The Georgia Collaborative ASO

Grady Memorial Hospital Corporation dba Grady Health Systems

Behavioral Health Quality Review Final Assessment

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Individual Records Reviewed: **35**	Current Review Frequency: **Semi-Annual**
Staff Records Reviewed: **5**	Date Range of Review: **12/15/2025 - 12/19/2025**

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

	Overall Score	Billing Validation	Focused Outcome Areas	Assessment & Planning	Service Guidelines
Review Date: 05/12/2025	82%	66%	93%	83%	84%
Review Date: 12/16/2024	86%	74%	97%	85%	88%
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

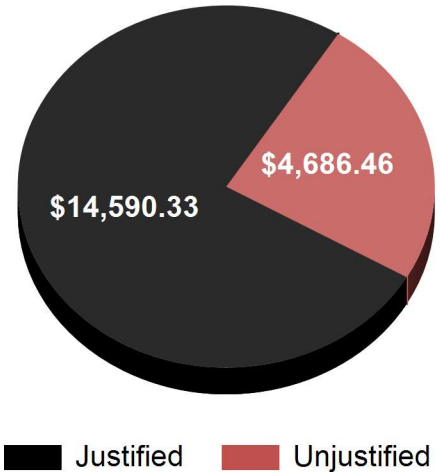
Strengths and Improvements:

- Individual Counseling progress notes contained the use of evidenced-based practices such as Skills Training in Affective and Interpersonal Regulation (STAIR), a brief trauma-specific therapy that focuses on managing emotions and improving relationships.
- The electronic medical record (EMR) contained a summary tab that was comprehensive and informative for the staff when entering the record.
- Assertive Community Treatment (ACT) progress notes completed by certain nurses were clear, thorough, and detailed.
- A staff credentialing review was conducted and all five staff members met the requirements for their respective credentials. This is an improvement from the previous behavioral health quality review (BHQR), when a staff member's supervisee/trainee (S/T) credential was not supported due to her attestation indicating that she was not working toward licensure.
- Early access to the EMR was granted to assessors on the first day of the review.

Opportunities for Improvement:

- Two individuals who were hospitalized within the last six months for suicidal ideation or behaviors did not have their records flagged as having high risk for suicide for the four months following discharge.
- Seven of 25 applicable records (28%) were not flagged with “suicide history” or "history of suicidal behavior" when the individual had any suicidal behavior in their lifetime.
- Two of eight applicable records (25%) lacked documentation indicating that individuals assessed to be at high or moderate risk for suicide received ongoing assessment, as required by DBHDD policy.
- Two of six applicable records (33%) were lacking documentation to support clinically appropriate actions or steps in response to identified risk factors.
- Six of 25 applicable records (24%) lacked documentation of the Abnormal Involuntary Movement Scale (AIMS), a safeguard, utilized for medications known to have substantial risk(s) or undesirable side effects.
- Twenty-nine claims were not justified because documented interventions were not related to individuals' recovery plans (IRP).

Billing Validation



	Medicaid	State Funded Services	Total
Justified	$3,478.00	$11,112.33	$14,590.33
Unjustified	$480.92	$4,205.54	$4,686.46
Total	$3,958.92	$15,317.87	$19,276.79

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	15
Performance Standards	Intervention unrelated to the IRP	29
	Content does not support units billed	7
	Content does not support code billed	5
	Content of note does not match service definition	4
	Minimum contacts not met per DBHDD Service Guidelines	2
	Multiple services billed at same time	2
	No overall progress documented	2
	Non-billable activity billed	2
	Diversionary activities billed	1
	High utilization without justification	1
	Intervention provided is outside the scope of practice for staff	1
Quantitative Standards	Billing code is missing or different from code billed	1
	Progress note not filed within seven calendar days	1

Billing Validation: 76%

Strengths and Improvements:

- All records contained a valid, verified diagnosis on the date that services were provided. This is an improvement from the previous Behavioral Health Quality Review (BHQR) when five claims were unjustified for this reason.
- Fifteen claims were unjustified due to the service not being ordered. This is an improvement from the previous BHQR, when there were 38 unjustified claims due to lack of a corresponding order for service by an appropriately licensed or credentialed practitioner for the date the service was provided.
- One progress note was filed more than seven calendar days after the date of service. This is an improvement from the previous BHQR, when there were 14 progress notes signed after seven calendar days.
- Minimum contacts were not met per DBHDD Service Guidelines for two claims. This is an improvement from the prior BHQR, when there were nine unjustified claims for this reason.

