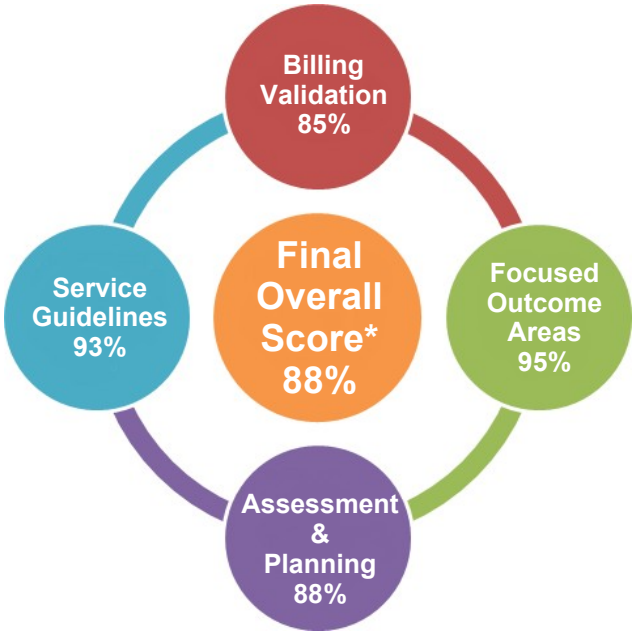
The Georgia Collaborative ASO

McIntosh Trail Community Service Board

Behavioral Health Quality Review Final Assessment	
Address: 1435 North Expressway, Suite 301, Griffin, GA 30223	
Assessors: Kristen Ponce, MFT; Latoya Polk, LPC, NCC; Michelle McIntosh, LPC, NCC; Natalee Fritsch, LPC; Edna Bryant, MSN, RN; Heather Hewett, LPC; Helen Rohrich, RN; Kelly Brown, LCSW	
Records Reviewed: 45	**Date Range of Review:** 12/9/2019 - 12/12/2019

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.



	Overall Score	Billing Validation	Focused Outcome Areas	Assessment & Planning	Service Guidelines
Review Date: 06/17/2019	86%	81%	92%	84%	85%
Review Date: 06/18/2018	87%	84%	93%	83%	86%
FY19 Statewide Average	90%	86%	94%	88%	90%

*The Final Overall Score is an average of the scored areas listed above minus any Quality Risk Items identified. Please refer to the next page for details.

Quality Risk Items

During Quality Reviews, items may be identified that could indicate significant risk to the individuals served, the provider agency, or to the Statewide provider network. At the direction of DBHDD, the Overall score (if applicable) is reduced in 2% increments for each risk item, with a maximum of 10% reduction total. The reductions in scoring are detailed below if Quality Risk Items were identified during this review. For a complete list of Quality Risk Items, please refer to Provider Handbook on The Georgia Collaborative website. The GA Collaborative ASO Provider Handbook

Original Overall Score	**90%**
Amount to Deduct from Overall Score	**2%**
Final Overall Score	**88%**
Quality Risk Item(s) *2% each (maximum 10%)*	Five or more repeated Quality Improvement Recommendations in any category from previous review

- Five or more repeated Quality Improvement Recommendations in any category from the previous Behavioral Health Quality Review (BHQR) were identified during this review:
  - Billing Validation: Ensure all Quantitative Standards are met in documentation.
  - Billing Validation: Ensure all Performance Standards are met in documentation.
  - Assessment and Planning: Ensure treatment/recovery/service plans address all areas of assessed need.
  - Assessment and Planning: Ensure treatment/recovery/service plans address co-occurring issues and/conditions.
  - Assessment and Planning: Ensure all transition discharge plan criteria are defined.
  - 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: Assertive Community Treatment (ACT)- Ensure the ACT team completes a Treatment Plan Review/Recovery Planning Meeting with staff, the individual, family, and informal supports prior to the re-authorization of services.
  - Compliance with Service Guidelines: ACT- Ensure the ACT team is working with informal supports/collateral contacts as required.
  - Compliance with Service Guidelines: Ensure Case Management services include referral and linkage to services identified in the individual treatment/recovery/service plan.

