The Georgia Collaborative ASO

Professional Associates Healthcare of Georgia

Behavioral Health Quality Review Final Assessment

Address: 316 South 9th Street, Griffin, GA 30224

Assessors: Kristen Ponce, MFT; Latira Barnett, BSN, RN; Faith M Simpson, LPC, CADCII, MATS; Heather Hewett, LPC; Jennifer Byrd, LPC, CPCS; John Dixon, CPRP; Joseph Sweeney, LPC, CPCS

Records Reviewed: 20

Date Range of Review: 5/30/2023 - 6/2/2023

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.

	Overall Score	Billing Validation	Focused Outcome Areas	Assessment & Planning	Service Guidelines
Review Date: 04/25/2022	95%	87%	98%	97%	96%
Review Date: 03/22/2021	91%	85%	93%	91%	93%
FY22 Statewide Average	90%	79%	94%	91%	95%

Note: The FY22 Statewide Averages represent the mean of scores for all reviewed providers.

Summary of Significant Review Findings

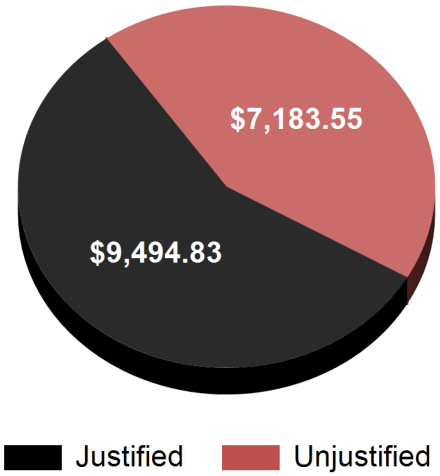
Strengths and Improvements:

- Three personnel files were reviewed for credentialing. All staff members reviewed met the minimum standard training requirements (STRs) to bill with their credentials of paraprofessional (PP), supervisee/trainee (S/T), and licensed professional counselor (LPC).
- The provider utilized a hybrid record keeping system with paper records and electronic medical record (EMR). Documentation filed in the paper records was organized and easy to locate.
- The provider consistently obtained releases of information (ROIs) for individuals and requested medical record documentation from primary care physicians (PCPs) and hospitals, and filed paperwork and/or fax confirmation sheets within the record which addressed attempts to coordinate care.

Opportunities for Improvement:

- Sixty four (64) progress notes were signed and filed after seven calendar days, as required. Many progress notes inside and outside of the billing review sample, as well as other documentation, were signed within the few days prior to the Behavioral Health Quality Review (BHQR) on 5/28/2023, 5/29/2023, and in the early morning of 5/30/2023.
- Multiple services inside and outside of the billing review sample continued to be provided with similar focus. This was also noted within the previous BHQR in April 2022.
    - As well, many records documented providing individuals with Case Management (CM), Addictive Disease Support Service (ADSS), and Psychosocial Rehabilitation- Individual (PSR-I). While these services may be authorized and provided at the same time to individuals with co-occurring mental health and substance use disorders, there is an expectation that one of these services serves as the primary coordination resource for the person. If these services co-occur, there must be documentation of coordination of supports in a way that no duplication occurs.
- Notes were billed that reflected diversionary activities such as individuals viewing YouTube videos with no other interventions.
- Three individuals with a history of suicide behavior did not have their record (paper or EMR) flagged with a "Suicide History" alert.
- An individual reported hearing loss in their right ear and wore bilateral hearing aids. Documentation did not demonstrate staff contacted the Office of Deaf Services (ODS) as standards and notification requirements outlined in DBHDD PolicyStat 15-114 were not followed. Refer to *Service Guidelines* for additional information.

Billing Validation



	Medicaid	Total
Justified	$9,494.83	$9,494.83
Unjustified	$7,183.55	$7,183.55
Total	$16,678.38	$16,678.38

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	9
	Diversionary activities billed	8
	High utilization without justification	5
	Content of note does not match service definition	4
	Intervention provided is outside the scope of practice for staff	3
	No overall progress documented	2
	Non-billable activity billed	2
	Mutually exclusive services billed	1
Quantitative Standards	Progress note not filed within seven calendar days	64
	Progress note is missing	4
	Units billed exceeded time and/or units documented	1

Billing Validation: 57%

Strengths and Improvements:

- Three personnel files were reviewed for credentialing. All staff members reviewed met the standard training requirements to bill with their credentials of PP, S/T, and LPC.

