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.

<table>
<thead>
<tr>
<th>Review Date</th>
<th>Overall Score</th>
<th>Billing Validation</th>
<th>Focused Outcome Areas</th>
<th>Assessment &amp; Planning</th>
<th>Service Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>05/13/2019</td>
<td>91%</td>
<td>90%</td>
<td>94%</td>
<td>87%</td>
<td>91%</td>
</tr>
<tr>
<td>05/21/2018</td>
<td>91%</td>
<td>93%</td>
<td>93%</td>
<td>89%</td>
<td>90%</td>
</tr>
<tr>
<td>FY20 Statewide Average</td>
<td>84%*</td>
<td>76%</td>
<td>93%</td>
<td>88%</td>
<td>90%</td>
</tr>
</tbody>
</table>

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

### Strengths and Improvements:
- Due to the COVID-19 pandemic, this review was conducted remotely instead of on site.
- Four of five staff files reviewed for credentialing contained all required components.
- "Behavioral Health Assessments" (BHAs) contained a Risk Assessment which documented suicide risk factors including family history of suicide, substance use, psychosis, social stressors, physical illness, etc. as well as suicide protective measures such as availability of immediate supports, religious beliefs, coping skills, willingness to use a safety/crisis plan, etc. Additionally, BHAs captured individuals' preferred learning style (i.e., visual, hearing, reading, hands on) to aid in tailoring treatment approaches.
- Documentation evidenced staff discussed telehealth services with individuals, obtained telehealth consent, and explored preferences of alternative options for services. One progress note described how the staff member consistently identified ways the individual could maintain privacy while participating in telehealth services at home with other family members in the house.

### Opportunities for Improvement:
- **Billing:**
  - Minimum contacts were not met per DBHDD Service Guidelines in 26 instances.
  - Content did not support the units billed within 22 progress notes.
  - Twenty-one progress notes were not filed within seven calendar days.

- **Assessment and Planning:**
  - Co-occurring health conditions were not addressed within six Individual Resiliency/Recovery Plans (IRPs).
  - Thirteen transition/discharge plans did not define all required criteria.

- **Focused Outcome Areas:**
  - Abnormal Involuntary Movement Scales (AIMS) were missing when required within nine records.
  - Seven safety/crisis plans were not developed, as needed.
  - Two individuals were not assessed for risk of suicide; and therefore, it could not be determined if ongoing assessment was needed.
  - Signed formal acknowledgement of rights and responsibilities were not completed annually within nine records.

- **Service Guidelines:**
  - Minimum contacts were not made/attempted as required within the services of Community Support Team (CST), Intensive Case Management (ICM), Addictive Diseases Support Services (ADSS), Case Management (CM), Psychosocial Rehabilitation-Individual (PSR-I), and Community Support.
  - Nearly half of individuals receiving ICM had no goal on the IRP to obtain or maintain housing of their choice.
  - Additionally, the majority of ICM Treatment Team Meeting Logs did not evidence that the individual was discussed at least monthly.
  - Nearly half of individuals receiving CM had safety/crisis plans that were not signed by them or the staff member.
  - Nearly half of individuals receiving Community Support had records that did not document that service and resource coordination was provided.
Billing Validation

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).

<table>
<thead>
<tr>
<th>Standard</th>
<th>Reason</th>
<th># of Discrepancies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility Standards</td>
<td>No valid, verified diagnosis on date service provided</td>
<td>5</td>
</tr>
<tr>
<td>Performance Standards</td>
<td>Minimum contacts not met per DBHDD Service Guidelines</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>Content does not support units billed</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>Content of note does not match service definition</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Content does not support code billed</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Intervention unrelated to IRP w/o clinical justification</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>No overall progress documented</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Non-billable activity billed</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Note does not include response to intervention</td>
<td>1</td>
</tr>
<tr>
<td>Quantitative Standards</td>
<td>Progress note not filed within seven calendar days</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>Units billed exceeded time and/or units documented</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Location missing</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Staff credential not supported by documentation</td>
<td>1</td>
</tr>
</tbody>
</table>

Billing Validation: 73%

Strengths and Improvements:

Improvements from the previous Behavioral Health Quality Review (BHQR) on 5/13/2019 included:

- Services were billed without overlapping time frames, which was an improvement from the two instances cited previously.
- Interventions were provided within the scope of practice for staff in all progress notes, an improvement from one instance.
- Staff credentials were documented on all progress notes, an improvement from four instances.