Summary of Significant Review Findings

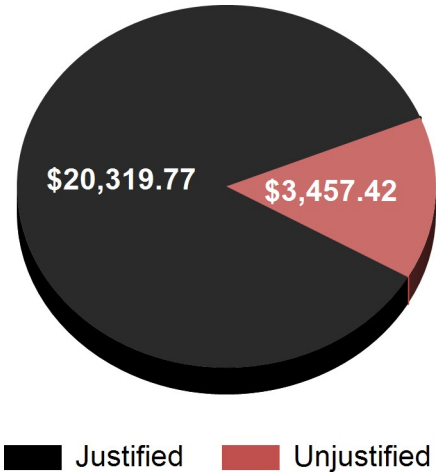
Strengths and Improvements:

- The ACT team has all required staff in accordance with the Provider Manual which is an improvement since the prior review in June 2019. The team currently has a vacancy for an additional licensed clinician position, of which they are currently looking to hire.
- In the event that an individual was unable to sign a document, such as an Individualized Recovery Plan (IRP) or crisis/safety plan, rationale was documented as to why the individual was not able to sign, i.e. "paranoia, agitation".
- All progress notes and assessments reviewed identified the individuals allergies to medications, foods, etc.

Opportunities for Improvement:

- Staff members did not sign and file notes in the electronic medical record (EMR) within seven calendar days, as required; for example, dates of entry were filed at 21, 49, and 62 days after the date the service was provided. Thirty progress notes were unjustified due to this trend.
  - One ACT staff member consistently signed progress notes with dates of entry beyond the required seven calendar day time-frame. The provider's staff self-reported this staff member is no longer employed with the agency.
- Many Mental Health (MH) Peer Support Program notes contained interventions which did not relate back to the clinical needs of the individual served, and were unjustified within billing claims reviewed. Examples included the history of Halloween, organ donation, and playing board games.

Billing Validation



	Medicaid	State Funded Services	Total
Justified	$6,833.44	$13,486.33	$20,319.77
Unjustified	$1,242.36	$2,215.06	$3,457.42
Total	$8,075.80	$15,701.39	$23,777.19

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
Performance Standards	Content does not support units billed	23
	Content of documentation is not unique	5
	Content does not support code billed	2
	Content of note does not match service definition	2
	Intervention provided is outside the scope of practice for staff	2
	Non-billable activity billed	1
Quantitative Standards	Progress note not filed within seven calendar days	30
	Location missing	1
	Staff credential missing	1
	Time in/Time out missing	1

Billing Validation: 85%

Strengths and Improvements:

- Staff members completed non-billable notes when appointments were rescheduled or individuals did not show for their sessions.

Opportunities for Improvement:

