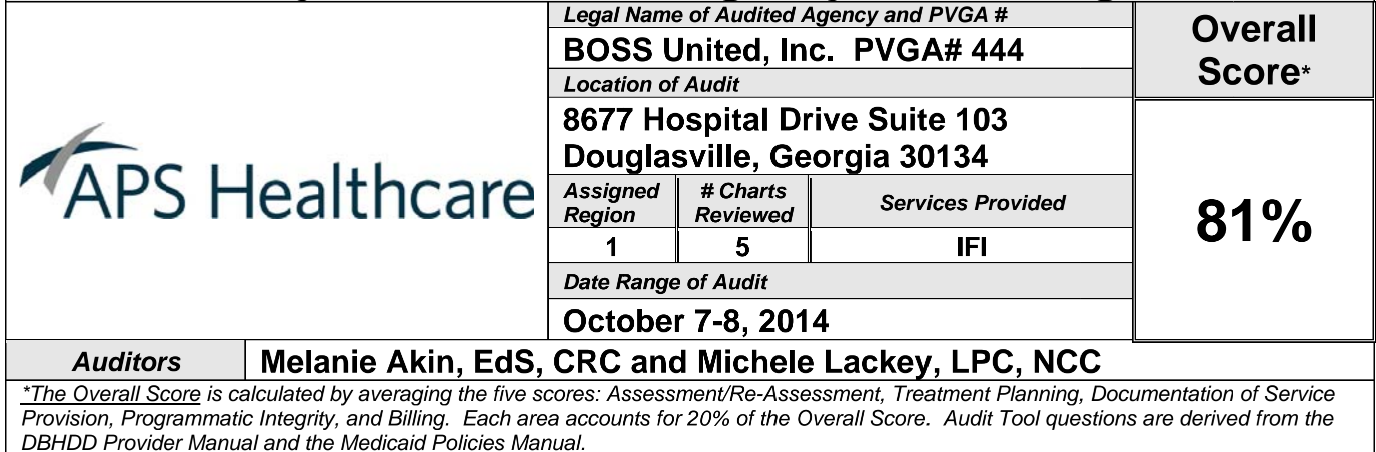
Summary of Audit Findings by the Georgia ERO