Opportunities for Improvement:

<table>
<thead>
<tr>
<th>Medicaid</th>
<th>State Funded Services</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Justified</td>
<td>$7,045.60</td>
<td>$3,460.81</td>
</tr>
<tr>
<td>Unjustified</td>
<td>$2,136.55</td>
<td>$1,652.84</td>
</tr>
<tr>
<td>Total</td>
<td>$9,182.15</td>
<td>$5,113.65</td>
</tr>
</tbody>
</table>
Eligibility Standards

- One record did not have a current verified diagnosis within the record, affecting five claims. The individual was last diagnosed by a medical doctor (MD) upon discharge from the Crisis Stabilization Unit (CSU) on 5/18/2019. A BHA completed on 7/27/2020 was by a Master of Social Work (MSW), Certified Addiction Counselor II (CACII) who does not possess qualifying credentials to provide a verified diagnosis.

Performance Standards

- There were 26 instances in which minimum contacts were not met per DBHDD Service Guidelines standards.
  - Thirteen instances were documented within ICM records. Specifically, there was not evidence that at least four contacts were made/attempted per month, with at least one being face-to-face.
  - Thirteen instances were documented within non-intensive outpatient (NIOP) records for services including CM, PSR-I, ADSS, CST, and Community Support.
- The content of 22 progress notes did not support the units billed.
  - Nineteen instances were found within the Mental Health (MH) Peer Support Program. These progress notes lacked detail to support the interventions provided to support four or five units of billing. Additionally, lunch and break times were not clearly noted.
  - Two CM progress notes documented check-in phone conversations with the individual that did not support a full hour of billing; therefore, one of four units billed was justified for each claim.
  - The majority of one PSR-I progress note documented Case Management interventions that included linking the individual to the grocery store and the pharmacy.
- The content of seven progress notes did not match the service definition.
  - Three were Nursing Assessment and Health Services progress notes provided via telehealth without at least 50% of the contacts being face-to-face. Per DBHDD provider manual, nursing services allow for 50% of nursing contacts to be telehealth, which would not require vitals, in response to the pandemic. For example, in one record all nursing contacts prior to 3/4/2021 were provided via telehealth; therefore, the Nursing Assessment and Health Services claim on 1/25/2021 was unjustified.
  - Two Community Support progress notes described staff asking the individual's guardian for an update on the individual's behaviors at home and school without providing any skill building or resource coordination.
  - One PSR-I progress note did not reflect any skills-building interventions and documented only service linkage and resource coordination.
  - One ICM progress note described staff assisting the individual while they were admitted to the CSU; therefore, Community Transition Planning (CTP) should have been billed.
- The content of two ICM progress notes did not support the code billed.
  - One progress note was billed with the "U7" out-of-clinic modifier; however, documentation described the session occurred in-clinic (U6).
  - While the other progress note was also billed with the "U7" out-of-clinic modifier; yet, the session occurred via phone (U6).
- The intervention was unrelated to the IRP without clinical justification within two progress notes. Within one record, Nursing Assessment and Health Services was not listed on the individual's IRP.
- One MH Peer Support Program progress note did not document overall treatment goal progress or response to the intervention as the staff member reported, "[Individual] did not give a response."
- One Nursing Assessment and Health Services progress note documented non-billable activities including receiving a verbal medication order from the agency's physician and calling in the medication with the pharmacy.

