The Georgia Collaborative ASO

GAC000502

Middle Flint Behavioral Healthcare

Behavioral Health Quality Review Final Assessment

Address: Remote Quality Review - 940 Georgia Hwy 96, Warner Robins, GA 31088

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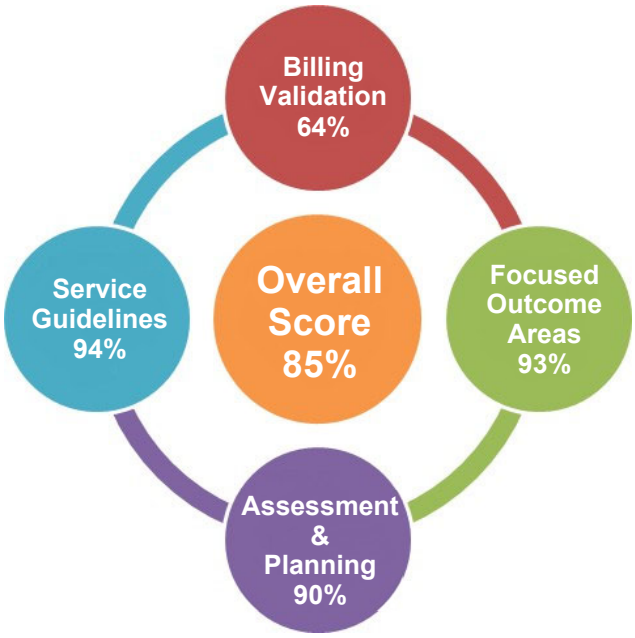
Records Reviewed: 35

Date Range of Review: 7/12/2021 - 7/15/2021

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: 09/14/2020	89%	83%	93%	89%	91%
Review Date: 11/04/2019	77%	61%	92%	88%	91%
FY21 Statewide Average	85%	70%	92%	88%	91%

Note: The FY21 Statewide Averages represent the mean of scores of all reviewed providers. Due to the COVID-19 pandemic, several reviews were postponed or conducted remotely (rather than on site). Additionally, reviews conducted in FY20 (July 1, 2019 to June 30, 2020), may have had points removed from the Overall Score due to identified Quality Risk Items; therefore, caution should be taken when comparing scores across fiscal years.

Summary of Significant Review Findings

Strengths and Improvements:

- Due to the COVID-19 pandemic, this review was conducted remotely instead of on site.
- The electronic medical record (EMR) has color-coded alerts on the face sheet that identify allergies, chronic medical conditions, suicide risk, histories of aggression or inappropriate sexual behavior, individual preferences for services, etc.
- The provider reported having ongoing communication with local Division of Family and Children Services (DFCS) officials to improve accessibility of services to families by hosting family team meetings at their site location(s). Additionally, the provider has also been making similar outreach efforts to local probation offices.
- Brief Assessments captured any cultural or religious considerations/preferences including dietary restrictions, leisure activities, and sexual orientation.

Opportunities for Improvement:

Billing Validation

- Nineteen claims were unjustified due to missing or incomplete service orders.
- Ten claims were unjustified due to not having a valid, verified diagnosis on or before the date the service was provided. This affected one record.
- Thirteen claims were unjustified due to a service not being included on the Individual Resiliency/Recovery Plan (IRP); all provided services must be planned and clearly coincide with services in the DBHDD Provider Manual.
- Thirty-nine claims were unjustified due to staff members' credentials not being supported by documentation.
- Ten claims were unjustified due to progress notes being filed more than seven calendar days after the date of service.

Assessment and Planning

- Transition/discharge plans did not document all required criteria within 17 records.