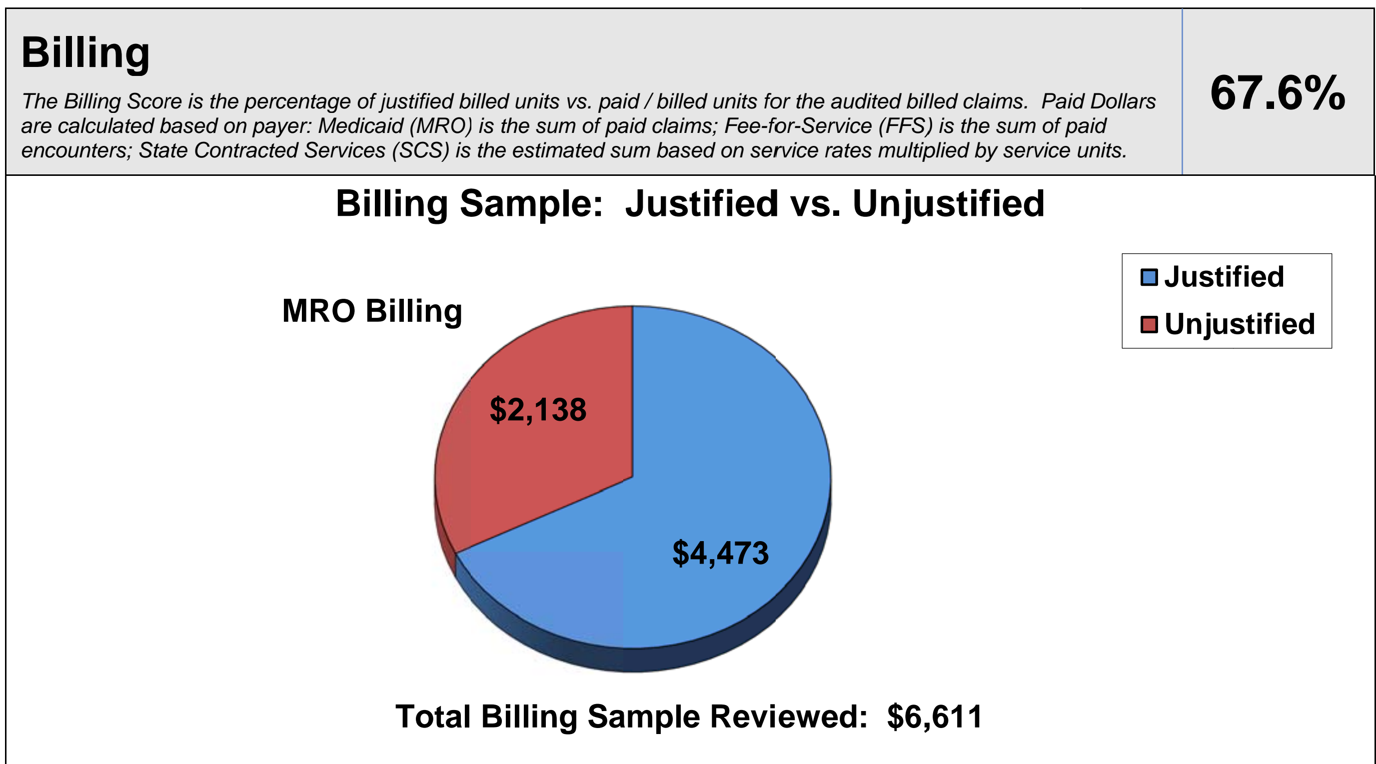


	Legal Name of Audited Agency and PVGA #			Overall Score*
APS Healthcare	BOSS United, Inc. PVGA# 444			81%
	Location of Audit			
	8677 Hospital Drive Suite 103 Douglasville, Georgia 30134			
	Assigned Region	# Charts Reviewed	Services Provided	
	1	5	IFI	
	Date Range of Audit			
	October 7-8, 2014			

Auditors Melanie Akin, EdS, CRC and Michele Lackey, LPC, NCC

**The Overall Score is calculated by averaging the five scores: Assessment/Re-Assessment, Treatment Planning, Documentation of Service Provision, Programmatic Integrity, and Billing. Each area accounts for 20% of the Overall Score. Audit Tool questions are derived from the DBHDD Provider Manual and the Medicaid Policies Manual.*

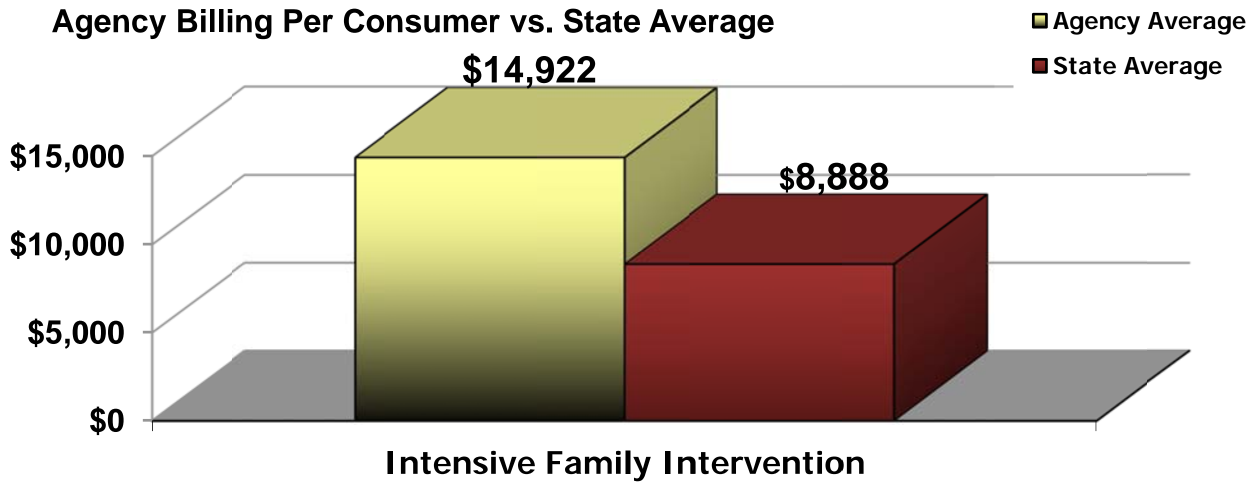
	Current	Previous	FY14 State Average
Assessment	100%	N/A	98.7%
Treatment Planning	70%	N/A	79.3%
Programmatic Integrity	67.3%	N/A	81.7%
Documentation of Service	100%	N/A	91.9%
Billing	67.6%	N/A	77.4%
Overall	**81%**	**N/A**	**86%**



Billing

67.6%

The Billing Score is the percentage of justified billed units vs. paid / billed units for the audited billed claims. Paid Dollars are calculated based on payer: Medicaid (MRO) is the sum of paid claims; Fee-for-Service (FFS) is the sum of paid encounters; State Contracted Services (SCS) is the estimated sum based on service rates multiplied by service units.