Quantitative Standards

- Twenty-one progress notes were not filed within seven calendar days.
  - Twelve instances were documented within ICM records. In one record, five progress notes were signed late; ranging from 12-20 days after the date of service.
  - Nine instances were documented within NIOP records including CM, PSR-I, ADSS, CST, and Nursing Assessment and Health Services progress notes.
- The units billed exceeded time and/or units documented within two MH Peer Support Program progress notes. The progress notes were billed for six and seven units; however, the time in/out was documented as 9:00am-1:50pm. Therefore, five units were justified.
- The out-of-clinic location was not specified within one ICM progress note.
- One supervisee/trainee (S/T) staff's credential was not supported by documentation prior to 2/11/2021, which affected one Individual Counseling progress note. This S/T's attestation was not completed until 2/11/2021; additionally, supervision for January 2021 was missing.
When all responses to a question are "Not Applicable", no percentage is displayed.
Assessment & Planning: 92%

Strengths and Improvements:

The following were improvements from the previous BHQR:

- Ninety-four percent of records contained a current behavioral health assessment of needs, an improvement from 87%.
- Ninety-seven percent of IRPs addressed all assessed needs, an improvement from 77%.
- Although still an area of opportunity for improvement; 76% of IRPs addressed co-occurring health conditions, an improvement from 46%.

The following were strengths identified during this BHQR:

- BHAs contained a Risk Assessment which documented suicide risk factors including family history of suicide, substance use, psychosis, social stressors, physical illness, etc. as well as suicide protective measures such as availability of immediate supports, religious beliefs, coping skills, willingness to use a safety/crisis plan, etc. Additionally, BHAs captured individuals' preferred learning style (i.e., visual, hearing, reading, hands on) to aid in tailoring treatment approaches.
- The "Notes" section of IRPs contained detailed information regarding individuals' current presentation and specific life circumstances that are contributing or hindering wellbeing, as well as detailed progress towards previous treatment goals.
- ICM Program scored a 99% in Assessment and Planning. Examples of Whole Health and Wellness on IRPs included:
  - "Educate on healthy eating habits and how to look for nutrition information on foods; provide linkage to a [primary care physician] PCP in the area, assisting client with utilizing resources in the area."
  - "Educate client on healthy lifestyle choices (being physically active, choosing to bake instead of fry foods, monitor intake, etc.); encourage and monitor for healthy lifestyle choices."
  - "Monitor for and encourage good hygiene; educate on good hygiene (brush teeth daily, change clothes daily, bathe daily, etc.)."

Opportunities for Improvement:

- Co-occurring health conditions were not addressed within six (24%) of 25 applicable IRPs. Examples included issues with bed wetting, hypertension, diabetes, chronic medical condition/immunocompromised, hearing impairment, intellectual disabilities, and neurodevelopmental disorders.
- Thirteen (37%) of all transition/discharge plans did not define all required criteria.
  - Step-down services were either vague (i.e., "NIOP," "community") or missing entirely.
  - Step-down dates were either expired or missing entirely.
  - Clinical benchmarks were either not measurable or missing entirely. Examples included:
    - "[Individual] will be evaluated for discharge when it is reported that bipolar SX are decreased by 6-7 days per week."
    - "He will discharge... when he meets goals established in his treatment plan."
Focused Outcome Areas

- Whole Health: 84%
- Rights: 86%
- Safety: 86%
- Choice: 98%
- Person Centered Practices: 98%
- Community: 98%

Focused Outcome Areas: 93%
Focused Outcome Areas: 93%

Strengths and Improvements:

The following was an improvement from the previous BHQR:

- All records contained documentation that the individual had been educated on the risks and benefits of all medications prescribed and there is a signed consent form that correlates to each medication, an improvement from 83%.

The following were strengths identified during this BHQR:

- Documentation evidenced staff discussed telehealth services with individuals, obtained telehealth consent, and explored preferences of alternative options for services. One progress note described how the staff member consistently identified ways the individual could maintain privacy while participating in telehealth services at home with other family members in the house.
- Advanced directives were not only discussed with individuals during their initial and annual assessments, Nursing Assessment and Health Services progress notes also documented conversations about individuals’ preferences to have one in their record.
- Documentation evidenced that the medical staff often communicate among one another and with the individuals, and make referrals as needed based on individuals’ needs. Examples included noting on lab reports that they were reviewed, a prescription was sent to the pharmacy based on lab levels, and a letter was mailed to the individual informing them that they should discuss their labs with their PCP at their next appointment. This was also a strength identified during the previous review.