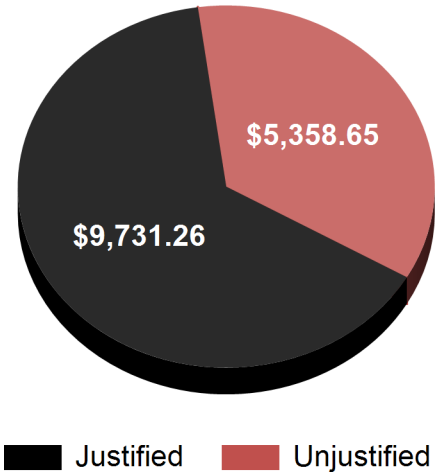
Focused Outcome Areas

- Documentation lacked evidence of clinically-appropriate actions or steps taken and linkages/referrals made for individuals that have been identified as at risk for suicide within one record.
- When an individual was assessed to be at high or moderate risk for suicide, there was no documented evidence of ongoing assessment within three records.
- There was no evidence of a psychiatric or other advanced directive in 11 records.

Service Guidelines

- Intensive Case Management (ICM) Treatment Team Meeting Logs within four records (40%) did not support that individuals had been discussed by the team at least monthly.
- Required staffing was incomplete for more than 90 days in the Intensive Case Management program. The ICM team currently consists of four of the ten required case managers and is missing an ICM supervisor; vacancies have been open for the past two years.

Billing Validation



	Medicaid	Total
Justified	$9,731.26	$9,731.26
Unjustified	$5,358.65	$5,358.65
Total	$15,089.91	$15,089.91

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
Eligibility Standards	Missing/incomplete service order	19
	No valid, verified diagnosis on date service provided	10
Performance Standards	Intervention unrelated to IRP w/o clinical justification	13
	Minimum contacts not met per DBHDD Service Guidelines	9
	Content does not support code billed	4
	Content does not support units billed	3
	Content of note does not match service definition	1
Quantitative Standards	Staff credential not supported by documentation	39
	Progress note not filed within seven calendar days	10
	Location missing	3

Billing Validation: 64%

Strengths and Improvements:

Improvements from the previous review:

- Diversionary activities were not found to be billed, an improvement from six claims.
- Staff credentials were documented on all progress notes, an improvement from five claims.

Opportunities for Improvement:

Eligibility Standards

- Service orders were either missing or incomplete within four records, which affected 19 claims.
  - Three records contained service orders that were incomplete. These service orders documented "Peer Support Whole Health and Wellness" without specifying whether they were ordering the individual or group form of these services, resulting in 13 unjustified claims.
  - Another record did not contain a service order on or before the dates services were provided. Specifically, Case Management was provided 2/19/2021-4/23/2021; however, the service order was not signed until 4/30/2021 (six reviewed claims were unjustified).

- There was no valid, verified diagnosis on the date services were provided for one individual, which affected all ten Case Management (CM) claims reviewed in a record. The claims were dated 2/23/2021-4/27/2021. The most recent verified diagnosis had expired on 8/23/2020. The most recent assessment was completed by a supervisee/trainee (S/T) on 10/20/2020.