Opportunities for Improvement:

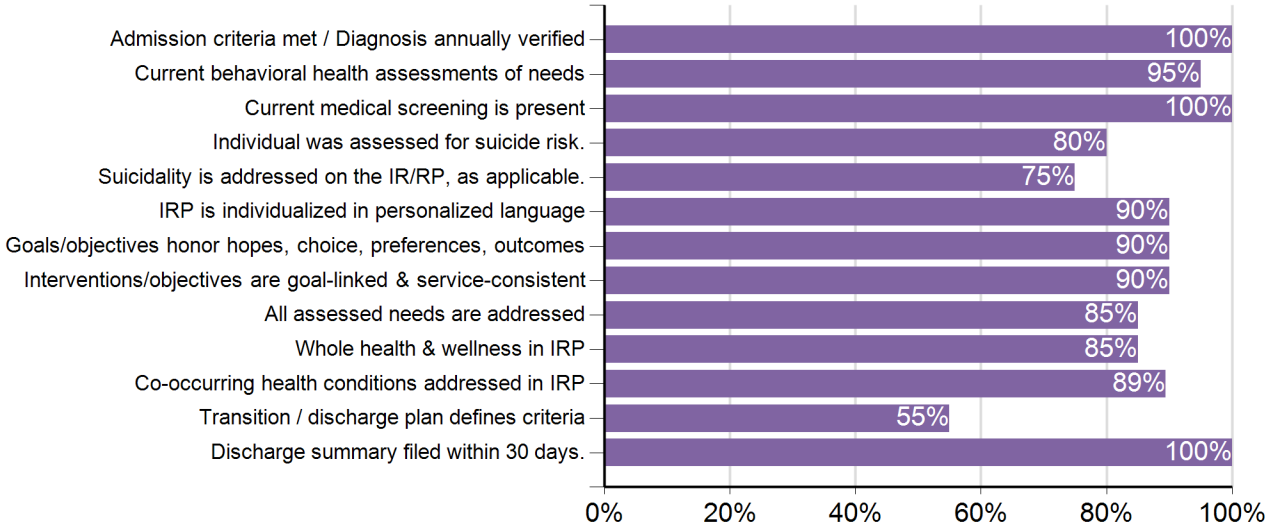
Performance Standards

- Content did not support the units billed in nine progress notes. Examples included,
  - One hour of service was billed to review the individual's treatment plan, but no changes were made to the IRP.
  - Staff billed H0031 for six units to complete a Columbia Suicide Severity Rating Scale (C-SSRS) and update a crisis/safety plan, but there was no supporting documentation filed in the record to demonstrate these assessments were completed on this date.
- Eight progress notes were billed which contained diversionary activities. Sessions were billed where the sole intervention was to show a YouTube video to an individual, without the staff member further documenting their efforts of intervention during the session.
- High utilization of services were evidenced within documentation within four records, affecting five progress notes reviewed for ADSS, CM, and Mental Health (MH) Peer Support Individual. Examples included,
  - CM: This four-unit claim follows a four unit claim for PSR-I and a six unit claim for Peer Support Whole Health and Wellness (WHW)- Individual. The individual received three and a half hours of services all related to his physical health. This third contact was redundant to the first and second prior contact for the day.
  - ADSS: The individual received four services on this date of Peer Support WHW- Individual (9:16am-10:38am), MH Peer Support Individual (10:41am-12:02pm), this service ADSS (12:45pm-1:47pm), then PSR-I (2:01pm-2:59pm) all in the home.
- The content of the progress note did not match the service definition in four CM progress notes reviewed. Case Management service was billed for a check-in and discussing coping skills and "*targeting triggers*," and lacked case coordination and resource linkage needs of the individual.
- Three Case Management progress notes were facilitated by a PP who documented counseling-focused interventions, which is outside the scope of practice for the staff member. Interventions consisted of "*explaining cognitive behavioral therapy highlights and how negative thoughts can lead to negative feelings and actions*," "*eliminating self-criticism*", "*re-channeling herself,*" addressing triggers for depression.
- Two CM progress notes reviewed lacked progress statements toward the individual's goals.
- Non-billable activity was billed in two progress notes reviewed. For example, an MH Peer Support Individual note was billed for updating administrative paperwork with the individual, such as rights acknowledgements and review Health Insurance Portability and Accountability Act (HIPAA) privacy and security rules, which is non-billable.
- Mutually exclusive services of Medication Administration and Nursing Assessment and Health Services were facilitated and billed on the same date of service within one record, affecting one progress note reviewed. This was also evidenced outside of the billing review sample.