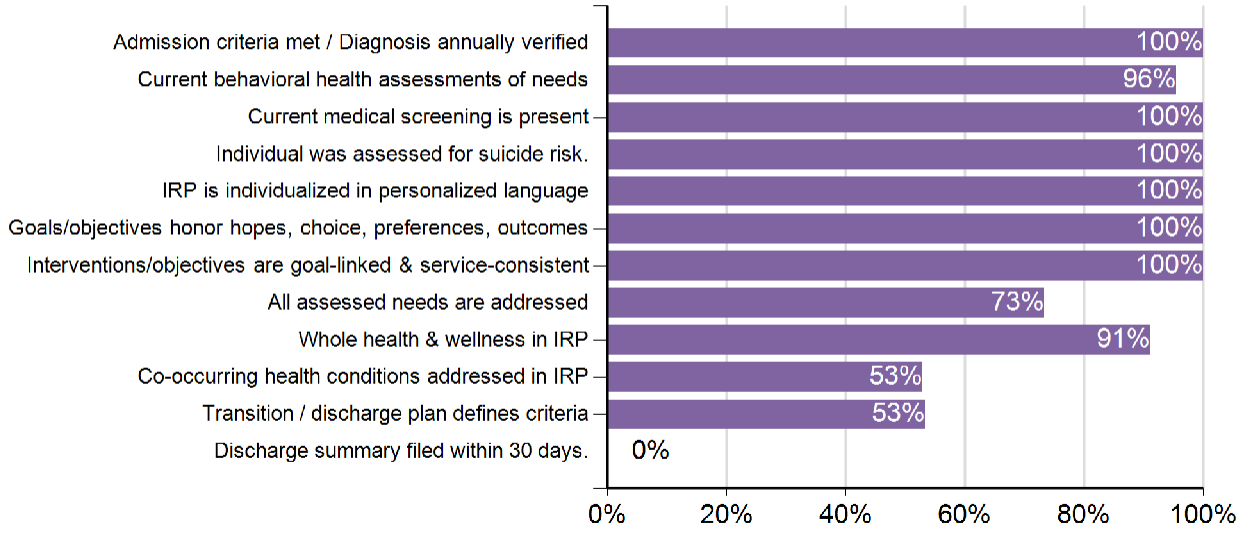
Performance Standards

- The content did not support the units billed in 23 notes. Examples included:
  - The majority of the progress notes which did not support the units billed were evidenced in MH Peer Support Program. This was due to interventions not relating back to the individual's clinical needs, or a portion of the note contained identical content to other dates inside and outside of the billing sample, or intervention(s) were vague as documented.
  - Time in/out of an ACT session 11:00AM-11:30AM; however, the physician signed the note on the date of service (10/10/2019) at 10:52AM, eight minutes prior to the session beginning.
- The content of the documentation was not unique in five notes reviewed. A staff member who provided the Psychosocial Rehabilitation- Individual (PSR-I) service duplicated interventions across notes. The provider's staff self-reported this staff member is no longer employed with the agency.
- The content did not support the code billed in two notes.
  - An ACT note billed with the out-of-clinic (U7) modifier occurred in-clinic, and should have been coded with the U6 modifier.
  - Another ACT note billed with the out-of-clinic (U7) modifier contained an intervention including making a telephone call, which would require the U6 in-clinic modifier.
- The content of the note did not match service definition in two notes. A note billed for PSR-I reflected resource linkage interventions instead of skill-building, and a note for Case Management documented skills-building interventions instead of resource linkage.
- The intervention provided within the progress note was outside the scope of practice for the staff member in two notes reviewed. One example was a paraprofessional (PP) documented an intervention of processing feelings regarding the individual's children being removed from their care.
- Non-billable activity was reflected in an ACT note, where the staff member documented the intervention as having the individual complete release of information (ROI) forms.

Quantitative Standards

- Thirty progress notes were not filed within seven calendar days. Examples included:
  - The ACT service was provided on 9/10/2019, yet, signed with date of entry 10/29/2019; 49 days after the date of service.
  - The ACT service was provided on 8/26/2019, yet, signed with date of entry 10/28/2019; 62 days after the date of service.
- The specific out-of-clinic location was missing in one ACT note, which simply identified the location as "in the community."
- The staff member's credential was missing in one note. A staff member documented therapeutic interventions regarding substance abuse counseling; however, the staff member did not sign with the Addiction Counselor Trainee credential, for which they are credentialed.
- Time in/Time out was missing in one MH Peer Support Program note.

Assessment & Planning



Assessment & Planning: 88%

Strengths and Improvements:

- All ACT IRPs contained evidence of whole health and wellness goals, interventions, and initiatives. For example:
  - "Staff will assist individual with budgeting, hygiene, medication management and healthy meal planning leading to independent living."
  - "..helping build medication management skills by setting alarms, calendars, pill planners, etc."
  - "I want to start exercising (join local gym).."
- Progress notes reflected staff administering the Columbia Suicide Severity Rating Scale (C-SSRS) was during sessions. The C-SSRS was also embedded within assessment tools, which were typically updated at least annually.

