- All individuals in both the ACT program and Non-Intensive Outpatient services continued to have a verified diagnosis, at least annually, when applicable.
- Documentation supported the majority of records documented goals and/or objectives that honored hopes, choice, preference, and outcomes of the individual. This is a recurring strength.
- The majority of records contained Behavioral Health Assessments (BHAs) completed annually and included medical screenings.

Opportunities for Improvement:

The following issues are re-occurring issues identified in previous reviews:

- Sixteen of 45 Individual Resiliency/Recovery Plans (IRPs) did not address all assessed needs; seven of these were ACT records. Five individuals had substance use issues that were assessed but not addressed on their IRPs. Four individuals had housing/homelessness issues that were assessed but not addressed on the IRP. Three individuals had trauma issues that were assessed but not addressed on the IRP.
- Whole health and wellness goals were not addressed in 20 of the 45 records reviewed; nine of these were ACT records. Issues like smoking, nutrition, fitness, and exercise were not addressed on the IRPs.
- Co-occurring health issues identified at assessment were not addressed on the Individual Recovery/Resiliency Plan (IRP) in 19 of 37 applicable records; nine of these were ACT records. Issues such as obesity, cannabis use, hypertension, epilepsy, and diabetes were assessed but not addressed on the IRPs.
- Fourteen of 45 transition/discharge plans did not contain all required criteria; seven of these were ACT records. Six plans were missing an appropriate step-down service. Seven plans had expired transition/discharge plans. Two plans did not have clear clinical benchmarks or discharge criteria.

Focused Outcome Areas



Focused Outcome Areas: 90%

Strengths and Improvements:

- All records contained documentation that demonstrated the individual was receiving individualized services.
- All ACT records reviewed contained a crisis/safety plan.
- All ACT records demonstrated the individual was provided with options of supports and services.
- There was evidence to support that communication with external referral sources (to determine the results of testing and treatment) in the majority of records reviewed. This is an improvement since the last BHQR in January 2018.
- There was no evidence to support that medical conditions were being monitored for in majority of applicable individuals reviewed. This is an improvement since the last BHQR in January 2018.
- The provider self-reported that they have formed a new collaboration with the Second Harvest Food Bank of South Georgia.

Opportunities for Improvement:

Safety

- Twenty-five of 42 applicable records did not contain consents explaining the risks and benefits of prescribed psychiatric medications; 10 of these were ACT records. Seven records were missing the medication consent form. Twelve records were missing medications prescribed by the provider's prescribing practitioner. Medications such as Haldol, Risperdal, Lexapro, and Cymbalta were not on the medication consent form. This is a re-occurring issue.

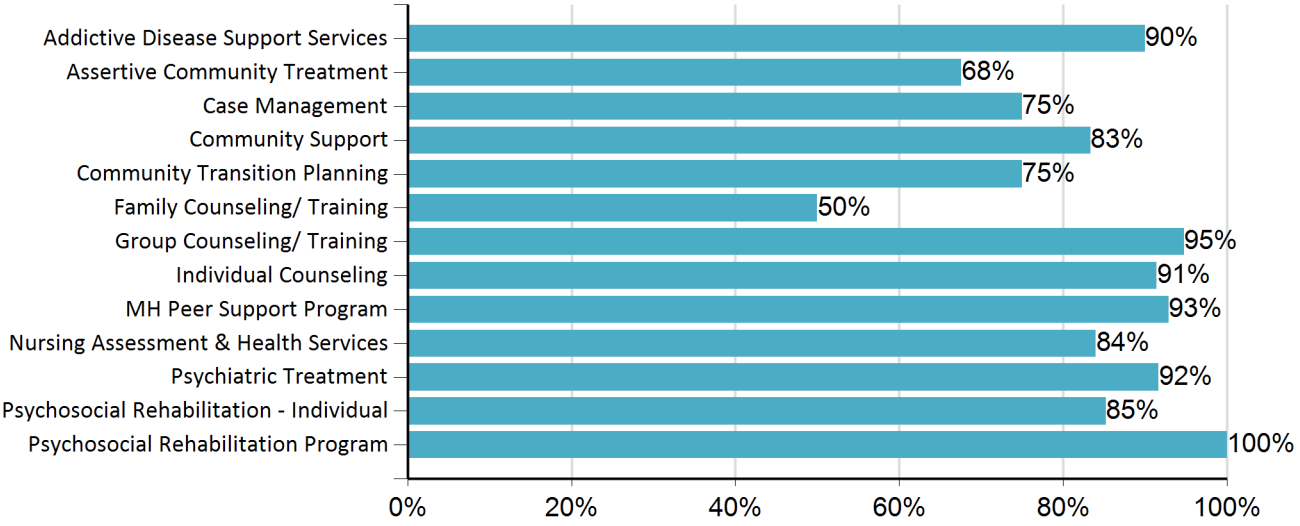
Rights

- Eighteen of 37 applicable records did not have their Rights and Responsibilities updated annually; eight of these were ACT records. Nine records were missing the Right and Responsibilities for 2016. Four records were missing the Right and Responsibilities for 2017. Three records were missing the Right and Responsibilities for 2018. Two records had Rights and Responsibilities that were unsigned by the individual and staff. This is a recurring issue from the past three reviews.