Data for July 1, 2013 to June 30, 2014

Strengths and/or Improvements Since Previous Audit:

- This was this agency's first audit. All of the records reviewed met Core Customer criteria and had a corresponding order for the services billed.

The Billing Discrepancies were as follows:

Reason	Detail	Total
Qualitative	Non-billable activity billed	1
Quantitative	Staff credential not supported by documentation	10

Qualitative:

- One billing claim was unjustified by a non-billable activity (i.e. providing services while the individual was hospitalized.)

Quantitative:

- Ten billing claims were unjustified due to a staff credential not being supported by documentation. One staff members became a LAPC in September 2014 but during the time period for the billing claims reviewed he was a "U4" level Paraprofessional. There was no evidence to support that he had all of the required Essential Learning. He was missing the Recovery Principles courses.

Assessment / Re-Assessment — 100%

Assessment Question	Answer	Total	
01. Consumer meets DBHDD Core Customer Criteria.	No	0	0%
	Yes	5	100%
02. Biopsychosocial assessment is present.	No	0	0%
	Yes	5	100%
03. Medical screening is present.	No	0	0%
	Yes	5	100%
04. Assessment includes individual's hopes, strengths, needs, abilities and preferences.	No	0	0%
	Yes	5	100%
05. Consumer was assessed for co-occurring disorders.	No	0	0%
	Yes	5	100%
06. Overall Assessment Score	*** Total: 25/25**	**25**	**100%**
** Total indicates total Yes answers / total possible Yes answers.*			

Strengths and/or Improvements Since Previous Audit:

- All of the records reviewed contained a biopsychosocial assessment, a medical screening, an assessment of the individual's SNAPs (strengths, needs, abilities, and preferences), and a screening for co-occurring disorders.

Areas of Non-Compliance / Opportunities for Improvement:

- There were integrated summaries that contained information inconsistent from the actual assessment. For example, there was a comment in a summary that the individual got in trouble for drinking alcohol at school; however, the assessment had N/A for all of the Substance Abuse assessment sections. Also, the assessment listed no trauma for the individual; however, there was a history of physical abuse charges toward the individual's mother.

Treatment Planning — 70%

Treatment Plan Question	Answer	Total	
01. Treatment plan includes goals that are specific and outcome based.	No	0	0%
	Yes	5	100%
02. Treatment plan objectives are Specific, Measurable, Achievable, Realistic, Time-limited (SMART).	No	2	40%
	Yes	3	60%
03. Treatment plan is driven by the assessed needs and preferences of the consumer and is individualized.	No	1	20%
	Yes	4	80%
04. Discharge criteria is clearly defined (i.e. clinical benchmarks, step down service(s) and transition date are identified).	No	1	20%
	Yes	4	80%
05. For discharged consumers, there is a discharge summary that contains all of the required components.	N/A	1	
	No	4	100%
	Yes	0	0%
06. Consumer has signed the treatment plan.	No	0	0%
	Yes	5	100%
07. If applicable, co-occurring disorders are addressed on the treatment plan.	N/A	4	
	No	1	100%
	Yes	0	0%
08. Overall Treatment Plan Score	*** Total: 21/30**	**30**	**70%**
** Total indicates total Yes answers / total possible Yes answers.*			

Strengths and/or Improvements Since Previous Audit:

- All of the treatment plans reviewed contained a majority of goals that were specific and outcome based.
- All of the treatment plans reviewed contained the signatures of the individual-served/guardian.

Areas of Non-Compliance / Opportunities for Improvement:

- Treatment plans were not consistently individualized. For example, one objective was seen in three of the five records reviewed, *"Cn will learn coping strategies i.e. physical exercise, less internal focus and constructive anger expression to eliminate self-threats daily for the next 3 months"*
- There were objectives seen that did not meet SMART criteria in two of the five records reviewed. Examples include,
    - "*Cn will learn how to follow adult directives at home and school and utilizing the 'thought stopping technique' to manage intrusive thoughts that trigger anger and acting out daily for the next 3 mths.*"
    - "*Cn will learn ways to overcome depression through activity i.e physical exercise, less internal focus, increase social involvement daily for the next 3 mths*"
- Discharge summaries in the four discharged records did not contain all of the required components. Specifically, progress, or lack thereof, towards the goals and objectives on the treatment plan was not addressed.