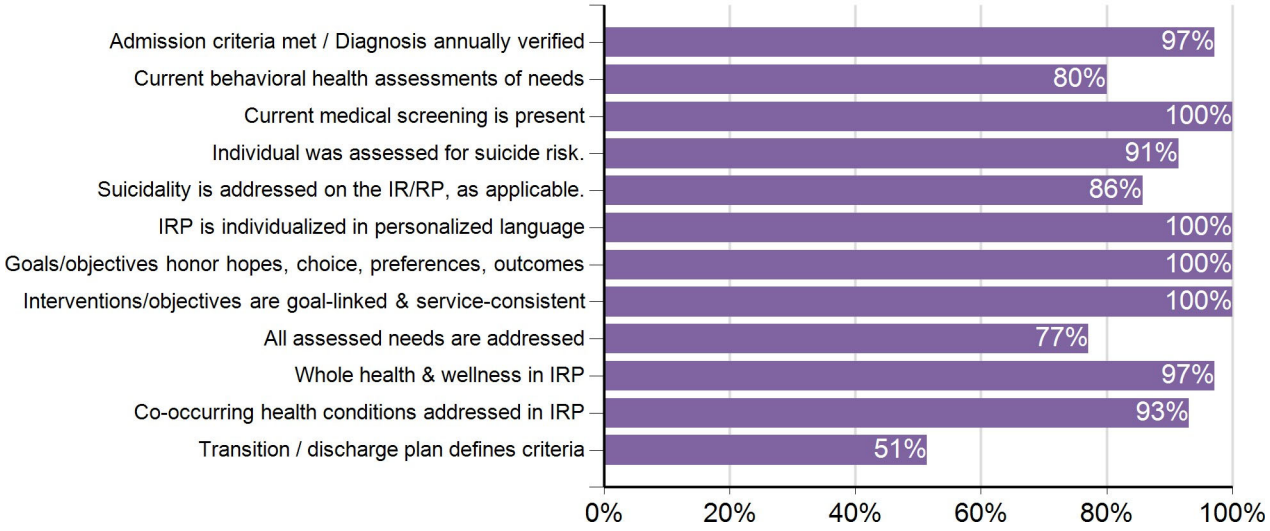
Performance Standards

- The intervention documented in 13 notes was unrelated to the associated IRP (without clinical justification). Peer Support Whole Health and Wellness-Individual and Peer Support Whole Health and Wellness-Group were both referred to as "Peer Support Whole Health and Wellness" on three IRPs; therefore, neither service was sufficiently delineated from the other.
- Minimum contacts were not met per DBHDD Guidelines within three records which caused nine claims (eight ICM and one Case Management (CM)) to be unjustified.
- The content of four progress notes did not support the code billed:
  - One Psychiatric Treatment progress note documented time in/out as 8:44am-9:09am (25 minutes) which supports 99213 (20-29 minutes); however, the claim was billed at 99214 (30-39 minutes).
  - Two Community Support progress notes documented that the individual was present; however, the "UK" collateral contact modifier was billed and documented.
  - One Crisis Intervention progress note documented that the session had occurred via phone; however, the "U7" (out-of-clinic) modifier was billed and documented.
- The content of three progress notes did not support the units billed:
  - One ICM progress note documented staff discussing the dangers of impulsive spending and "linking" the individual to transportation (without details to support 14 units of billing); therefore, only one unit was justified.
  - Another ICM progress note documented, "individual had a great visit and explained to the doctor what he needed and that he will continue his injections;" therefore, only one of 14 billed units was justified.
  - One progress note for Community Support Team documented that a staff member had "linked him to the courthouse for his court appearance" and "collaborated with court officials" without describing how staff participated in the meeting for three hours; therefore, one of 12 units was justified.
- The content of one Nursing Assessment and Health Services progress note did not match the service definition as vital signs were not documented as required for all face-to-face contacts which, currently, must occur at least every other Nursing Assessment contact.

Quantitative Standards

- Staff credentials were not supported by documentation, affecting 39 claims:
  - One ICM staff member using the paraprofessional (PP) credential lacked documentation of three hours of in-agency training, causing 26 claims to be unjustified.
  - A second PP staff member lacked three hours of in-agency training causing three claims to be unjustified.
  - A third PP staff member lacked documentation of two hours of in-agency training causing three claims to be unjustified.
  - One supervisee/trainee (S/T) staff member did not have three hours of in-agency training documented within their file and their attestation lacked required components including date employee became an S/T, type of Master's Degree obtained, licensure type seeking, and anticipated date of licensure. This affected seven claims.
- Progress notes were not filed within seven calendar days (as required), which caused 10 claims (nine ICM and one Individual Counseling) to be unjustified. Examples included:
  - One ICM progress note dated 3/30/2021 was not signed until 4/26/21, 27 days after the date of service.
  - Another ICM progress note dated 3/26/2021 was not signed until 4/22/2021, 27 days after the date of service.
  - One Individual Counseling progress note dated 3/3/2021 was not signed until 3/12/2021, nine days after the date of service.
- The out-of-clinic location was not specified within three progress notes (two ICM and one CM) when the U7 (out-of-clinic) modifier was billed.