Opportunities for Improvement:

- The following items identified during this review are recurring issues identified in previous BHQRs, most recently June 2019.
  - All assessed needs were not addressed in six of 30 Non-Intensive Outpatient Services (NIOP) IRPs, and six of 15 ACT IRPs. Examples of assessed needs not included in IRPs were individuals' trauma histories, sexual and physical abuse, domestic violence, history of suicide attempts, body image issues, desire for employment, intellectual disability, and substance abuse.
  - Ten of 21 applicable NIOP IRPs and six of 13 applicable ACT IRPs did not reflect co-occurring health conditions of the individuals, including physical health issues, intellectual and developmental disabilities, and substance abuse. Specific conditions not included on IRPs were hypothyroidism, arthritis, pre-diabetes, hypertension, high cholesterol, cannabis use, and an intellectual disability.
  - Anticipated transition/discharge criteria was not defined in 21 records (five of which were ACT).
    - All five ACT records contained expired dates for transition/discharge, such as 7/17/2019 and 9/27/2019. Four of these records identified an unspecific support or service upon transition/discharge, of either "LLOC" (lower level of care), or "Non-Intensive Outpatient Services".
    - "Non-Intensive Outpatient Services" was also identified as the unspecific step-down service for NIOP individuals. Additionally, some individuals' discharge criteria contained vague and unclear clinical outcomes to meet toward discharge, such as, "[Individual] will transition/discharge when she reports depressive sxs <1x monthly over a 1 year period." One individual's anticipated discharge date was expired.
- One individual's discharge summary was not filed within 30 days after the last date of service. The individual last received services, and was discharged, on 8/30/2019; yet, a discharge summary was not completed until 10/8/2019.

Focused Outcome Areas

Focused Outcome Areas: 95%

Strengths and Improvements:

- Transition planning was evident in all 45 records reviewed, which included specific objectives to be met prior to discharge or a decrease in the intensity of services. Examples included:
  - An individual receiving Supported Employment had been employed consistently for 180 days and the individual and staff member were discussing the likelihood of the individual stepping-down due to meeting this goal.
  - The frequency and scheduling of sessions were discussed with an individual, whereas the individual and staff member would determine if they could reduce the frequency of sessions and attend group and individual sessions on opposite days of one another.
- All applicable individuals signed formal acknowledgement of rights and responsibilities at the onset of services, supports, and treatment.

Opportunities for Improvement:

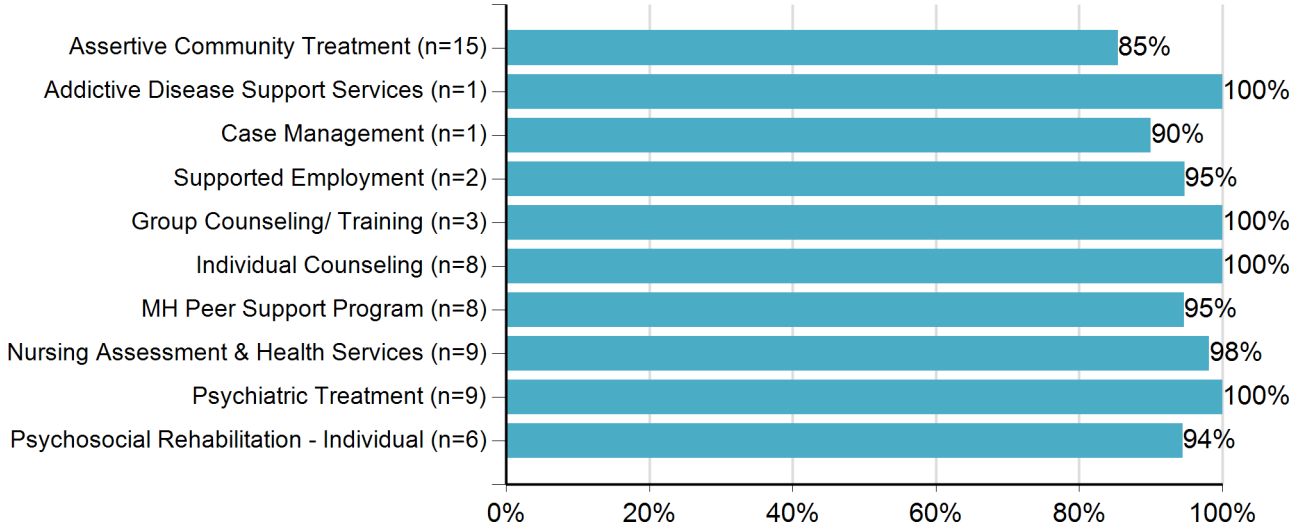
Rights

- The individual and/or guardian had not signed formal acknowledgement of rights and responsibilities reviewed at least annually during services in nine of 36 applicable records (two of which were ACT). One individual who has been receiving services since 2014 did not have rights filed in the record since January 2017. This was identified as a recurring issue.