Quantitative Standards

- Sixty four (64) progress notes reviewed were not filed within seven calendar days, as required. Examples included,
  - An Individual Counseling progress note was signed on 3/20/2023, 19 days after the date of service.
  - A Peer Support WHW- Individual progress note was signed 5/29/2023, 54 days after the date of service.
  - A CM progress note was signed 5/29/2023, 66 days after the date of service.
- Four (4) progress notes reviewed were missing.
- An MH Peer Support Individual progress note was billed for 14 units, but four units were documented on the note.

Assessment & Planning



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

Assessment & Planning: 87%

Strengths and Improvements:

- Individuals were assessed multiple times throughout the year, which included Behavioral Health Assessments (BHAs) as well as Diagnostic Assessment, and Addiction Severity Index for individuals with identified substance abuse needs.
- All records reviewed included a current medical screening. Many individuals received at least an annual nursing assessment through this provider; otherwise, medical concerns were captured within the BHA, Diagnostic Assessment, or Psychiatric Treatment services. In addition, records included external correspondence with identified providers and specialists to determine current medical health status.
- One individual reviewed had been discharged from the provider's care. A discharge summary was filed timely within the paper record and included all required components.

Opportunities for Improvement:

- Four (4) individuals were not thoroughly assessed for suicide risk. Examples included,
  - An individual readmitted to services with this provider in January 2023 and did not have a C-SSRS Lifetime/Recent completed upon intake, and one was not facilitated to the individual until 5/26/2023.
  - One individual who has a history of suicide risk had C-SSRS Lifetime/Recent assessments which were inaccurately and inconsistently scored. The most recent C-SSRS did not capture the individual's prior suicidal ideation with plan to overdose on pills, and in the C-SSRS which did capture this information, the timeframe was not included for when the ideation was present.
- Two (2) of eight applicable IRPs did not address suicidality. Both individuals referenced above were not thoroughly assessed for suicide risk and suicidality was not included on their IRPs as a need to be monitored.
- Anticipated transition/discharge criteria was not defined within nine of 20 records reviewed. Transition/discharge plans contained expired dates, as well as clinical outcome criteria which was not measurable. Examples below were clinical outcomes that were subjective and vague,
  - "*Effective medication management,*" and "*management of his symptoms*,"
  - "*[Individual] will discharge after six consecutive months of effectively managing her symptoms without incident*."

Focused Outcome Areas

Focused Outcome Areas: 94%

Strengths and Improvements:

- All 20 records reviewed included evidence of communication with external providers. Staff members with this agency consistently obtained ROIs from individuals and requested medical record documentation from PCPs and hospitals, and filed paperwork and/or fax confirmation sheets within the record which addressed attempts to coordinate care.
- All 20 records reviewed demonstrated staff assisted individuals in updating safety/crisis plans at least annually, with or without evidence of a preceding crisis event.
- All applicable records reviewed contained formal signed acknowledgements of rights and responsibilities at the onset of services, as well as at least annually throughout treatment.

Opportunities for Improvement:

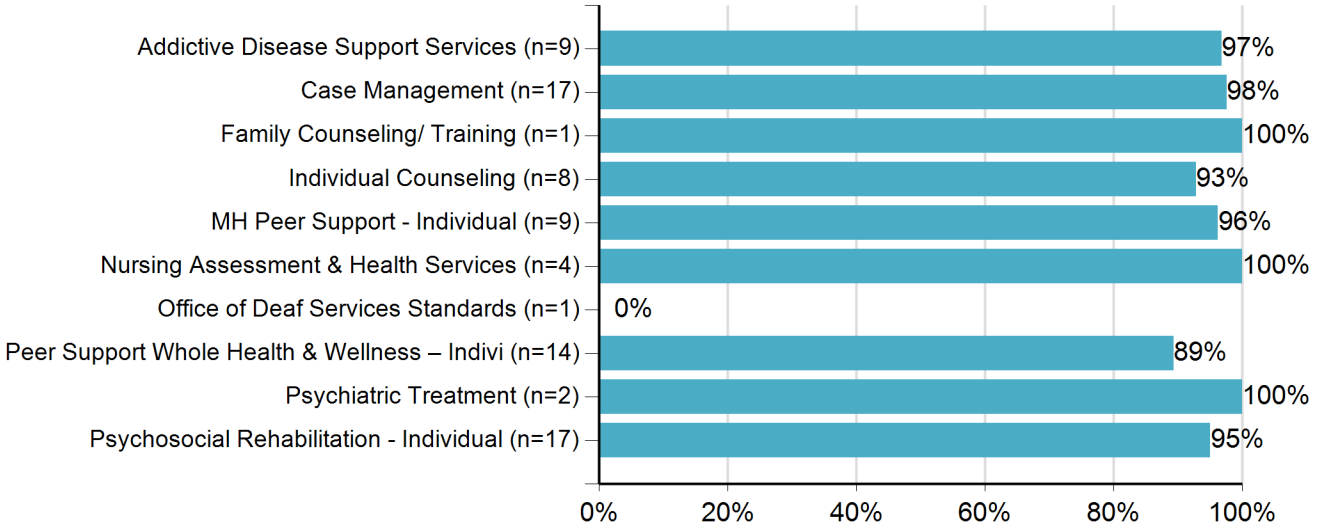
Whole Health

- Documented safeguards were not utilized for medications known to have substantial risk or undesirable effects in three of 11 applicable records.
  - Two records did not contain an abnormal involuntary movement scale (AIMS) assessment when the individual was prescribed psychotropic medication, such as Seroquel and Risperdal.
  - One individual was prescribed the medication Depakote and did not have a Valproic Acid blood level ordered and/or completed to ensure therapeutic range.

Safety

- Three (3) of eight applicable records did not include a "Suicide History" risk alert flag on the paper record or within the EMR for individuals who had a history of suicide behavior at any point within their lifetime.
- One of two applicable records did not document evidence of ongoing assessment according to DBHDD PolicyStat 01-126 when an individual was identified to be at moderate or high risk for suicide. The individual entered services in March 2022 with suicide risk and the only C-SSRS filed was upon intake, until one additional C-SSRS was facilitated with date of service 3/13/2023 but not signed until 5/30/2023 by a staff member. This is a recurring issue last noted in the prior BHQR in April 2022.

Service Guidelines



Service Guidelines: 94%

Strengths and Improvements:

- All 17 records reviewed for Case Management included a safety/crisis plan relevant to the individual, and identified the provider as the primary responsible party in the event of a crisis situation. Specific staff member contact information (name and phone number) were included in the signed document.
- Health engagement and health management of the individual was the primary focus of interventions within the Peer Support Whole Health and Wellness-Individual records reviewed. Staff members documented interventions which included the importance of keeping and following up with medical appointments to understand medical diagnoses, education to limit fried foods to once a week and stick with baked and broiled foods, drink more water and eat more vegetables, maintain physical health awareness, be sure you can hear/see as well as possible, etc.

Opportunities for Improvement:

Office of Deaf Services (ODS) Standards

- Within an individual's record, documentation evidenced an individual reported experiencing hearing loss in her right ear and wore bilateral hearing aids. There was no documentation filed in the record in which ODS had been contacted and policy standard requirements were followed. The following indicators were scored "No,"
  - The provider notified ODS within two business days of first contact with the individual served.
  - The Communication Assessment Report (CAR) is in the medical record.
  - The CAR is addressed in IRP to include individual's preferred mode of communication.
  - Notification of Right to Free American Sign Language (ASL) Services and Accommodations form is in the individual's medical record.
  - Individual indicated a change in preference to utilize (or not) ASL-fluent services, and provider contacted ODS.
  - Registration identifies individual as deaf/hard-of-hearing.

Addictive Disease Support Services (ADSS)

- Coordination with family and significant others was not documented within one of two applicable records. This is a recurring issue last noted in the prior BHQR in April 2022.

Peer Support Whole Health and Wellness- Individual

- Collaboration with other healthcare providers to assure the individual had access to needed services was not documented within four of 14 records.
- A minimum of one contact weekly was not filed in six of 14 records. Within these records, there was no documentation filed of attempts to meet or rationale for the gap in service provision. This is a recurring issue last noted in the prior BHQR in April 2022. Examples included,
  - An individual received sessions with gaps in their care from 2/26/2023 to 3/11/2023 to 3/21/2023.
  - An individual was missing weekly contacts in January 2023 (three sessions), and April 2023 (2 sessions).
- While not scored under Service Guidelines, the requirement of monthly team meetings to include the certified peer specialist (CPS) and registered nurse (RN) was not met for the month of April 2023.