Assessment & Planning



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

Assessment & Planning: 90%

Strengths and Improvements:

Strengths identified during this review:

- Behavioral Health Assessments contained a "Problem List" that identified whether needs are active, deferred, referred, refused, or resolved.
- Brief Assessments captured any cultural or religious considerations/preferences including dietary restrictions, leisure activities, and sexual orientation.

Continued strengths from the previous review on 9/14/2020:

- Ninety-one percent of individuals were assessed for suicide risk using the age-appropriate Columbia-Suicide Severity Rating Scale (C-SSRS). Additionally, all applicable individuals, with the exception of one, had suicidality addressed on their IRP.

Improvements from the previous review:

- Ninety-three percent of IRPs addressed co-occurring health conditions, an improvement from 69%.

Opportunities for Improvement:

- All assessed needs were not addressed within eight (23%) records (two were ICM records). Examples of unaddressed needs included grief, physical and sexual abuse, post-traumatic stress disorder, sexually acting out behaviors, and probation requirements.
- Co-occurring health conditions were not addressed within two (25%) of eight applicable ICM IRPs. Both individuals had substance abuse (SA) diagnoses (i.e., severe cocaine use disorder, severe cannabis use disorder) with IRPs that did not include a plan for how the agency will address SA. Instead, IRPs appeared to refer SA services out, "Coordinate/Collaborate w/inpatient facility/other agency including: Law enforcement, Probation/Parole, DFCS, DOL, [Mental Health]/SA outpatient tx." The agency confirmed these individuals were receiving SA services internally.
- Transition/discharge plans did not document all required criteria within 17 (49%) records (five were ICM records). Most often, the anticipated transition/discharge date was expired. There were also a few plans that documented "outpatient services" or "NIOP" as step-down services, which are not specific.

Focused Outcome Areas

Focused Outcome Areas: 93%

Strengths and Improvements:

Continued strengths from the previous review:

- When barriers were identified, alternatives were explored in all 19 applicable records. In three records, individuals were diagnosed with an intellectual or developmental disability (i.e., autism, moderate intellectual disabilities, borderline intellectual functioning), and progress notes documented individuals responding well to staff's specific approaches to therapeutic interventions.
- There was evidence within all 34 applicable records that individuals had given consent for telehealth services.
- Documentation described how individuals were active participants in the planning and receiving of services as well as in modifying the IRP and/or services within all records.
- Documentation supported that individuals had age-appropriate responsibilities/valued roles in the community as desired within all 30 applicable records. Examples included attending day programs, school enrollment, employment, etc.
- Documentation reflected that informed choice drove the selection of housing options within all eight applicable records. Examples included:
  - Staff worked diligently to identify multiple emergency shelters for one individual when he became homeless. Staff also assisted the individual with applying for Georgia 811 Housing.
  - In another record, staff assisted with getting an individual on the Georgia 811 Housing waiting list and linked her to other resources to aid in sustaining stable housing (i.e., employment opportunities, obtaining a vehicle, arts and crafts as a form of coping with stress, local tech schools considering interest in owning her own business).
- In all applicable records, services consisted of resource coordination to assist individuals in gaining access to necessary services to promote recovery/resiliency. Examples included coordination with banks to aid in opening new accounts, referrals for housing and medical services, linkage to recovery support groups, collaboration with school counselors, etc.