Opportunities for Improvement:

Eligibility Standards

- There were 15 claims that were unjustified due to the service not being ordered. The services included: Medication Administration, Psychiatric Treatment, and Case Management (CM). For the majority of these claims (13), medical services were included on order sheets but were not signed by a physician or physician-extender, as required. This was a reoccurring issue from the previous BHQR (5/2025).

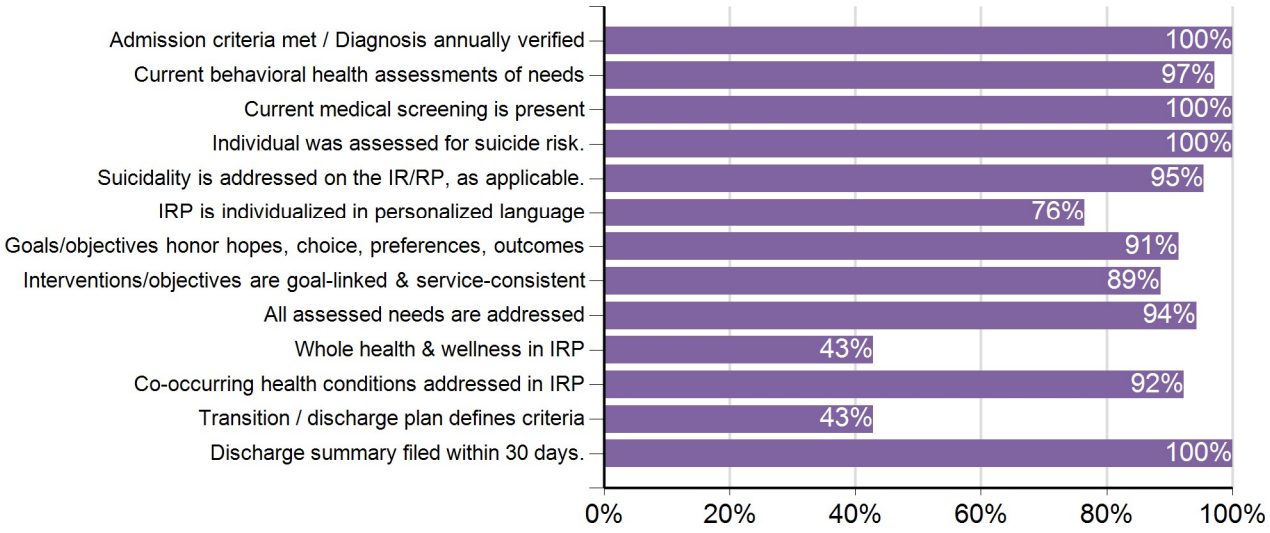
Performance Standards

- There were 29 claims that were not justified because the intervention was not related to the IRP. The following services were provided but not included as a planned service on the corresponding IRP or the IRP was duplicated from year to year: Intensive Case Management (ICM), CM, Psychiatric Treatment, Medication Administration, and Psychosocial Rehabilitation Individual (PSR-I). This was an issue noted in the previous two BHQRs (5/2025 and 12/2024).
- The content of progress notes did not support units billed for seven reviewed claims for the following services: Assertive Community Treatment (ACT), Addictive Disease Support Services (ADSS), CM, Group Skills Training, and PSR-I. This was a reoccurring issue from the previous BHQR. For example, three subsequent ADSS progress notes documented repetitive intervention which represented check-ins with the individual rather than addressing any skill or resource needs.
- The content of five CM progress notes did not support the CM code billed. This was an issue noted in the previous BHQR. In all instances, the session was face-to-face with the individual, but the "UK" modifier was used (indicating a collateral contact was made).
- The content in four progress notes did not match definition of the service billed. For example, two PSR-I progress notes documented interventions reflective of Supported Employment. Also, two claims were billed for Individual Counseling when the individual's partner was present and participating in the session. Family Counseling should have been billed.
- Minimum contacts were not met per DBHDD Service Guidelines for two CM records. In one record, CM was provided only once in August 2025. In another record, there was only one contact for the month of October 2025. This was an issue noted in the last five BHQRs (5/2025, 12/2024, 6/2024, 11/2023, 5/2023).
- There were two instances of multiple services being billed at the same time. In one example, Medication Administration was billed at the same time as Group Skills Training on 9/19/2025. In another record, Medication Administration was documented at the same time as Psychiatric Treatment on 10/28/2025. Multiple services must not be billed during the same timeframe and services times must be accurate.
- Within one ACT and one CM progress note, no overall progress was documented.
- Two progress notes documented non-billable activities. This was an issue noted in the previous BHQR. ACT was billed for transportation and CM was billed for an attempted contact.
- One ACT claim was unjustified due to diversionary activities billed. The writer repeatedly documented "connecting" the individual to telemedicine which she was using for medical contacts on a regular basis. In this note, the PP documented "connecting her to telemedicine" during her third ACT contact of the day where her first contact was with the ACT physician via telemedicine. This contact was also cited as high utilization without clinical justification due to lack of intervention and justification for the third contact.
- The intervention provided was outside the scope of practice for staff within one ACT progress note. A Certified Alcohol and Drug Counselor (CADC) documented providing counseling for non-substance-related issues.

