

Behavioral Health Quality Review Final Assessment Report



The Georgia
Collaborative ASO

Provider Name:

Hephzibah Behavioral Health Services PVGA #219

Location of Review:

6601 Zebulon Rd., Macon, GA 31220

Regions of Operation:

2

Date Range of Review:

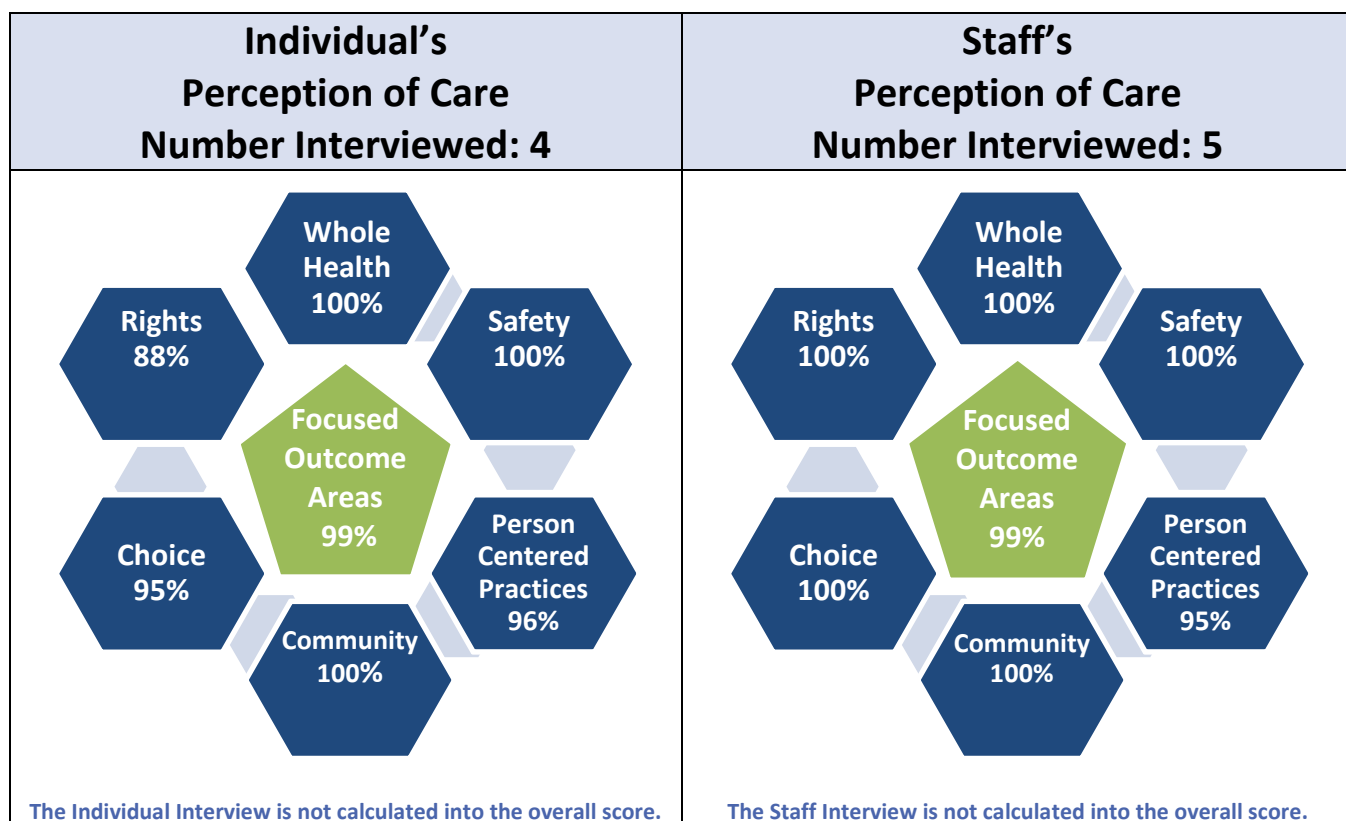
October 27-29, 2015

Quality Assessors: John Dury, LMFT, LPC, MAC, CPCS; Michele Lackey LPC, NCC, CPCS; Jerald Carter, MPA