Opportunities for Improvement:

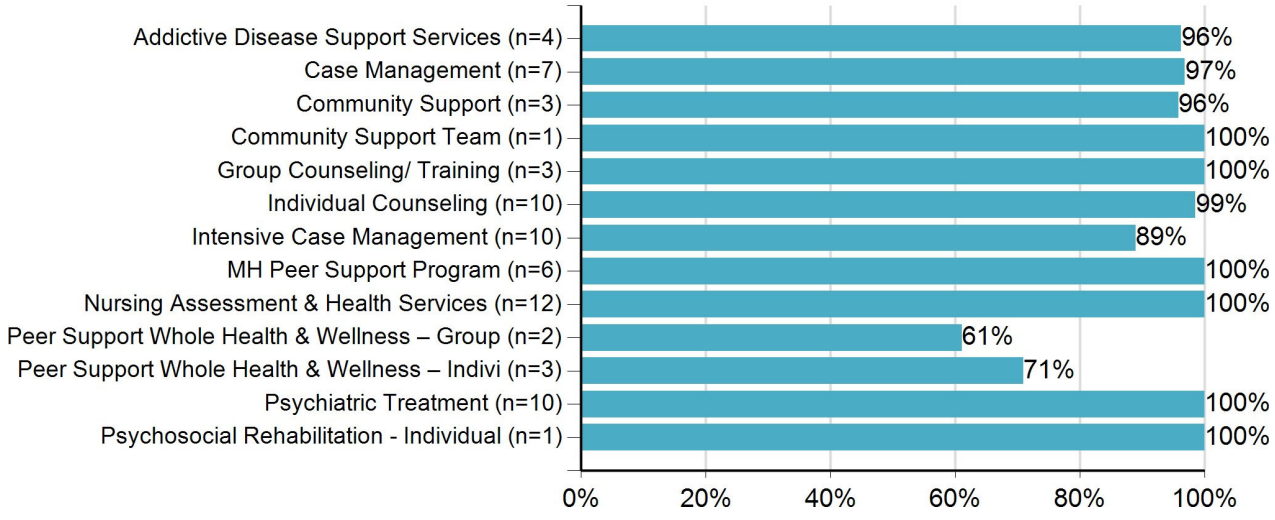
Safety

- Documentation lacked evidence of clinically-appropriate actions or steps taken and linkages/referrals made for individuals that have been identified as at risk for suicide within one (25%) of four applicable records (all were NIOP records). This individual had a C-SSRS with "yes" answers endorsed without comments.
- When an individual was assessed to be at high or moderate risk for suicide, there was no documented evidence of ongoing assessment, as required by DBHDD policy, within three (75%) of four applicable records (all were NIOP records). In addition to the reason stated above:
  - one record contained evidence of monthly risk assessment, but not at each visit as required
  - another record's most recent C-SSRS Since Last Visit was completed in March 2020

Rights

- There was no evidence that individuals/guardians had signed formal acknowledgement of rights and responsibilities at least annually within nine (27%) of 33 applicable records (three were ICM).
- There was no evidence of a psychiatric (or other) advanced directive; or, documentation indicating that the individual has either denied the existence of a directive or declined to have it in their record within 11 (52%) of 21 applicable records (five were ICM).

Service Guidelines



Service Guidelines: 94%

Strengths and Improvements:

Strengths identified during this review:

- Nurses documented a whole health approach to sessions specifically discussions regarding medical conditions (i.e., "Discussed hypertension and the importance of taking medication and checking blood pressure often. Discussed following up with a [primary care physician] as soon as possible for elevated [blood pressure]."); importance of eating a healthy diet (including fruits and vegetables), and drinking plenty of water daily; importance of daily exercise such as walking at least 30 minutes per day to stay healthy; and reviewed COVID-19 precautions.
- There was evidence that staff were incorporating information from other staff's documentation within their progress notes. For example, a physician documented that they incorporated information from the nursing notes and risk alerts into their documentation.
- The agency reported having ongoing communication with local Division of Family and Children Services (DFCS) officials to improve accessibility of services to families by hosting family team meetings at their site location(s). Additionally, the agency has also been making similar outreach efforts to local probation offices.