Quantitative Standards

- The billing code documented was different from the code billed in one progress note, a re-occurring issue from the previous BHQR. A CM note that was documented as having occurred over the phone but was billed using the out-of-clinic (U7) modifier.
- A CM progress note for 9/12/2025 was not signed until 9/22/2025, 10 days after the date of service. This was an issue noted in the previous BHQR.

Assessment and Planning



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

Assessment and Planning: 85%

Indicators scoring below 80%

	Yes	No	NA	%
IRP is individualized in personalized language	26	8	1	76%
Whole health & wellness in IRP	15	20	0	43%
Transition / discharge plan defines criteria	15	20	0	43%

Assessment and Planning

Strengths and Improvements:

The following are improvements from the previous BQHR in May 2025:

- All four applicable records contained a discharge summary filed within 30 days.
- All records contained a current medical screening.
- All individuals were screened/assessed for suicide risk.

Opportunities for Improvement:

- Eight records (two ICM) contained IRPs that were not individualized and in personalized language. Additionally, "goal" statement tended to lack any outcome for the individual to achieve. Examples included:
  - An individual who had no documented history of suicidal ideation had an IRP that contained the goal "Individual] wants to communicate any suicidal thoughts." This statement appears to be a part of a template for recovery plans.
  - Two IRPs contained both male and female pronouns; for example, "Patient would like to improve his/her efforts to obtain employment so he/she can become more self-sufficient etc. Patient would like to improve his/her efforts to obtain and maintain housing." and "Patient would like to improve his/her efforts to obtain and maintain housing."
- Whole health and wellness objectives or interventions was missing from 20 of 35 IRPs (three ICM). Opportunities for whole health and wellness could include addressing sleep hygiene, smoking cessation, exercise options, meditation, and yoga. This is a recurring issue noted in the two previous BHQRs (5/2025 and 12/2024).
- Transition/discharge plans lacked one or more of the three required criteria in twenty of 35 records (one ACT and two ICM). This was noted as an issue during the last five BHQRs.
  - Ten transition/discharge plans lacked clear clinical benchmarks. Examples included:
    - The section for clinical benchmarks was listed as "None" within three plans.
    - "Readiness for discharge will be measured by successfully meeting all goals on the treatment plan." This plan was also duplicated across three records. Further, the goals listed on most plans did not represent achievable outcomes.
  - Seven transition/discharge plans lacked an identified step-down service.
  - Three transition/discharge plans were expired.

Focused Outcome Areas

Focused Outcome Areas: 93%				*Indicators scoring below 80%*
Whole Health - 93%	**Yes**	**No**	**NA**	**%**
There are documented safeguards utilized for medications known to have substantial risk or undesirable effects (lab work, assessments, AIMS, etc.).	19	6	10	76%
Safety - 87%	**Yes**	**No**	**NA**	**%**
If the individual/youth was hospitalized or in a CSU within the last six months for suicidal ideation/behavior, their record has been flagged for high risk of suicide for four months following discharge.	0	2	33	0%
The records of all individuals who have a history of suicide behavior any time in their lifetime are flagged with "suicide history."	18	7	10	72%
When an individual has been assessed to be at high or moderate risk for suicide (within the past six months), there is documented evidence of ongoing assessment, as required by DBHDD policy.	6	2	27	75%
Documentation supports that clinically-appropriate actions or steps were taken and linkages/referrals were made if the individual has been assessed to be at risk for suicide (within the past six months).	4	2	29	67%
Community Life - 88%	**Yes**	**No**	**NA**	**%**
Documentation of transition planning (including individual, family, other supports) is evident throughout service delivery and includes specific objectives to be met prior to discharge or decrease in intensity of services.	19	11	5	63%