Records Reviewed: 20

Provider Tier Level: 2

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 Interview Observations:

- One mother whose child has been in services for approximately one year with the agency indicated that her child was on nine different medications when he first came to Hephzibah. She indicated that she was “scared to come home because (her child) would meet her at the door with fists balled up” due to his pervasive anger and anxiety. She stated that the current therapist and psychiatrist “listen and give her child a choice.” She indicated that her child is now on one anti-depressant and one mood stabilizer and “that is it.” She related that “my child is like a totally different person and I tell God every day thank you for this miracle.” She also stated that she appreciates Hephzibah’s availability of appointments on weekends and late evenings and “that they have never let us down.”
- This individual’s child was also interviewed and the youth stated that, “the doctor talks to me and listens.” The child shared that “when I was on all that medicine I was always angry and upset and I haven’t had any angry moods lately”. The youth also stated that “I haven’t been to the hospital in over a year.”
- One individual receiving services with the agency stated that “I love the services here” and “that they have been good to me. I would recommend them to anyone.”
- Another individual indicated that “we were referred here and (the) staff is very pleasant and show concern for me and the family.” The counseling has really helped my child to grow, mature, and blossom.”

Staff Interview Observations:

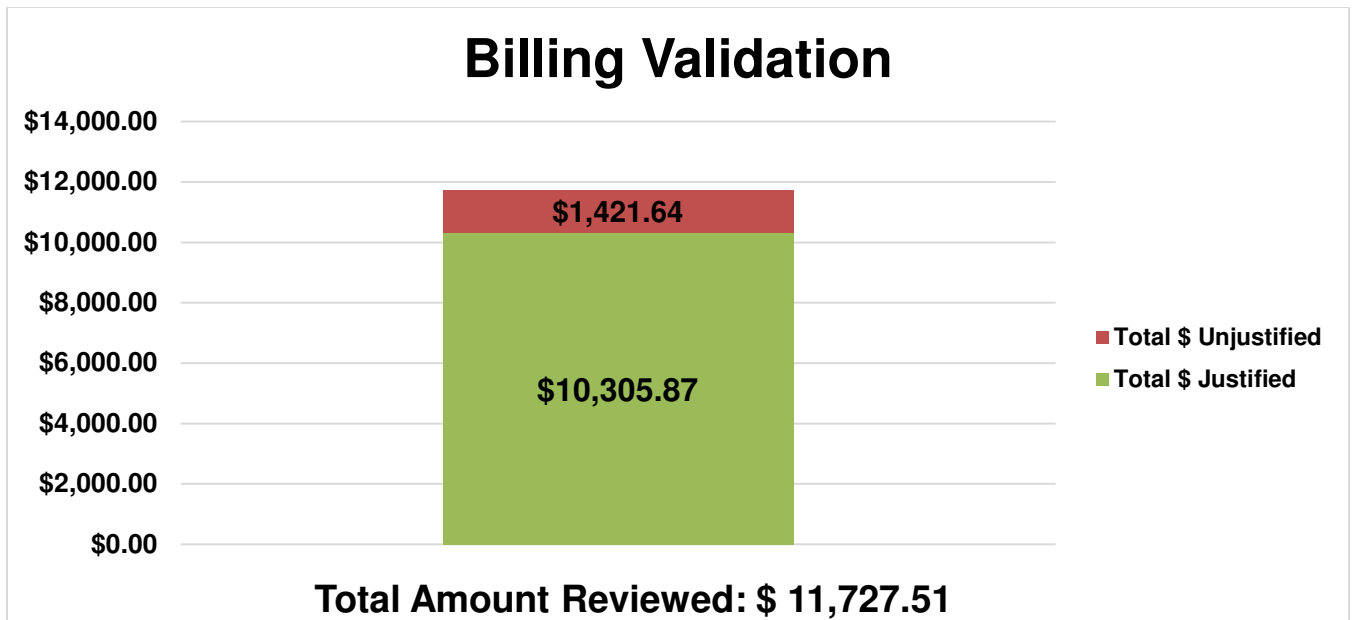
- One staff member indicated, “The family is the root of everything, that’s what I love about it” (her work at the agency). “When I see the “aha” moment (seeing the kids gain insight), I want to cry.”
- A staff member with over 23 years of experience who just completed her Certified Peer Specialist training that included an emphasis on Whole Health approaches to behavioral healthcare and WRAP (Wellness Recovery Action Planning), shared how she values that the Hephzibah team works together to match the right family and child with the right therapist to customize their approach given the unique needs of each family and individual.
- Another staff member shared her love for working with children who are in foster care and have suffered from abuse and neglect. She stated that she was able to engage a child who presented with serious anger issues through his love of art and assisted him in identifying impulsive behaviors through the “cognitive triangle” intervention which in working with him has led to significant change.
- A staff member who has worked for the agency for four years discussed how discharge planning for the individuals starts at the beginning of treatment. He indicated that Hephzibah is really an environment that emphasizes team work and lots of support. He stated that, “there is no internal bickering here at Hephzibah found in other agencies”. He also stated that the agency is “very organized.”
- And finally a staff member stated that, “The Hephzibah Children's Home is a place where individuals can come here and get help.” She stated, “We help all people.” She also indicated, “We are not judgmental and we put our money where our mouth is. We do what we are going to do to help our clients. We help individuals in the community whether we get paid or not.”