Individual Counseling

- Progress statements were lacking in two of eight records reviewed for this service. Progress statements were addressed in vague and general terminology, and did not document specific progress toward goals or discharge criteria.

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.

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

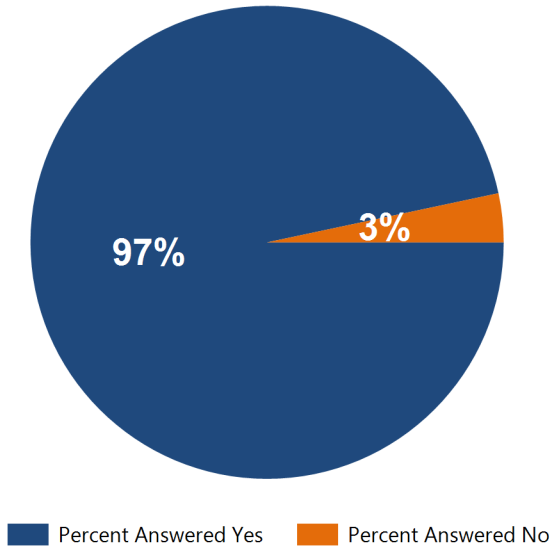
Additional strengths and concerns beyond the general scope of the review were discovered by reviewers. Additional issues/practice concerns may have the potential to impact service delivery, quality of care, or may represent a risk to the provider.

- The provider is reminded of documentation delivery timeframes during the BHQR. Some documentation (Team Meeting Minutes and staff credentialing supporting documentation) was submitted after the initial requested documentation delivery time windows on day one of the review.
- A C-SSRS Lifetime/Recent was facilitated with date of service 3/21/2023, but was not signed by the LPC until 5/30/2023 at 3:53am. Further, the assessment was incongruent with the prior assessment and not reflective of the individual's actual risk, nor did it capture prior attempt(s) and ideation.
- It was noted in at least two records that the nurse documented separately of an individual's medication injection subsequent to a four-unit nursing assessment. When completed on the same day as Nursing Assessment and Health Services, Medication Administration cannot be billed but becomes a part of the nursing assessment activity. Further, medication administration activities require patient education (which would have also been a part of the nursing assessment).
- It was noted in multiple records reviewed that AIMS monitoring for neuroleptic medication was occurring for an adult anywhere from 14 to 24 months apart. The minimum monitoring for adults is every six months and every three months for children and adolescents.
- In at least two records, a progress note for MH Peer Support Individual documented the administrative tasks of completing paperwork and reviewing the individual's rights, giving HIPAA notification, and getting signatures from the individual. One note was in the claims sample; the following note example was not in the claims sample. The note stated:
    - *"The primary focus of the session was to look over important forms to remind [individual] of his rights as a client, rights to accept and reject treatment and services. And, to remind him that his information was confidential. CPS performed an administrative update that is discussing company policies, client rights, consent to treatment, emergency contact, release of information for medical records, etc. CPS went over all the documents with [Individual]. CPS explained the purpose and intent of each form. CPS offered examples to help [Individual] understand the consent he was signing. For example, CPS explained the HIPPA [*sic*] policy by reiterating the legal demand to keep his information confidential. CPS emphasized to [individual] his rights as a client. For instance, "the right to participate in planning your own treatment, and the rights to request choice over the composition of the service delivery team, etc." ("Rights of a Consumer"). CPS collected his caregiver's contact information.* [Already in the record] *CPS stressed the importance of his participation in all areas of the delivery of treatment and services. CPS asked [individual] if he had any questions."*
- It was noted in several records that nursing staff did not complete documentation of assessment, injections, etc. for days after the date of service. Although DBHDD allows up to seven (7) calendar days to complete documentation, waiting up to a week to document an injection poses risk to the individual and the provider agency alike.
- Documents were created electronically months beyond the service date. i.e., Behavioral Health Assessment with a service date 4/28/2023 but not created in the EMR until 5/29/2023 and signed 5/30/2023; early morning prior to our review beginning.
- The psychiatrist did not include their "MD" (medical doctor) credential in psychiatric treatment notes, only "Psychiatrist". As well, signatures are supposed to include the name as they are written on their designated license. Often the signature was illegible to the printed name.
- Some documents (i.e., Addiction Severity Index) were uploaded to Sharenote in an editable format (i.e., Microsoft Word); a reoccurring issue noted within the last BHQR in April 2022.
- When an individual had a "Suicide History" alert checked in the EMR, this did not populate on any main messaging to alert the reader of the risk. It is hidden within the individual's "Details" section only of the EMR.
- An individual was referred to by a different name in at least two progress notes within their record within the Peer Support Whole Health and Wellness- Individual service.