Focused Outcome Areas

Strengths and Improvements:

- The EMR contained alerts that were specific to the individual. An example included an alert to let staff know the individual had a history of aggression and other "inappropriate behaviors."
- Eighty-two percent (82%) of applicable records contained documentation that the plan was re-assessed based on changing needs, circumstances, and/or response by the individual. This is an improvement from the prior BHQR, when 64% contained documentation to support reassessment, as needed.

Opportunities for Improvement:

Whole Health

- Six applicable records (one ICM) lacked documentation of the Abnormal Involuntary Movement Scale (AIMS), a safeguard, utilized for medications known to have substantial risk or undesirable effects. This is a re-occurring issue noted in the prior BHQR (5/2025). Examples included:
  - An individual was prescribed Depakote, Abilify, and Remeron. The AIMS was last completed 10/30/2024 (over 13 months).
  - An individual was prescribed Abilify, but AIMS were last completed 2/2025 (eight months).
  - An individual was prescribed Abilify, but there was no documentation of the AIMS within the record.

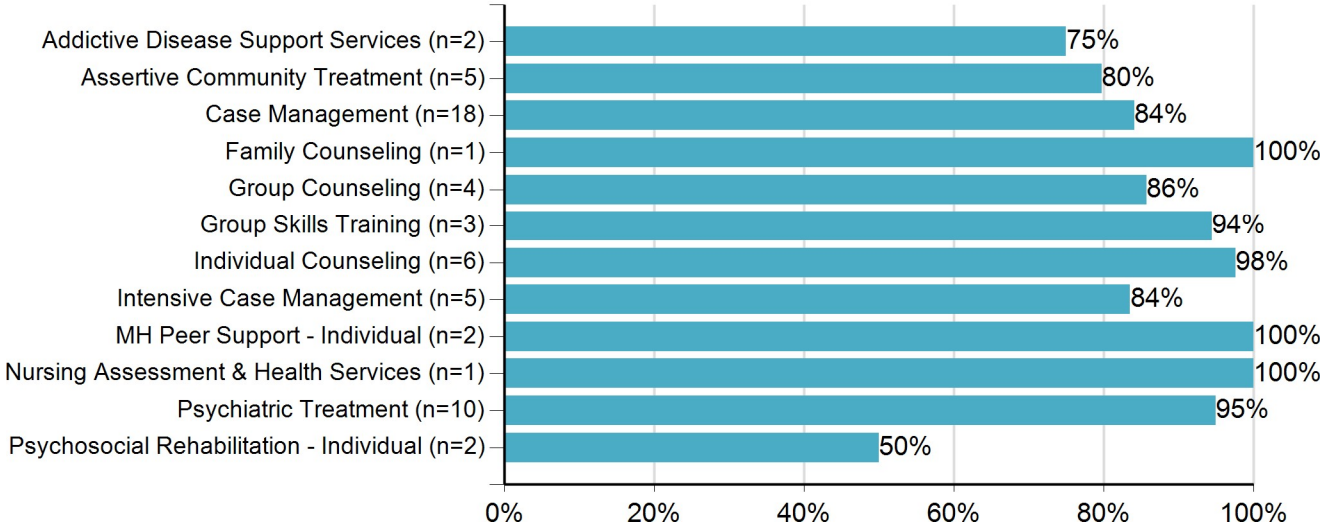
Safety

- Two individuals who were hospitalized within the last six months for suicidal ideation or behaviors did not have their records flagged as having high risk of suicide for the four months following discharge. An example included one individual who was hospitalized for cutting their wrists and neck with the intention of ending their life.
- Seven of 25 applicable records (one ICM) were not flagged with “suicide history” or "history of suicidal behavior" when the individual had any history of suicidal behavior in their lifetime. Examples included:
  - Two individuals had put a gun to their head and tried to shoot themselves.
  - An individual had a suicide attempt by walking into traffic.
  - An individual with multiple inpatient admissions for suicidal behavior had a "low risk" suicide flag.
- Two of eight applicable records were lacking documentation indicating that individuals assessed to be at high or moderate risk for suicide received ongoing assessment, as required by DBHDD policy. This is a reoccurring issue noted in the prior BHQR(5/2025). Examples included:
  - A Psychiatric Treatment progress note contained, "[Individual] meets 1013 criteria due to being a danger to himself." The individual's flagged risk status was "low risk" and ongoing monitoring was not documented.
  - An individual did not receive ongoing monitoring at each visit when receiving Medication Administration appointments.
- Two of six applicable records were lacking documentation to support clinically appropriate actions or steps in response to identified risk factors. This is a reoccurring issue noted in the prior BHQR (5/2025). An example included: An individual with a history of "suicide attempts a couple of months ago" did not have suicidality addressed on their IRP nor was it addressed in Individual Counseling sessions.

Community Life