Programmatic Integrity — 67.3%

Service	Question	Answer	Total	
Intensive Family Intervention	01. The Team Leader is meeting with families at least 2x/month. (review authorization period)	No	3	60%
		Yes	2	40%
	02. Safety planning with the family and all parties involved evident in the record from the onset of services.	No	1	20%
		Yes	4	80%
	03. Transition planning is evidenced by documentation of how the team works with the family and other agencies/support systems (such as LIPTs, provider agencies, etc.) to build a clinically oriented transition and discharge plan.	No	5	100%
		Yes	0	0%
	04. A team approach is used, as evidenced by more than one person and at least one licensed team member. (review authorization period)	No	0	0%
		Yes	5	100%
	05. Services are a mix of individual/family counseling and skill development according to the needs of the consumer/family. (review authorization period)	No	0	0%
		Yes	5	100%
	06. There is evidence that the provider is helping the parents/responsible caregivers increase capacity to care for their children. (review authorization period)	No	0	0%
		Yes	5	100%

	Question	Response	Count	Percent
	07. The Team leader is licensed/credentialed or CAC-II or equivalent.	No	0	0%
		Yes	5	100%
	08. Documentation reflects a tapering of services.	N/A	1	
		No	4	100%
		Yes	0	0%
	09. The team is making at least three contacts a week and at a frequency that is clinically appropriate. (review authorization period)	No	3	60%
		Yes	2	40%
	10. Services over 6 hours are related to a crisis and has supporting documentation signed by the Team Leader.	N/A	5	
		No	0	
		Yes	0	
	11. Progress notes contain documentation of the consumer's progress (or lack of) toward specific goals/objectives on the treatment plan.	No	0	0%
		Yes	5	100%
	12. NON-SCORED: Youth has received documented services through other services or treatment at a lower intensity has been attempted (must be documented)	No	0	0%
		Yes	5	100%
	13. NON-SCORED: Youth and/or family has insufficient or severely limited resources or skills necessary to cope with an immediate behavioral health crisis	No	0	0%
		Yes	5	100%
	14. NON-SCORED: Youth and/or family behavioral health issues are unmanageable in traditional outpatient treatment and require intensive, coordinated clinical and supportive intervention	No	0	0%
		Yes	5	100%
	15. NON-SCORED: Youth is at immediate risk of out-of-home placement or is currently in out-of-home placement and reunification is imminent.	No	0	0%
		Yes	5	100%
	16. NON-SCORED: Because of behavioral health issues, youth is at immediate risk of legal system intervention or is currently involved with DJJ for behaviors related to SED and/or Substance-related disorder.	No	0	0%
		Yes	5	100%
Overall Service Score		*** Total: 33/49**	**49**	**67.3%**
	** Total indicates total Yes answers / total possible Yes answers.*			

Strengths and/or Improvements Since Previous Audit:

- In all of the records reviewed, a team approach was used and there was a service mix of individual/family counseling and skill development according to the needs of the family.

Areas of Non-Compliance / Opportunities for Improvement:

- In three of the five records the Team Leader was not meeting with the family members/guardians of the individual-served at least two times monthly. For example, in one record, the Team Leader met with the family only one time in June and no other times were documented after that.
- The majority of records received a 'no' for tapering and transition planning. The last team note in one record documented increasing services for that individual, not decreasing or referring to another provider. Tapering or transitioning of individuals-served was not documented in records prior to their discharge from services. It appeared individuals were only discharged at the end of authorizations rather than after a natural tapering down and transitioning out of services as clinically appropriate or based on the specific and individual needs of the consumer.
- In three of the five records, the minimum of three contacts per week were not consistently met. For example, in one record, between July 11 and July 31 the individual only had four sessions total.

Documentation of Service Provision — 100%

Question	Answer	Total	
1. Staff intervention related to plan	Yes	38	100%
2. Individual response is present	Yes	38	100%
3. Consumer progress is present	Yes	38	100%
4. Overall Documentation Of Service Provision Score	* Total: 114/114	**114**	**100%**
** Total indicates total Yes answers / total possible Yes answers.*			

Strengths & Improvements Since Previous Audit:

- All of the progress notes reviewed contain staff interventions related to the treatment plan and both individual responses and consumer progress was present.

Areas of Non-Compliance / Opportunities for Improvement:

- None identified during this review.

Overall Programmatic Integrity

Audit Tool questions are derived from the DBHDD Provider Manual and the Medicaid Policies Manual. These questions do not impact the audit scores.