Person-Centered

- Nine of 33 applicable records did not document that the plan is reassessed based upon any changing needs, circumstances and the response by the individual. This issue was mainly due to expired IRPs in the records with no updates.

Compliance With Service Guidelines



Compliance With Service Guidelines: 80%

Strengths and Improvements:

Community Support

- Staff met the minimum monthly requirements for of two contacts per month in the records reviewed. This is an improvement since the last BHQR in January 2018.
- All Community Support progress notes continued to contain documentation of skills building and teaching to assist individuals in the development of interpersonal, community, coping, and functional skills.

Case Management

- Case Management documentation continued to reflect evidence of referral and linkage to services and resources identified in the individual's IRP.

Group Counseling

- All Group Counseling progress notes continued to contain evidence that interventions provided were directed toward achievement of specific goals defined by each individual.

Psychosocial Rehabilitation Program

- The provider scored 100% in this area.

Opportunities for Improvement:

Assertive Community Treatment (ACT)

- There was no evidence that the ACT Team completed a Treatment Plan Review with the staff, the individual, and his/her family/informal supports prior to the re-authorization of services within all 15 records reviewed. There were no Treatment Plan Review forms present for these individuals that met the requirements. This is a re-occurring issue.

- Six of 15 ACT records did not have documentation that demonstrated the Team Leader's involvement in the clinical care of the individual served. This is a re-occurring issue.
- Two of eight applicable records did not contain evidence to support Substance Abuse (SA) services were integrated into the treatment plan. This is a re-occurring issue.
- There was no evidence the ACT Team worked with informal support systems/collateral contacts at least 2-4 times per month in thirteen of 15 records reviewed. These individuals had supports listed within assessments and other documentation, but there was no evidence to support that informal supports were contacted or documentation of attempted contacts. The most affected months were September through November 2018. This is a re-occurring issue.
- The ACT team does not have all of the required staff due to vacancies for the Licensed Therapist, Case Manager, and a Certified Addiction Counselor.
- Progress notes did not contain documentation of the individual's progress (or lack of) toward specific goals/objectives on the treatment plan in four of 15 records.
- Four of 15 records did not have staff interventions reflected in the progress notes related to the staff interventions listed on the treatment plan.

Addictive Disease Support Services (ADSS)

- Staff did not meet the monthly minimum requirement of two (2) contacts per month for one of three individuals. The individual did not have any contacts in September and November of 2018.
- One of two records did not document coordination with family and significant others.

Community Transition Planning (CTP)

- One record reviewed did not have interventions that were related to the coordination of care, services, and support needs to ensure a coordinated plan of transition from the hospital to the community.

Case Management

- Staff did not meet the monthly minimum requirement of two (2) contacts per month in two records reviewed. One individual did not have any contacts in October or November of 2018. Another individual had only one contact in September and no contacts in October 2018.
- One of two records did not document interventions that assisted the individual in developing natural supports to promote community integration.
- Progress notes did not contain documentation of the individual's progress (or lack of) toward specific goals/objectives on the treatment plan in one of two records.
- One of two records did not have staff interventions reflected in the progress notes related to the staff interventions listed on the treatment plan.

Community Support

- Resource and service coordination was not present in one record reviewed.

Family Counseling/Training

- One record did not have documentation that indicated achievement of specific goals defined and agreed upon by the individual and family member (or parents/responsible caregivers) and specified in the IRP.
- Progress notes did not contain documentation of the individual's progress (or lack of) toward specific goals/objectives on the treatment plan in one record.
- One record did not have staff interventions reflected in the progress notes related to the staff interventions listed on the treatment plan.

Group Counseling/Training

- One of four records did not demonstrate that group counseling interventions provided were directed toward achievement of specific goals defined by the individual and specified in the Individual Recovery Plan.

Mental Health Peer Support Program

- Progress notes did not contain documentation of the individual's progress (or lack of) toward specific goals/objectives on

the treatment plan in three of seven records.