Opportunities for Improvement:

Whole Health

- There were no documented safeguards utilized for medications known to have substantial risk or undesirable effects (lab work, assessments, Abnormal Involuntary Movement Scale (AIMS), etc.) within nine (33%) of 27 applicable records.
  ◦ Medications prescribed included Risperdal, Invega Sustenna, Seroquel, and Abilify.
  ◦ Three instances were found within ICM records.

Safety

- Safety/crisis plans were not developed, as needed, within seven (22%) of 32 applicable records. Two instances were found within ICM records.
  ◦ Four records did not contain safety plans for individuals with histories of suicidality, domestic violence, and/or substance use.
  ◦ While three safety/crisis plans were present in the record, they were not signed by the staff member or the individual; one of these plans was mostly blank.
- When an individual had been assessed to be at risk for suicide, there was no documented evidence of ongoing assessment within two (25%) of eight applicable records.
  ◦ While one individual’s assessment noted a history of suicidal ideations, the Columbia-Suicide Severity Rating Scale (C-SSRS) Lifetime was scored “no” for all questions.
  ◦ Another record contained six C-SSRSs that were incomplete, as only the first two questions were answered while the Suicidal Behavior sections were blank. This individual has a history of suicidal ideation and multiple inpatient hospitalizations.

Rights

- Individual/guardian had not signed formal acknowledgement of rights and responsibilities at least annually within nine (32%) of 28 applicable records.
  ◦ Five instances were found within ICM records.
Service Guidelines: 88%

Strengths and Improvements:

The following were improvements from the previous BHQR:

- Intensive Case Management:
  - Eighty percent of records contained documentation that supported the individual was involved in the development of a safety/crisis plan that was complete, current, adequate, and communicated to all appropriate parties with the provider listed as primarily responsible; an improvement from 60%.

- Nursing Assessment and Health Services:
  - Ninety-two percent of nursing goals and objectives were individualized and addressed health issues to include medical, physical, nutritional, and behavioral needs; an improvement from 67%.

The following were strengths identified during this BHQR:

- Psychiatric Treatment progress notes contained a running log of presenting symptoms, which documented individuals' improvements/decompensation over time.
- A MH Peer Support Program progress note documented the staff member being concerned about the individual's disheveled appearance and decompensating behaviors in group that day. Staff documented reaching out to the individual's ICM case manager to discuss and coordinate care.
- ICM progress notes documented case managers providing a thorough approach to referral and linkage to services and resources including assistance with Social Security, food stamps, housing options/vouchers, medication refills, paying utility bills/budgeting, dental needs, vehicle repairs, and accessing resources at the Salvation Army; additionally, staff linked individuals to legal assistance/services, food banks, and the Dublin Police Department in times of crisis.

Opportunities for Improvement:

Office of Deaf Services Standards

- While the provider notified the Office of Deaf Services (ODS) within two business days of first contact with the only applicable individual served, the following requirements were not met:
  - The Communication Assessment Report (CAR) was not in the medical record.
  - The CAR was not addressed in the IRP to include the individual's preferred mode of communication.
  - The Notification of Right to Free American Sign Language Services and Accommodations form was not in the individual's medical record.
  - Registration did not identify the individual as deaf/hard-of-hearing.
Community Support Team

- Within both records reviewed, CST Team Meeting Logs did not document that the individuals were discussed, even briefly, at least one time per week. Both individuals were only staffed twice in January 2021 and once in February 2021.
- A minimum of four contacts/attempts per month were not made within either of the two records reviewed.
  - One individual was only documented to have had two contacts in January 2021 (with no attempted contacts), and only two contacts in February 2021 (with only one attempted contact).
  - Services for another individual appeared to stop in mid-February 2021 without explanation, while other services continued to be provided.