Non-scored

Service	Question	Answer
Intensive Family Intervention	01. The Team Leader convenes team meetings a minimum of 1x/week that serve as a way to staff a child with the team, perform case reviews, team planning and team supervision (AEB a record or log of minutes, review authorization period).	No
	02. Team Leader provides weekly individual supervision which is documented in the staff personnel record or supervision log. (review authorization period).	No
	03. Each staff member of the team is dedicated to a specific team and is not cross-utilized from one team to another.	Yes
	04. There is documentation indicating each team member has been trained on the chosen evidenced-based in-home model beginning January 1, 2011.	No
	05. The IFI Organizational Plan is present and contains all required components.	No
	06. The IFI provider has policies and procedures governing the provision of outreach services, including methods for protecting the safety of staff that engage in outreach activities.	Yes
	07. The organization has policies that govern the provision of services in natural settings and can document that the organization respects individuals' rights to privacy and confidentiality when services are provided in these settings.	No
	08. The organization has procedures/protocols for emergency/crisis situations that describe methods for intervention when youths require psychiatric hospitalization.	No

Strengths & Improvements Since Previous Audit:

- The provider has policies and procedures governing the provision of outreach services, including methods for protecting the safety of staff that engage in outreach activities. The agency has a very detailed safety manual for staff members that covers a wide variety of scenarios and what steps to take to ensure their safety while working with individuals-served in natural settings/the community.

Areas of Non-Compliance / Opportunities for Improvement:

- The last Team Meeting note found in the records reviewed was 9/6/2014. In one record, there were no Team Meeting notes for the whole month of July even though the individual was still in services.
- Agency reports that the Team Leader provides weekly individual supervision but it is not documented.
- CBT is the chosen model for the agency but there was no documentation to support

that each team member has received training regarding it.

- The agency does not have a specific policy regarding ensuring the privacy and confidentiality of individuals-served when receiving services in natural settings/the community.
- The agency has a Crisis Intervention Policy but it is does not describe the specific methods of intervention for individuals requiring Psychiatric Hospitalization.

Additional Issues *Issues beyond the general scope of the audit were discovered by auditors that may have the potential to impact service delivery, quality of care, or may represent a risk for the agency. The following practices or concerns were noted during the audit:*	**Non-scored**

- In one of the records, the dates on the discharge summary did not match the dates on the MICP. The authorization was for 4/22/14-7/20/14 but the dates on the discharge summary was 6/9/14 - 9/10/14.
- All of the signatures on the treatment plan signature page were dated by the same person.
- Paraprofessional staff members were referred to as "CSI" in some of the documentation rather than "PP".
- Progress notes were being signed beyond seven days after the service was provided. For example, in one record some of the notes by the team leader were signed more than a month after the service was provided.
- There were instances of services starting several weeks after the beginning of the authorization. For example, the authorization started on 4/30/14 but services did not start until June.

Corrective Action Recommendations

The following are recommendations given as a result of this audit.
A provider may appeal their audit findings up to 10 business days following the receipt / notification of their written audit summary. The date of notification is the date the email is sent notifying your agency's identified staff persons that your audit summary had been posted to the APS Knowledgebase.

Refer to the Audit Appeals policy and procedure at:
http://apsero.com/webx/About%20Us/APS%20Policies%20and%20Procedures/

Billing Recommendations	
Recurring:	**Ensure the following:**
	Qualitative: Documentation fully justifies time and services billed by appropriately-credentialed staff.
	Staffing documentation is submitted within the timeframes and supports staff credentialing.

Treatment Planning Recommendations

Recurring:	Ensure the following:
	Objectives are written in Specific, Measurable, Achievable, Realistic, and Time-limited (SMART) terms.
	Discharge summaries include all components as required by the FY15 Provider Manual.
	Treatment plans address assessed co-occurring disorders.

Programmatic Integrity Recommendations

Recurring:	Ensure the following:
	Intensive Family Intervention is provided in accordance with the FY15 Provider Manual: • Team Leader meets with families 2x per month. • Transition planning is evidenced by documentation of how the team works with the family and other agencies/support systems (such as LIPTs, provider agencies, etc.) to build a clinically oriented transition and discharge plan. • Documentation reflects a tapering of services. • The team is making at least three contacts a week and at a frequency that is clinically appropriate. (review authorization period)

Overall Programmatic Integrity Recommendations

These questions are answered per program and are non-scored.

Recurring:	Ensure the following:
	The Intensive Family Intervention program meets all requirements: • The Team Leader convenes team meetings a minimum of 1x/week that serve as a way to staff a child with the team, perform case reviews, team planning and team supervision (AEB a record or log of minutes) • Team Leader provides weekly individual supervision which is documented in the staff personnel record or supervision log. • There is documentation indicating each team member has been trained on the chosen evidenced-based in-home model beginning January 1, 2011. • The IFI Organizational Plan is present and contains all required components. • The organization has policies that govern the provision of services in natural settings and can document that the organization respects individuals' rights to privacy and confidentiality when services are provided in these settings. • The organization has procedures/protocols for emergency/crisis situations that describe methods for intervention when youths require psychiatric hospitalization.