Nursing Assessment and Health Services

- Progress notes did not contain documentation of the individual's progress (or lack of) toward specific goals/objectives on the treatment plan in three of ten records. The progress notes documented responses to that day's interventions.

Psychosocial Rehabilitation - Individual

- Staff did not meet the monthly minimum requirement of two (2) contacts per month for seven of ten individuals. Three individuals had no contacts for October and November of 2018. Four other individuals had only one contact in September, October and November of 2018.

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.

Strengths and Improvements:

- Georgia Pines Community Service Board (CSB) self-reported that they continue to provide community training of Mental Health First Aid, not only to adults but to youth as well throughout the year.
- The provider self-reported that they provided information about services, as well as support, during and following the recent Hurricane Michael disaster in October. Staff not only assisted in helping their own individuals served, but the provider was in contact with various agencies such as churches to refer people to get help and supplies.
- Georgia Pines CSB self-reported that they provided training to individuals who wanted the skills to share their personal recovery. The provider hosted "Respect Institute Trainings", and sent individuals to the Peer Support Training and Certification workshops and the Annual Mental Health Conference. One of their individuals was awarded as "Peer Of The Year".
- Georgia Pines CSB self-reported that the agency provided Crisis Intervention Training (CIT) for local law enforcement. They also distributed CIT awareness bracelets to both ACT and residential individuals, as well as law enforcement.

Opportunities for Improvement:

- Individual progress notes and some PSR-I progress notes were billed with the "U7" modifier, but the note documented the service location as Mental Health Clinic and should have been billed as in-clinic. These were outside of the billing sample.
- Interchanging pronouns were found in at least one progress note. "He" was documented within the record for a female individual.

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.

The following are recommendations given as a result of the review:
Billing Validation - Eligibility
• Ensure services are ordered by an appropriately-credentialed professional.
Billing Validation - Quantitative
• Ensure documentation supports what is billed (see comments in Billing Validation section).
• Ensure codes billed are consistent with codes documented.
• Ensure units of services billed are consistent with units of services documented.
Billing Validation - Performance Standards
• Ensure services billed are consistent with documented interventions.
• Ensure codes billed are consistent with the type of contact and content of the documentation.
• Ensure time/units billed is supported by documentation.
Assessment and Planning
• Ensure objectives and interventions are relevant to and support stated goals of individuals.
• Ensure treatment/recovery/service plans address all areas of assessed need.
• Ensure treatment/recovery/service plans address co-occurring issues and/conditions.
• Ensure treatment/recovery/service plans contain goals, objectives, and interventions that promote whole health and wellness.
• Ensure transition/discharge plans include specific step-down services/activities/supports that will meet individuals' needs.
• Ensure transition/discharge plans include a target date.
• Ensure transition/discharge plans include clear, relevant, achievable, and individualized clinical benchmarks.
Focused Outcome Areas - Safety
• Ensure that individuals (or parent/guardian) have been educated on the risks and benefits of all prescribed medications.
Focused Outcome Areas - Rights
• Ensure individuals are informed of their rights and responsibilities at the onset of services and at least annually thereafter.
Focused Outcome Areas - Person Centered
• Ensure individuals served are assessed and re-assessed for changing needs and circumstances and updated plans are reflective of current assessments.
Compliance With Service Guidelines - All
• Ensure all services are provided in accordance with the DBHDD Provider Manual.
• Ensure documentation addresses individuals' progress toward specific goals and objectives.
• Ensure individuals are referred/linked to community resources that meet their unique needs.
• Ensure the minimum face-to-face contacts are made as required for each service.

Compliance With Service Guidelines - Case Management
• Ensure the minimum monthly contacts are made with individuals served.
• Ensure the minimum face-to-face contacts are made as required for each service.
Compliance With Service Guidelines - ACT
• Ensure the ACT team has all required staff/credentials as required.
• Ensure the ACT Team Leader is meeting with individuals and families as required.
• Ensure the ACT team completes a Treatment Plan Review with staff, the individual, family, and informal supports prior to the reauthorization of services.
• Ensure the ACT team is working with informal supports/collateral contacts as required.

Additional Recommendations
• Ensure all services billed are ordered as required.

The Programmatic standards below, relevant to services reviewed during this BHQR, are not calculated into any scored area of this review at this time; however, they are assessed, reported, and may become scored items in the future. The provider should note any negatively-scored item or area as an opportunity for quality improvement activities and take steps to ensure adherence to the Service Definitions in the DBHDD Provider Manual.

Overall Programmatic (Non-Scored)

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
	# Yes	**# No**	**# N/A**	**SCORE***
	3	**0**	**0**	**100%**

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