The overall score is calculated by averaging the four areas:

- Billing Validation
- Focused Outcome Areas
- Assessment and Treatment Planning
- Compliance with Service Guidelines

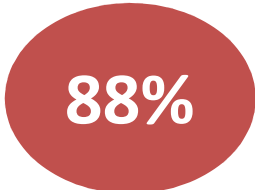
Each area accounts for twenty-five percent (25%) of the Overall Score. Review questions are based on DBHDD and Medicaid requirements.



Revocations/Rollbacks of Authorization

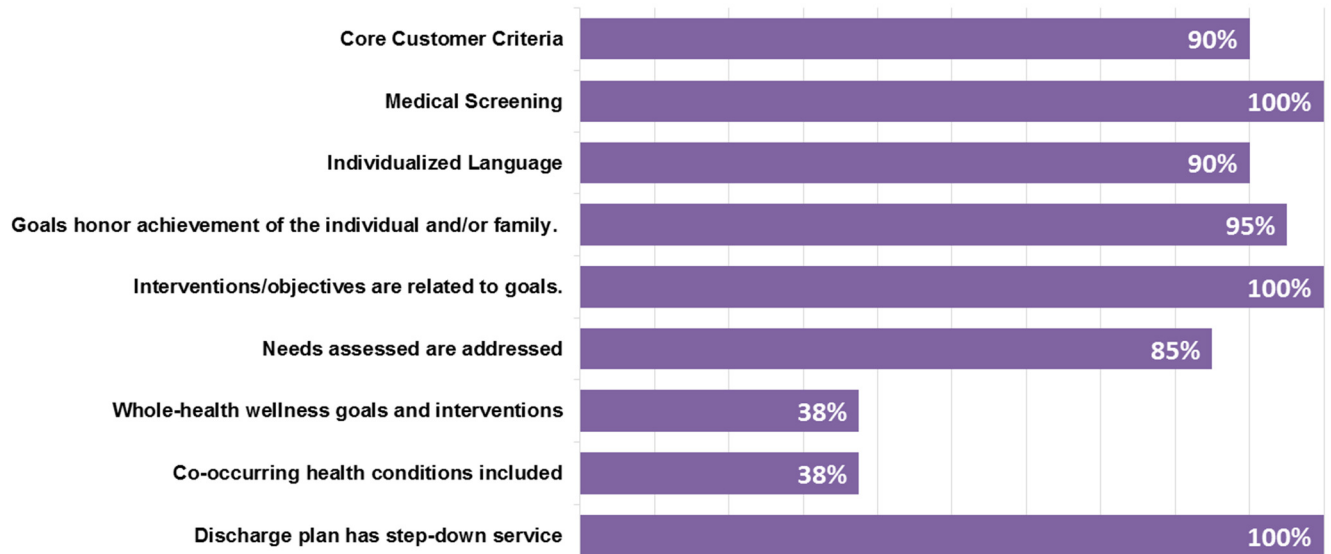
- Two records contained authorizations that were subject to revocation or rollback.
 - For example, in the first case the record was missing an Axis I diagnosis that qualified the individual for Core Customer Criteria. The diagnosis of record in this case was “Mental Disorder due to Brain Trauma in Vitro” which is a clinical exclusion as indicated in the DBHDD Provider Manual. The authorization for this individual began on 12/3/14 and the individual had been discharged from services by the provider prior to the start of the review. This revocation resulted in one unjustified paid claim.
 - The second record was missing a verified diagnosis delivered by a qualified practitioner which resulted in a rollback of a Brief registration that began on 1/9/15 and was rolled back to day 31 of the Brief Registration (2/8/15). This issue also impacted an ongoing authorization that began on 4/9/15 through 10/5/15. The rollback resulted in eight unjustified paid claims.