- Eleven of 30 applicable records (including one ACT and one ICM) lacked evidence of transition planning throughout service delivery. The record an individual receiving ACT for several years lacked evidence of regularly noting progress against planned discharge criteria. Often, the stated discharge criteria were different than what was referenced in interdisciplinary treatment team meetings to justify ongoing services. There should be alignment between the individual's transition/discharge plan and continuing stay criteria for the service. Often, progress notes did not address how individuals were progressing or moving towards transitioning to a lower level of care.

Service Guidelines



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

Service Guidelines: 86%	*Indicators scoring below 80%*			
Addictive Disease Support Services - 75%	**Yes**	**No**	**NA**	**%**
Coordination with family and significant others is documented and with adult individual's permission. Answer "Yes" if attempt is made, but permission is not given. (Review authorization period.)	0	2	0	0%
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%
Assertive Community Treatment - 80%	**Yes**	**No**	**NA**	**%**
There is documented evidence that the ACT Team is working with informal support systems/collateral contacts at least 2-4 times per month (with or without the individual present) to provide support and skills training to assist the individual in his/her recovery.	1	3	1	25%
The ACT Team is working with the individual towards educational or vocational needs, interests, per IRP. (1 x per authorization.)	2	2	1	50%
The ACT Team has all required staff. (List missing staff in comment box.)	2	3	0	40%
The psychiatrist for this team participates in weekly team meetings.	0	5	0	0%
Case Management - 84%	**Yes**	**No**	**NA**	**%**
There are a minimum of two (2) contacts per month, with at least one (1) face-to-face in a non-clinic setting. (Review authorization period.)	5	11	2	31%
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.)	9	7	2	56%
Group Counseling - 86%	**Yes**	**No**	**NA**	**%**
Documentation indicates achievement of specific goals defined by the individual and specified in the IRP.	2	2	0	50%
Progress notes contain documentation of the individual's progress (or lack of) toward specific goals/objectives on the treatment plan.	2	2	0	50%
Group Skills Training - 94%	**Yes**	**No**	**NA**	**%**
Progress notes contain documentation of the individual's progress (or lack of) toward specific goals/objectives on the treatment plan.	2	1	0	67%

Intensive Case Management - 84%	Yes	No	NA	%
Treatment Team Meeting Logs contain evidence that the individual was discussed at least 1x/month (6 month timeframe)	1	4	0	20%
The timeframe from receipt of referral to engagement with an individual no more than 5 days (NA if more than one year from admission).	3	1	1	75%
The Georgia Housing Need & Choice Survey was completed upon admission.	2	2	1	50%
Psychosocial Rehabilitation - Individual - 50%	**Yes**	**No**	**NA**	**%**
There is a minimum of two (2) contacts each month and one (1) is face-to-face. (Review authorization period.)	0	2	0	0%
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	0	2	0	0%

Service Guidelines

Strengths and Improvements:

- Individual Counseling progress notes contained the use of evidenced-based practices such as the Skills Training in Affective and Interpersonal Regulation (STAIR), a brief trauma-specific therapy that focuses on managing emotions and improving relationships.
- Assertive Community Treatment (ACT) progress notes completed by certain nurses were clear, thorough, and detailed.