Person-Centered

- Documentation did not demonstrate the plan was reassessed based upon changing needs, circumstances, and/or response by the individual in five of 24 applicable records (two of which were ACT). Examples included:
  - An individual declined participating in substance abuse group programming; however, this was still identified on their IRP as a part of their treatment planning.
  - An individual's sibling passed away in September 2019, which exacerbated the individual's suicidal ideations. The suicidal thoughts nor the sibling's death were added to the individual's IRP.

Service Guidelines



Service Guidelines: 93%

Strengths and Improvements:

- ACT nursing notes identified the risks and benefits for each medication prescribed.
- Both ACT and NIOP Psychiatric Treatment progress notes contained a running list of previously captured vital signs during appointments.
- When medications were prescribed externally, this was documented within Psychiatric Treatment progress notes and detailed the medication, the prescriber/clinic, and why it was prescribed.
- Psychiatric Treatment progress notes were comprehensive and documented pertinent details such as the individuals's stage of change, co-occurring health conditions, side effects of medications both current and historically, and reflected the use of motivational interviewing.

Opportunities for Improvement:

ACT

- None of the 15 records reviewed contained evidence in which the ACT team conducted Treatment Plan Review/Recovery Planning meetings with the staff members, individual, family/informal supports, at least quarterly and prior to re-authorization of the service. This is a recurring issue identified in the previous BHQR in June 2019.
    - The provider's staff self-reported that a plan has been developed to begin incorporating these Recovery Planning meetings in regular rotation for the ACT team. However, at the time of review, the assessors did not see evidence these were occurring as of yet.
- Eight of 11 records did not provide evidence the ACT team was working with informal support systems/collateral contacts at least two-four times per month (with or without the individual present) to provide support and skills training to assist the individual in his/her recovery. This is a recurring issue identified in the previous BHQR in June 2019.
    - An individual who identified both parents as a support system, with whom the individual also lives, were only included in coordination of care one time in October, and none in September or November 2019.
    - Another individual identified their mother as a natural support; yet, there were no collateral contacts documented in the months September or November 2019.
- The ACT team did not work with two of nine applicable individuals toward educational or vocational needs or interests, per the IRP. This was identified as an opportunity for improvement in the previous BHQR in June 2019.
    - One individual expressed desire to obtain a job with their Certified Peer Specialist (CPS) credential; however, there was no evidence the ACT team was assisting the individual with this employment search.
    - An individual wanted to take computer efficiency classes, but there was no documentation staff was assisting in this effort.

Case Management (CM)

- One record reviewed for CM did not contain evidence of referral and linkage to services and resources as identified in the individual's IRP. The content of this individual's CM notes were skills-building interventions, not resource linkage. This was identified as a Quality Improvement Recommendation in the previous BHQR in June 2019.

Supported Employment

- One applicable record did not contain an updated Vocational Profile after the individual was terminated from their employment, as required. This update should also include assistance in updating the individual's resume and employment plan.

MH Peer Support Program

- Two of eight records reviewed did not contain evidence of progress statements (or lack of) toward specific goals/objectives on the individual's IRP in progress notes. This was identified as an opportunity for improvement in the previous BHQR in June 2019.

Overall Programmatic

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.

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
	# Yes	**# No**	**# N/A**	**SCORE***
	5	**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.

- The provider is reminded all credentialing documentation is required to be delivered within the designated two-hour time frame.
- A staff member on the ACT team was signing their education credential as "MAC," but had a Master of Science degree with emphasis in Addiction Counseling. Technical Assistance was provided on appropriate credential documentation after reviewing the staff member's personnel file.
- An individual's IRP contained the name of another individual not being reviewed. Additionally, interchanging gender pronouns were documented within progress notes in different records.
- Multiple documents ("Controlled Substance Prescription Management Medication" form, ROIs) for one individual were scanned into the EMR of another individual in the review sample.