Continued strengths from the previous review:

- In all Intensive Case Management records, documentation reflected referral and linkage to services and resources identified on the IRP. Examples included linkage to anger management group, employment opportunities, job fairs, and housing options; and recommendations for exercise videos to promote whole health and wellness, and budgeting tips.
- The one Community Support Team record documented focused interventions geared toward the promotion of developing community living skills that support the individual's ability to function more independently. Examples included staff discussing the importance of taking medication as prescribed, how to avoid multiple hospitalizations, defining quality of life and ways to sustain it, applying to barber school per career interests, etc.
- Physician notes included a running log of historical clinical information which captured several months of data as well as individuals' treatment progress/regression.

Improvements from the previous review:

- There was evidence of skills building within the one Psychosocial Rehabilitation-Individual (PSR-I) record reviewed, an improvement from 25%.
- Minimum contacts were met within the one PSR-I record reviewed, an improvement from 0%.
- Progress toward the individual's specific goals/objectives on the IRP was documented within the one PSR-I record reviewed, an improvement from 75%.

Opportunities for Improvement:

Intensive Case Management

- The documented time from receipt of the referral to engagement with an individual was more than five days within three (75%) of four applicable records.
- A minimum of four contacts/attempts per month was not documented within three (30%) records.
- Treatment Team Meeting Logs did not contain documentation supporting that the individual had been discussed (at least monthly) within four (40%) records, most often during January 2021 and February 2021.

Addictive Diseases Support Services

- Coordination with family and significant others was not documented within one (50%) of two applicable records. This individual identified his sister as his support, yet there was no documentation that staff were making efforts to include her in his treatment.

Case Management

- The minimum requirement of two contacts made/attempted per month was not documented within two (29%) of seven records.
    - One individual was only seen once per month during five months and not seen at all during three months of their authorization period 7/2/2020-7/2/2021.
    - Another individual was seen only once in March 2021.

Peer Support Whole Health and Wellness - Individual

- Considering this service was only referred to as "Peer Support Whole Health and Wellness" (without specifying "Individual") within the IRPs of all three records, the following questions could not be determined and were, consequently, scored "no:"
    - Progress notes contain documentation of the individual's progress toward specific goals/objectives on the IRP.
    - The staff interventions reflected in the progress notes are related to the staff interventions listed on the IRP.
    - Service is provided as planned within the IRP.

Peer Support Whole Health and Wellness - Group

- Considering this service was only referred to as "Peer Support Whole Health and Wellness" (without specifying "Group") within the IRPs of both records, the following questions could not be determined and were, consequently, scored "no:"
    - Progress notes contain documentation of the individual's progress toward specific goals/objectives on the IRP.
    - The staff interventions reflected in the progress notes are related to the staff interventions listed on the IRP.
    - Service is provided as planned within the IRP

Community Support

- There was no evidence of service and resource coordination within one (33%) of three records. Considering one of the youth's goals was to socialize more and make friends, efforts could have been documented to coordinate with school officials or other community resources to encourage participation in extra-curricular activities, volunteer work, etc.

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.

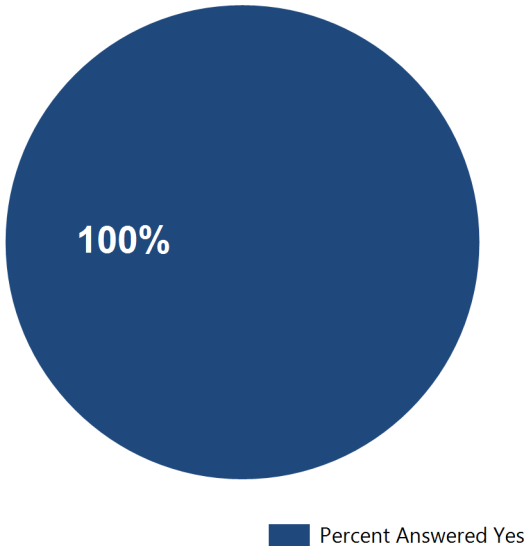
Although Quality Risk Items (QRIs) no longer represent a point deduction from the Overall Score, the following QRIs were noted during this review:

- Required staffing was incomplete for more than 90 days in a program. The ICM team currently consists of four of the ten required case managers and is missing an ICM supervisor; vacancies have been open for the past two years.
- Contact frequency requirements were not met in six records for services including ICM, CM, and Peer Support Whole Health and Wellness-Group.
- There were seven repeated Quality Improvement Recommendations from the previous review on 9/14/2020:
  - Ensure all Performance Standards are met.
  - Ensure all Quantitative Standards are met.
  - Ensure treatment/recovery/service plans address all areas of assessed need.
  - Ensure co-occurring conditions are addressed on the individual recovery plan.
  - Ensure transition/discharge plans define criteria for discharge, planned discharge date, and specific services.
  - Ensure individuals are informed of their rights and responsibilities at the onset of services and at least annually thereafter.
  - Ensure the individual's record includes a psychiatric or other advanced directive; or, documentation indicates the individual has either denied the existence of a directive or declined to have it in their record.

Individual Interviews

Individual Interviews Conducted: 4

Individual Interviews are not calculated into the Overall Score



All three interviewed individuals reported being involved in the development of their IRP goals and feeling supported in moving toward their desired goals and dreams:

- *"It's a process. They help me stay focused. I got a job even before the due date I gave myself to get one."*
- *"I'm graduating from the inpatient program on August 3. I've been there five months. I'm going home!"*

All individuals shared feeling supported to achieve their desired level of involvement in the community. One individual stated, *"I get to go to the library on the days I'm not in group. We go on outings to the movies and go swimming. We exercise and do things here at the center, too."*

All individuals noted that staff have followed up on whole-health-related needs and requested assistance to ensure these were addressed:

- *"They take me to my medical appointments to get my physical exams."*
- *"I get all my medications at Middle Flint, including those for my high blood pressure."*
- *"I had problems with my health, and they've made sure I get my [magnetic resonance imaging] and [computed tomography] scans done timely."*

All individuals reported believing that confidential matters are maintained and treated respectfully. One individual specified, *"as long as you are not going to hurt yourself or someone else."*

When asked what keeps them coming back to Middle Flint for services, individuals replied:

- *"Because of my diagnoses, I want to make sure I stay stable and get the help and medicine I need. The staff are always willing to help no matter what. They're always there to talk. They're a very good support."*
- *"This place has really helped me a lot. All the staff here are really nice. You can talk to them about your thoughts and cravings and they don't judge you. They tell you, 'it's a process.' You have everything you need here, if you want the program. They are understanding and help you a lot, with things like relapse prevention and parenting classes."*
- *"They've always met my needs. They've been awesome! If you meet them halfway, they will meet you halfway. I'm in phase two, and I'm working. They have great doctors and case managers."*

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. • Ensure the individual's record includes a psychiatric or other advanced directive; or, documentation indicates the individual has either denied the existence of a directive or declined to have it in their record.
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.
Focused Outcome Areas - Safety • Ensure there is documented evidence of ongoing assessment when an individual has been assessed to be at risk for suicide. • Ensure documentation supports that clinically-appropriate actions or steps were taken and linkages or referrals were made based upon the findings/outcome of suicide risk assessment.
Compliance With Service Guidelines - All • Ensure documentation addresses individuals' progress toward specific goals and objectives. • Ensure documentation is related to goals and objectives on the plan.

Additional Recommendations

- Compliance with Service Guidelines: Intensive Case Management: Ensure that individuals are engaged in services within five days from receipt of the referral.
- Compliance with Service Guidelines: Intensive Case Management: Ensure that individuals are discussed in treatment team meetings at least once per month.
- Compliance with Service Guidelines: Addictive Disease Support Services: Ensure there is documented coordination of services with family and significant others (according to the wishes of the individual).
- Compliance with Service Guidelines: Peer Support Whole Health & Wellness - Individual: Ensure services are planned and provided accordingly.
- Compliance with Service Guidelines: Peer Support Whole Health & Wellness - Group: Ensure services are planned and provided accordingly.
- Compliance with Service Guidelines: Community Support: Ensure there is evidence of service and resource coordination.