Opportunities for Improvement:

Addictive Disease Support Services (ADSS)

- In both records reviewed, coordination with family or significant others (who were identified as supportive to the individual) was not found in documentation. This is a recurring issue noted in the prior two BHQRs (5/2025 and 12/2024).
- Within one record:
  - progress notes did not include statements related to progress (or lack of) towards IRP goals.
  - the interventions documented in progress notes did not align with those listed on the IRP.

Assertive Community Training (ACT)

- Three records did not contain evidence that the ACT Team was working with informal supports at least twice per month, as required. This was noted during the prior two BHQRs.
- Two records lacked documentation of working with the individual to support their vocational interests.
- Two of the three ACT teams were lacking a licensed clinician.
- The psychiatrist did not participate in weekly team meetings per the DBHDD provider manual p.186, Required Components, 2.: “The psychiatrist must participate at least one time/week in the ACT team meetings.”

Case Management (CM)

- Seven of 16 applicable records did not reflect face-to face CM services delivered in non-clinic settings at least 50% of the time. Documentation in each record reflected that services were delivered in-clinic 100% of the time.

Group Counseling

- Two of four applicable records lacked documentation indicating achievement of specific goals defined by the individual and specified in the IRP. For example, in a record the IRP did not specify what goal was associated with the Group Counseling intervention.
- Two of four applicable records did not contain documentation of the individual's progress (or lack of) toward specific goals/objectives on the treatment plan within progress notes. This is a reoccurring issue noted in the previous BHQR. An example included, the individual's progress statements were documented as "moderate" without further description or behavioral support for this subjective rating.

Group Skills Training

- One of three applicable records did not contain documentation of the individual's progress (or lack of) toward

specific goals/objectives on the treatment plan within progress note. This is a reoccurring issue noted in the previous BHQR. Progress was documented as "moderate" and did not identify progress towards specific goals/objectives.

Intensive Case Management (ICM)

- Treatment team meeting logs in four of five records reviewed lacked documentation that individuals were discussed at least once per month. This is a reoccurring issue noted in the previous BHQR.
- One of four applicable records lacked referral to engagement for ICM services for the individual within five days.
- The Georgia Housing Needs & Choice Survey was not completed upon admission or was not present in the record (having been completed at a later date) in two of four applicable records. This is a reoccurring issue noted in the previous BHQR.

Psychosocial Rehabilitation - Individual (PSR-I)

- PSR-I was not listed on the IRP as a planned service on IRPs within two applicable records. This affected the entire review period for one record and 8/21/2025 forward in the other record.
- As a result of having no current IRP that included PSR-I, the following were scored "no" for one record:
  - Progress notes contained 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 were related to the staff interventions listed on the treatment plan.

The minimum contacts were not met within Case Management and Psychosocial Rehabilitation-Individual services. Often, individuals receive both services and minimum contacts must be met for each service. Progress notes for both of these services tended to lack focus (planned interventions and objectives) or evidence that the services were provided as defined (linkage to community supports and skill use development in the living, learning, working, and/or social environments, respectively), with these services being used primarily for checking in with individuals. This is a re-occurring issue noted during the previous BHQR (5/2025).

Overall Programmatic

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

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

- Within the IRPs, planned services were incongruent with planned interventions. Each intervention had listed the entire array of planned services, regardless of the intervention; this, in many instances, planned for services to do things that are outside of the service definition. For example, for the intervention to link the individual with the housing voucher program, the associated services were: Behavioral Health Assessment, Service Plan Development, Case Management, Diagnostic Assessment, Medication Administration, and Nursing Services. The only appropriate service for this intervention is Case Management. This practice has been identified during previous reviews.
- The Assertive Community Treatment (ACT) recovery planning meeting notes included a check box to indicate whether the individual participated, but the content of these notes did not provide any details of the individual's involvement. This has been noted during prior reviews.
- A Case Management note dated 8/22/25 was defined by the providing paraprofessional (PP) as a "safety check" since the individual had expressed "recent" suicidal ideation at admission to the program. Question one of the Stanley Brown Safety Plan was not adequately addressed in the related progress note. The note affirmed that the individual had to use their Stanley Brown Safety Plan within the last week, but instead of the required explanation, "n/a" was documented. This may represent a training need for the team.
- An ICM progress note included a template regarding telehealth consent where the individual's name was listed as "XX.": "In lieu of an in-person visit, XX has given verbal consent for a telephone visit instead."
- A progress note documenting a collateral contact did not identify who had been contacted or provide relevance and context for the contact.
- Documentation supporting the credentials of reviewed staff was due at the end of the day on the first day of the review as additional time had been allowed due to past challenges with accessing personnel records; however, all of the documentation to support the reviewed employees' credentials was not presented until the morning of day three. The provider is reminded of the requirement to provide all credentialing information (to include hours of training in each topic) in a timely and organized way to support the credentials of all reviewed members of staff.
- Although not affecting any claims in the sample, one paraprofessional (PP) using the U4 service code modifier lacked evidence that his college degree was in a helping profession. When a PP has a degree that is not in a helping profession, the U5 modifier must be used.
- The same PP mentioned above had an employment date that was 25 days prior to the date of the DBHDD criminal records background check.