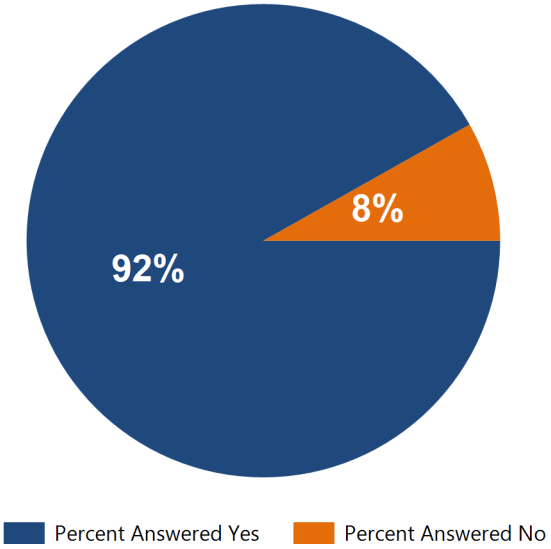
At the request of DBHDD, a site visit of the Crisis Respite Apartments (CRA) was conducted during the BHQR. The CRA site visit results are not included in the Overall score of a provider's BHQR. Crisis Respite Apartments Site Visit Questions are based on DBHDD Provider Manual and the U.S. Department of Housing and Urban Development Inspection Form.

McIntosh Trail has three Crisis Respite Apartments; all three apartments have two bedrooms each. Staff are onsite 24 hours a day to provide transportation, assist with searching for housing, employment, linkage to community resources, activities of daily life (cleaning, budgeting, cooking, etc.). Staff complete safety checks every 30 to 60 minutes, 24 hours a day. Please refer to the Crisis Respite Apartment site visit table at the end of this report for details.

Individual Interviews

Individual Interviews Conducted: 5

Individual Interviews are not calculated into the Overall Score



Comments shared by individuals interviewed included:

- "They definitely made sure I was working on what I wanted to work on. They encourage me to meet my goals, and offer to take me somewhere when I need; they put in effort to go the extra mile."
- "If I did not come to group, I would be in the bed all day. That's not good for me. Group gets me out and gets me active."
- "My case manager helped me out with my housing. She also made sure I got my medication."
- "I go to groups and meet other people with my diagnosis. I want to get involved in the things at the respite center, like the 'hearing voices group'."
- ".. I get transportation to groups and that is one thing I don't have to worry about, how I am going to get here."
- "I don't have any physical health needs, but they asked me if I have a primary care doctor."
- "They know I have GERD (Gastroesophageal reflux disease), but no one asks me about it. I do have a primary care physician that helps me with it."
- "[The physician] listened to me when I thought that I should discontinue (treatment), but she encouraged me to keep trying, and it was the best idea. She is very patient with me."
- "They're kind and supportive. They're professional, but they also treat you like a human being, and not just another client."

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.

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 all areas of assessed need.
- Ensure treatment/recovery/service plans address co-occurring health conditions and concerns.
- Ensure transition/discharge plans define criteria for discharge, planned discharge date, and specific services.

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 - Case Management

- Ensure Case Management services include referral and linkage to services identified in the individual treatment/recovery/service plan.

Compliance With Service Guidelines - ACT

- 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.

Recommendations: Current Review

Compliance With Service Guidelines - All

- Ensure documentation addresses individuals' progress toward specific goals and objectives.

Additional Recommendations

Current Review Recommendation:

- Compliance with Service Guidelines: ACT- Ensure ACT Team is working with the individual towards educational or vocational needs, interests, per IRP.