Billing Validation*

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|  | Strengths: <ul style="list-style-type: none">• There were no missing progress notes identified during this review. |
| | Opportunities for Growth: <ul style="list-style-type: none">• As previously noted, nine paid claims were unjustified due to a rollback or revocation of authorizations.• One progress note did not have a corresponding order for services. For example, the provider billed the code H2011U3U7 (Crisis Intervention) on 4/28/15 for four units but the service was not ordered. This resulted in one unjustified paid claim.• One progress note contained documentation that did not match the service definition billed. For example, the provider billed the code 90837U4U6 (Individual Counseling) on 4/29/15 for one unit and then documented Family Counseling. This resulted in one unjustified paid claim. |

*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; Fee for Service (FFS) is the sum of paid encounters; State Contracted Services (SCS) is the estimated sum of the value of accepted encounters.

Assessment & Treatment Planning



Assessment & Treatment Planning

86%

Strengths:

- 100% of the records reviewed contained a medical screening as required.
- 100% of records contained discharge plans with specific step-down services as required.

Opportunities for Growth:

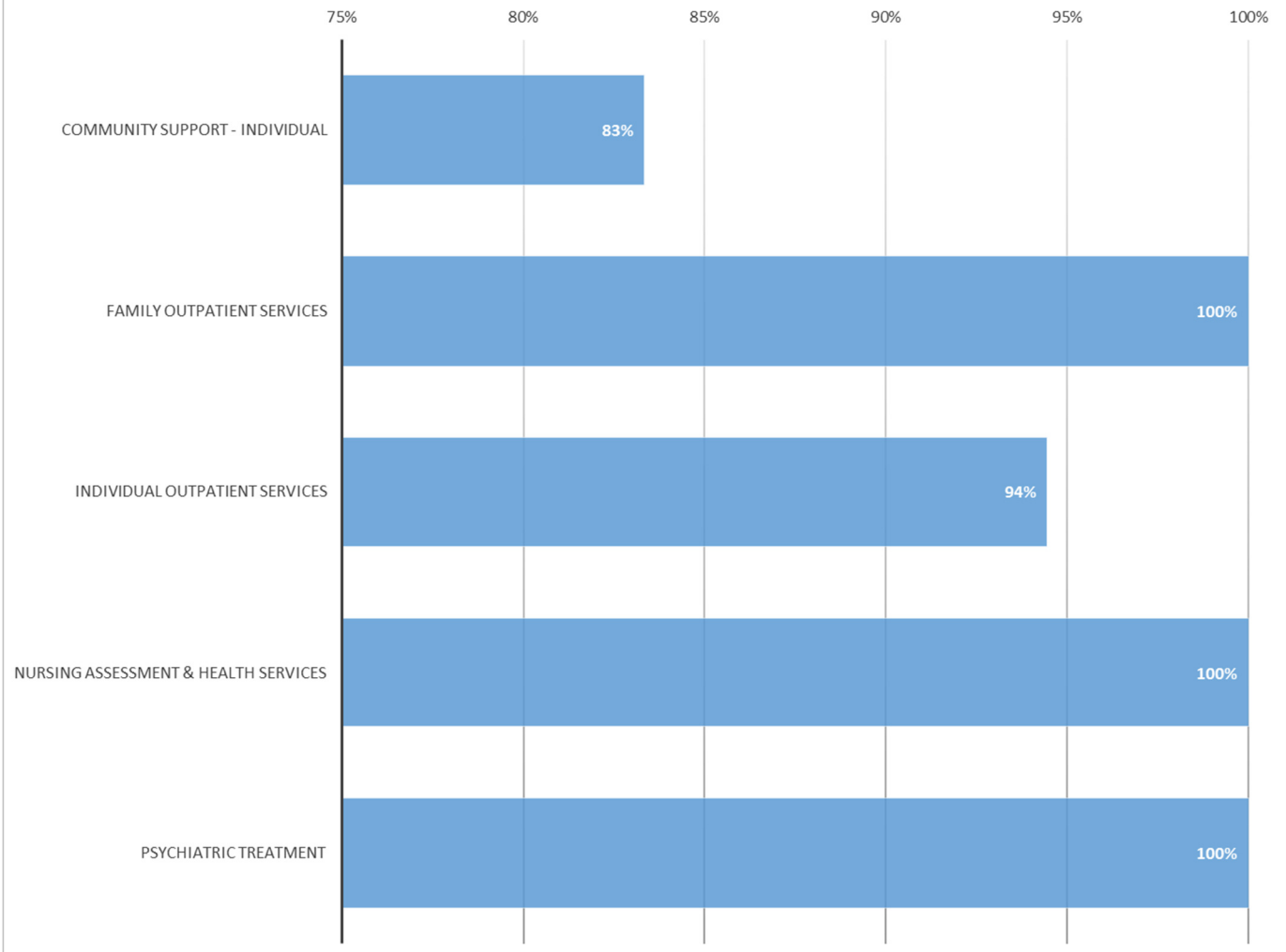
- Sixty-two percent of the individuals reviewed did not have whole health and wellness goals identified on their respective treatment plans as appropriate. For example, a seven year old child diagnosed with Bipolar Disorder, Schizophrenia, Epilepsy and Enuresis did not have any goals related to the his assessed physical health conditions.