Intensive Case Management

- Within the only applicable record, the timeframe from receipt to engagement with the individual could not be determined as there was no ICM referral date documented within the record.
- The individual had no goal on the IRP to obtain or maintain housing of their choice within four (40%) of 10 records. Although three individuals had stable housing, there could have been a goal supporting the individual in maintaining their housing and/or exploring more permanent/preferred housing options.
- A minimum of four contacts with at least one face-to-face was not made/attempted with the individual per month within six (60%) of 10 records. Examples included:
  - One individual was documented to have only been seen twice in December 2020 and March 2021.
  - Another individual was documented to have only been seen three times in November and December 2020 and twice in January and February 2021.
- Treatment Team Meeting Logs did not evidence that the individual was discussed at least monthly within seven (70%) of 10 records. Examples included:
  - One record did not evidence that the individual was discussed from October 2020-February 2021.
  - Another record did not contain documentation that the individual was staffed in November 2020 or February 2021.

Addictive Diseases Support Services

- Contact was not made at least twice per month within four (80%) of five records.
  - Three records contained only one contact made/attempted in January 2021 and no contact/attempts documented throughout the months of February and March 2021.
  - Another record documented only one contact in January, February, and March of 2021.
- Coordination with family and significant others was not documented within either of the two applicable records.

MH Peer Support

- Program Progress notes did not contain documentation of the individual's progress toward specific goals/objectives on the IRP within two (40%) of five records.

Case Management

- There was no evidence of joint development of a crisis plan to include the provider and individual within three (43%) of seven records. In all instances, the plan was not signed by the staff member or the individual.
- Contact was not made at least twice per month within six (86%) of seven records. Examples included:
  - One record only contained two contacts from 10/1/2020 through 3/31/2021.
  - Another record documented the individual was only contacted once in January 2021 with no contacts during the months of November-December 2020 or March-April 2021.

Psychosocial Rehabilitation-Individual

- Contact was not made at least twice per month within either of the two records reviewed.
  - One individual had no contacts documented during November 2020 and only one contact in March 2021.
  - Another individual was contacted only once in December 2020.

Community Support

- Contact was not made at least twice per month within three (60%) of five records. Examples included:
  - One record evidenced that only two contacts were made from October 2020 through March 2021.
Another record documented only one contact during the months of January and February 2021.

- Evidence of service and resource coordination was not documented within two (40%) of five records.
- While staff met with the individual within the school setting, there was no documentation of resource coordination with school personnel.

Overall Programmatic

The Programmatic standards below, relevant to services reviewed during this BHQR, are not currently calculated into any scored area of the review; however, Quality Improvement Recommendations are made based on findings.

<table>
<thead>
<tr>
<th>Provider-Level Indicators</th>
<th># Yes</th>
<th># No</th>
<th># N/A</th>
<th>SCORE*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  Where applicable, all services are provided at approved Medicaid sites.</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2  On-site nurse is present 10 hours/week.</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3  Staff safety and protection policies/procedures are present.</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4  Quality Assurance Plan includes assuring/monitoring quality of services for individuals at risk for suicide.</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5  The provider employs an ASL-fluent practitioner.</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6  The provider has policies and procedures for providing reasonable accommodations to individuals who are deaf/hard of hearing.</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Overall Programmatic Score is not calculated into the Overall score at this time.
Additional strengths and concerns beyond the general scope of the review were discovered by reviewers. Additional issues/practice concerns may have the potential to impact service delivery, quality of care, or may represent a risk to the provider.