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

- Individuals felt that they could access appointments, provider staff, and other agency supports in a timely manner when requested. Examples included:
  - "They could get me an appointment today if I called."
  - "Yes, they are flexible like that."
  - "Yes, 100%."
- All individuals were involved in the development of, and updates to, their IRPs. An example included: "They always include me. I like that they include and explain to me what is suggested. I appreciate that."
- Individuals reported feeling supported to achieve their desired level of involvement in the community. Examples included:
  - "I feel supported in the groups."
  - "I don't participate in things too much, but they told me it will take time."
- When asked, "What about this agency keeps you coming back?" The individuals shared:
  - "Grady has been a great support system in the community for those that are unable to pay. They don't turn you away. I am always greeted with a smile. They have great service. They always think about the patient."
  - "I like how they give me groups to go to and they help me with whatever I need."
  - "They are all in the community. They don't miss a beat."

Quality Improvement Requirements

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

Requirements: Current and Prior Review

Provider Level - Overall Programmatic

- Paraprofessional (PP) and supervisee/trainee (S/T) staff members must complete the Standard Training Requirements (STR) within their first 90 days of employment (or prior to further contact with individuals when this standard has not been met).

Billing Validation

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

Assessment and Planning

- Treatment/recovery/service plans must contain goals, objectives, and interventions that promote whole health and wellness of the individual.
- 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 - Whole Health

- Documented safeguards must be utilized when medications known to have substantial risk or undesirable effects are prescribed.

Focused Outcome Areas - Safety

- There must be documented evidence of ongoing assessment when an individual has been assessed to be at risk for suicide.
- Documentation must support that clinically-appropriate actions or steps were taken and linkages or referrals were made based upon the findings/outcome of suicide risk assessment.

Compliance with Service Guidelines - Addictive Disease Support Services (ADSS)

- Documentation should support coordination efforts with the individual's family and significant others when the individual requests/permits it.

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 - Assertive Community Treatment (ACT)

- The ACT team must work with informal supports/collateral contacts, as required.

Compliance with Service Guidelines - Intensive Case Management

- The Georgia Housing Need & Choice Survey must be completed for all individuals upon admission to Intensive Case Management.

Requirements: Current Review

Provider Level - Overall Programmatic

- DBHDD-approved criminal record background checks must be obtained on all employees, members of staff, and/or contractors prior to their having any contact with individuals served.

Assessment and Planning • Treatment/recovery/service plans must be individualized and in the language of the individual served.
Focused Outcome Areas - Safety • The record must be flagged for high risk of suicide for at least four months if the individual/youth was hospitalized or in a CSU within the last six months for suicidal ideation/behavior. • The record must be flagged with “suicide history” when an individual has had any suicidal behavior in their lifetime.
Focused Outcome Areas - Community Life • Transition planning should be evident throughout service delivery and involve the individual and their significant others.
Compliance with Service Guidelines - Assertive Community Treatment (ACT) • The ACT team must have all required staff as outlined in the DBHDD Provider Manual. • The ACT Team must work with the individual toward their educational or vocational needs and interests. • The ACT team psychiatrist must participate in ACT team meetings at least weekly and review each case with the physician extender on a monthly basis.
Compliance with Service Guidelines - Intensive Case Management • Individuals referred to ICM must be engaged in services within five days. • Treatment team meeting logs must contain evidence that the individual was discussed at least monthly.

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/