FY 2020 Crisis Respite Apartments Site Visit for McIntosh Trail CSB Assessors: **Nicole Griep, Kristy Ponce, Edna Bryant, Keikilani Bennett** Date: **12/11/2019**		
	Observations of Assessors	**Score**
1	Unit exterior is in good repair, maintained, safe for the provision of services; free of trash, debris, or other hazards. • McIntosh Trail has three Crisis Respite Apartments; all three apartments have two bedrooms each. Two apartments have a bedroom on the ground and second floor. One apartment has both rooms on the second floor. • All three apartments were clean, nicely decorated, had working appliances, and contained comfortable-looking furniture. • Crisis Respite staff are onsite 24 hours a day to provide transportation, assist with searching for housing, employment, linkage to community resources, activities of daily life (cleaning, budgeting, cooking, etc.) Staff complete safety checks every 30 to 60 minutes, 24 hours a day. • Residents are linked with Rushton's Hope for donated furniture and household appliances; First Baptist Church for food, clothes, hygiene items, and assistance with obtaining birth certificates, social security cards, and identification cards. • During the site visit, CRA staff reported one of the residents is moving into her own apartment within the week. • Under staff supervision, a computer is available to the CRA residents for internet use only. • All three apartments were fully stocked with food and water. No expired food noted. All apartments contained temperature logs and water logs.	**YES**
2	Unit has all utilities required: electricity, water, gas, sewer, etc.	**YES**
3	All electrical outlets are properly installed *(no exposed wiring, cover plates present, etc.).*	**YES**
4	Windows are in state of good repair, lockable on ground floor, free of rot/ deterioration, sealed properly.	**YES**
5	Ceilings, walls, and floors are in good repair and free of: holes, loose or falling surfaces or paint, water damage, water or air infiltration, etc.	**YES**
6	Emergency food supply *(at least three days' worth)* is present *(water, canned food, dry food, etc.).* • All three apartments contained multiple gallons of water and a three day emergency food supply. Emergency food supply was stored in kitchen cabinets and had an expiration date of 2048. • No expired food was found in any of the three apartments.	**YES**
7	Medications are properly stored *(refrigerated as needed)*, secure, safe, etc. • Medications were stored behind double locks in one of the apartments.	**YES**
8	Individual has access to private space in home *(own bed, shower/bathing facility does not require access through another's bedroom, living space is not shared with provider's administrative office space)*. • The CRA does not currently have an office located in the apartment complex. • The CRA staff utilize the living room corner in one of the apartments for office space and storage of medications in the utility closet (behind double locks). Additionally, staff occupy this apartment during down time and between safety checks. • Laundry facilities are not located within each apartment. The laundry facility is located in one of the apartments for all CRA residents to use. CRA residents are allowed to do laundry between 4pm – 6pm on specified days. The CRA residents that occupy that apartment are aware and consent to other residents doing laundry. A staff member always accompanies residents when doing laundry.	**NO**
9	Living space is clean, accessible, and free of: pests, hazards, bad odors, trip hazards, dirt, etc. • Overall, the living space was clean; the apartments had recently been vacuumed, counters wiped, and contained a pleasant smell. However, minor cleaning recommendations are as follows: o A ceiling fan needs to be dusted in one of the bedrooms. o An A/C vent located in the hallway on the second floor needs dusting. o There are cob webs and a skeleton of a dead frog in the window seal of one of the bedrooms.	**YES**
10	Living space is age-appropriate and respectful of individual(s) served.	**YES**
11	Lighting is adequate to the needs of individuals present/served. • All three apartments had good, operational lighting. • However, several light bulbs needed to be changed.	**YES**
12	Individual has access to kitchen that is clean, in good repair, is functional, and refrigerator maintains food at appropriate temperatures.	**YES**
13	Individual has 24-hour access to outside communication via telephone. • All apartments contained landlines.	**YES**

14	Individuals have emergency contact numbers / numbers for all supports. • Contact numbers are available in each apartment that include staff contact numbers, crisis line, medical assistance, etc.	**YES**
15	First aid kit is present is present and residents know where it is stored. • First Aid kits are present in every apartment.	**YES**
16	Smoke detector, CO detector, and fire extinguisher are present and in working order. • Two of the smoke detectors were beeping; the staff placed a maintenance order to have them replaced with the apartment complex.	**NO**
17	If residents use wheelchair, walker, etc., unit is ADA accessible to them *(both interior and exterior - ramps, grab bars, etc.)* • Two apartments have a bedroom located on the ground floor.	**YES**