- It is recommended an individual enrolled in MH Peer Support Program be re-evaluated for the most appropriate level-of-care as he may be more appropriately served by Intellectual Developmental Disabilities (IDD) specific services at the agency. He is diagnosed with attention-deficit/hyperactivity disorder (ADHD), Neurocognitive Disorder, and is deaf. He gestures and reads lips to communicate, but is unable to speak other than saying "mom." Response sections of MH Peer Program progress notes only indicated he is able to point to pictures of objects as a form of responding to group interactions, and this appears to be related to his IDD related needs.
- In one record, a Release of Information (ROI) form for the individual's mother indicated "verbal consent." Verbal consents are not sufficient on this type of release form.
- Some staff members' credentials were conflicting within signatures. For example, some paraprofessionals (PPs) were also signing as S/Ts.
- Non-billable notes reflecting attempted contacts did not always identify the service the staff member was attempting to provide.
- Although Quality Risk Items (QRIs) no longer result in a reduction of the Overall Score, the following QRIs were noted during this review:
  - Required staff was incomplete for more than 90 days in a program; specifically, the ICM team has had one to three vacancies for case managers since August 2020.
  - Contact frequency requirements were not met in 23 instances including CST (2), ICM (6), ADSS (4), CM (6), PSR-I (2), and Community Support (3).
  - Safety/crisis plans were lacking for those needing a plan in seven records.
  - Five repeated Quality Improvement Recommendations in any category from the previous review:
    - Billing Validation: Ensure Quantitative Standards are met.
    - Billing Validation: Ensure Performance Standards are met.
    - Assessment & Planning: Ensure treatment/recovery/service plans address co-occurring issues and conditions.
    - Focused Outcome Areas: Ensure that individuals have individualized safety/crisis plans (as needed).
    - Focused Outcome Areas: Ensure individuals are informed of their rights and responsibilities at the onset of services and at least annually thereafter.
Individual Interviews

Individual Interviews Conducted: 5

All five individuals/guardians reported:

- they were involved in the development of and updates to the IRP:
  - "We are working on my response to anger (lowering my voice and not having melt downs) and coping skills."
  - "They ask us what would be the best fit and what will work. They take their time to talk to us and let us know what is going on."
  - "We just did that this morning! They are pretty good. We are on the same page with what we need to do with [individual]. They have worked with us very well, I have no complaints."

- staff followed up on any expressed whole health related needs and requested assistance to ensure these were addressed:
  - "Whenever I have pain or need medication for my joints, they make sure I'm okay and contact my doctor to get my medications."

- when asked what keeps them coming back to this agency:
  - "I can call my case manager any time I need him. If I have a crisis, they are there for me."
  - "The way they help me, and they are very knowledgeable about my conditions."
  - "They can notice if I'm getting bad or worse. If it's an emergency, they let me see the doctor."
  - "My daughter is a very picky person, so if she is going to them, they are doing something right. [She] sees something in them and believes they are helping her. If they are doing that for my daughter, and I'm seeing improvement, we are staying for a while."
  - "I know that with the children I have in services, they are going to get the help they need. They will do what's necessary to get them to that place. I have had several children to go through services there, and I have nothing but positive things to say about the services they received."
Providers are reminded of the responsibility to maintain internal processes which ensure immediate and permanent corrective actions on issues identified during the quality review process. DBHDD may request corrective action plans (CAPs) as quality review findings warrant as well as review agencies’ internal documentation regarding corrective actions and ongoing quality assurance and quality improvement. Please refer to the comments documented in each section above for specific information pertaining to the recommendations below.

### Recommendations: Current and Prior Review

#### Billing Validation - Quantitative
- Ensure all Quantitative Standards are met in documentation.

#### Billing Validation - Performance Standards
- Ensure all Performance Standards are met in documentation.

#### Assessment and Planning
- Ensure treatment/recovery/service plans address co-occurring health conditions and concerns.

#### Focused Outcome Areas - Safety
- Ensure that individuals have individualized safety/crisis plans (as needed).

#### Focused Outcome Areas - Rights
- Ensure individuals are informed of their rights and responsibilities at the onset of services and at least annually thereafter.

#### Compliance With Service Guidelines - All
- Ensure the minimum required contacts are met for all services (as required).

### Recommendations: Current Review

#### Provider Level
- Ensure all program staffing vacancies are filled within 90 days.

#### Billing Validation - Eligibility
- Ensure documentation supports that all Eligibility Standards are met.

#### Assessment and Planning
- Ensure transition/discharge plans define criteria for discharge, planned discharge date, and specific services.

#### Focused Outcome Areas - Whole Health
- Ensure there are documented safeguards utilized for medications known to have substantial risk or undesirable effects.

### Additional Recommendations
- Ensure the timeframe from ICM receipt of referral to engagement with the individual is clearly documented and does not exceed five days.
- Ensure all ICM individuals have a goal on the IRP to obtain or maintain housing of their choice.
- Ensure ICM Treatment Team Meeting Logs document that all individuals are discussed at least monthly.