- Sixty-two percent of the individuals served who had co-occurring health issues identified did not have those issues addressed in the treatment plan. For example, a child who was diagnosed with Schizoaffective Disorder and Autism and had a documented history of neglect and abuse suffered from migraine headaches. The individual was also assessed with issues related to difficulty paying attention, violence toward others, and impulse control issues such as temper tantrums. While the record contained multiple external assessments, including a PET scan from the Amen Clinic, there was no evidence of consents for medications, transition planning, or wellness goals related to the physical health of the individual.



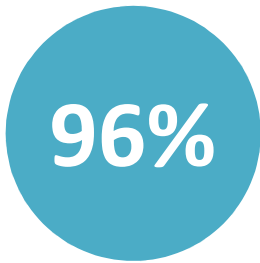
| Focused Outcome Areas | |
|-----------------------|--|
| | <p>Strengths:</p> <ul style="list-style-type: none"> • 100% of the records reviewed contained documentation that demonstrated the provider followed the individual’s known preferences to the extent that it was possible. • 100% of the records reviewed contained documentation that reflected that persons served were receiving individualized services. |
| | <p>Opportunities for Growth:</p> <ul style="list-style-type: none"> • When individuals were identified to have co-occurring medical conditions such as epilepsy, migraines, asthma, or other chronic health conditions, releases to a Primary Care Physicians or other medical providers were not present in records to help in the coordination of care. For example, a child who was diagnosed with needs related to Bipolar Affective Disorder, ADHD, and Mild Mental Retardation had a documented medical issue that included drug exposure in utero, a (stroke) CVA on the right side at birth with a history of aggressive behavior. There were no nursing assessments in the individual’s medical record. There were no releases to other medical providers. In addition there was no documentation that the individual was being routinely assessed to determine whether or not medical services were necessary. There were no lab reports or AIMS in the record and no safety plan documented in this record as well. |