Individual Interviews

Individual Interviews Conducted: 3

Individual Interviews are not calculated into the Overall Score



Three individuals were interviewed regarding their services with this provider. The following information was shared,

- Individuals have been involved in the development of and updates to the IRP.
  - *"I told them I'd like to go sit in on a support group."*
  - *"I'm trying to get my living arrangements changed differently. They have tried to help me with that, but I have some legal issues I need to take care of and they are on top of it."*
- Individuals felt supported in moving toward their desired goals and dreams.
  - *"I told [staff] I wanted to find my father's family and she is helping me with that."*
- Individuals felt supported to achieve their desired level of community involvement.
  - *"They gave me some good advice about finding a job, and I got a job and they always encourage me to do good."*
  - An individual discussed their church involvement and continued encouragement to maintain her good family support.
- Individuals reported staff have followed up on expressed whole health needs and ensured the needs, and referrals if applicable, were addressed.
  - *"[Staff] brought me some weights to help me lose some pounds."*
  - *"The nurse comes out and gives me suggestions about how to eat better and what I can do to lose some weight."*
  - *"With them and my primary care, everything is being taken care of."*

When asked, "*What about this agency keeps you coming back?*," individuals shared,

- *"I am happy with all the services with them."*
- *"They keep my information very confidential, they don't share anything unless they are meeting together to discuss all the clients."*
- *"[Staff], my substance abuse counselor, if it wasn't for her, I'd probably be dead by now."*
- *"The friendly service, because when I got diagnosed with schizophrenia and depression, before them, I didn't have that one-on-one contact."*
- *"Professional Associates explains stuff, like what's going on with you, and let you know if you are doing good."*
- *"They always call to see how you are doing."*
- *"Well, since I've been with them, I've progressively seen that all my needs are being taken care of."*

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.

Focused Outcome Areas - Safety

- Ensure there is documented evidence of ongoing assessment when an individual has been assessed to be at risk for suicide.

Addictive Support Services (ADSS)

- Ensure that documentation supports coordination efforts with the individual's family and significant others when the individual requests/permits it.

Compliance with Service Guidelines - All

- Ensure documentation addresses individuals' progress toward specific goals and objectives.
- Ensure the minimum required contacts are met for all services (as required).

Recommendations: Current Review

Provider Level

- Ensure utilization of services is appropriate to the clinical needs of all individuals served.

Assessment and Planning

- Ensure all individuals are assessed for suicide risk at intake (and as needed thereafter) using age-sensitive C-SSRS tools.
- Ensure suicidality is addressed on the IR/RP when the individual is assessed as having any suicide risk.
- 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.

Focused Outcome Areas - Safety

- Ensure the record has been flagged with "suicide history" when an individual has had any suicidal behavior in their lifetime.

Office of Deaf Services

- Ensure the Office of Deaf Services is notified within two business days of contact with an individual who is deaf or hard-of-hearing.
- Ensure a Communication Assessment Report is in the record of each individual who is deaf or hard-of-hearing.
- Ensure that any changes in communication preference is documented and communicated to ODS for any individual who is deaf or hard-of-hearing.
- Ensure the preferred mode of communication is addressed in the IRP of each individual who is deaf or hard-of-hearing.
- Ensure the Notification of Right to Free American Sign Language Services and Accommodations is in the medical record of each person who is deaf or hard-of-hearing.
- Ensure the registration for services correctly identifies individuals who are deaf or hard-of-hearing.

Compliance with Service Guidelines - Additional Recommendations

Peer Support Whole Health and Wellness- Individual: Ensure documentation demonstrates collaboration with other healthcare providers to assure the individual had access to needed services.

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/