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| | <ul style="list-style-type: none">• Individuals that were prescribed neuroleptic medications or medications that may cause tardive dyskinesia did not have Abnormal Involuntary Movement Scales (AIMS) filed in their records consistently.• Although some Individual Recovery Plans addressed medication compliance, when an individual had a specific medical condition this was also not included in the IRP.• Fifteen of the records reviewed did not contain a medication consent form. When medications were prescribed, there was not documentation provided to the individual and/or guardian about risks and benefits of the medication and there was not a signed informed consent for each medication prescribed.• Individual's Rights were not found to be updated annually in the records as required.• Safety plans were not consistently documented in the records as required.• Seven of the twenty records reviewed were missing documentation of transition planning throughout the service delivery. |
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Compliance With Service Guidelines



Compliance with Service Guidelines



Strengths:

- In most cases, the documentation reviewed in the Individual and Family Outpatient Services was detailed and clinically meaningful. For example, the progress note for an individual receiving counseling for issues related to the perpetration of sexual abuse contained clear examples of the interventions that the therapist utilized with the individual. The staff member described the individual's progress related to the specific curriculum interventions as well as the goal of reintegrating the individual into the community along with his attendance in a mainstream school.
- 94% of Individual Outpatient Services were found to be in compliance with DBHDD Service Guidelines.
- 100% of Family Outpatient Services were found to be in compliance with DBHDD Service Guidelines.

Opportunities for Growth:

- The one record reviewed in the Community Support Service was missing documentation of service and resource coordination as required.
- In some cases, the documentation in the Individual Counseling service was vague and was missing a clinically meaningful statement of the individuals' progress related to the person's IRP goals. For example, "(Individual) participated in session. He shared about his feelings and how they are connected to his thoughts and behaviors.

Additional Comments on Practices

Practices/Concerns beyond the general scope of the review were discovered by the Quality Assessors that may have the potential to impact service delivery, quality of care, or may represent a risk for the provider. The following practices or concerns were noted during the review:

Strengths:

- The agency's records contained a monthly summary of treatment team meetings that consistently reflected detailed clinical information for each of the individuals served.

Opportunities for Growth:

- The provider was missing a nurse on staff as required by DBHDD contract from January 19th through February 26th, 2015. Nursing services were routinely ordered but were infrequently provided as reflected in the documentation. Some records had initial nursing assessments and no other nursing services follow up. In other records, nursing services were not documented.
- In some records reviewed the dates of entry were modified by simply writing over the date on the form rather than utilizing the proper method. Best practice for correction of error is single line strike, the date and the initial of the staff making the modification or correction of errors.

Technical Assistance 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.

The following are recommendations given as a result of the review:

Billing Validation

Ensure services are provided to individuals who meet DBHDD Core Customer eligibility criteria.

Ensure services are ordered by an appropriately-credentialed professional.

Ensure documentation supports what is billed (*see comments in Billing Validation section*).

Assessment & Treatment Planning

Ensure all individuals served meet Core Customer criteria.

Ensure treatment/recovery/service plans contain goals, objectives, and interventions that promote whole health and wellness.

Ensure treatment/recovery/service plans address co-occurring issues and/ conditions.

Focused Outcome Areas

Ensure there is documented communication with external referrals and resources to determine the results of testing, treatment, and referral.

Ensure individuals' current medical conditions are assessed, monitored, and recorded.

Ensure there are documented safeguards utilized for medications known to have substantial risk or undesirable effects.

Ensure documentation supports that individuals (as appropriate) have individualized safety/crisis plans.

Ensure documentation supports that individuals (or parent/guardian) have been educated on the risks and benefits of all prescribed medications.

Ensure documentation supports that individuals have been informed of their rights and responsibilities at the beginning of services and then at least annually thereafter.

Ensure documentation reflects transition planning is evident throughout the delivery of services.