Summary of Audit Findings by the Georgia ERO

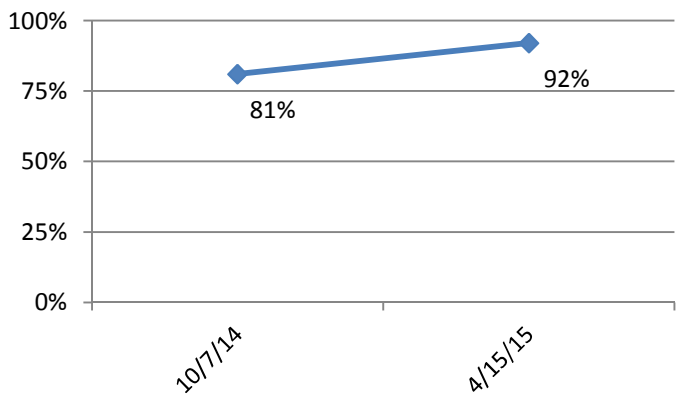
Legal Name of Audited Agency and PVGA #	Overall Score*
BOSS United, Inc. PVGA #444	92%
Location of Audit	
8677 Hospital Drive, Suite 103 Douglasville, GA 30135	

Assigned Region	# Charts Reviewed	Services Provided
1	8	IFI

Date Range of Audit
April 15, 2015

Auditors	Michele Lackey, LPC, NCC and Mark Knopp, PsyD

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.



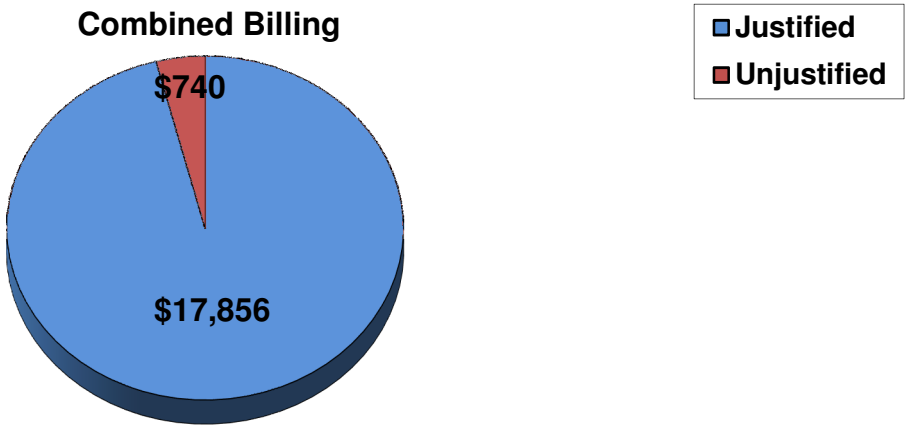
	Current	Previous	FY14 State Average
Assessment	100%	100%	98.7%
Treatment Planning	81%	70%	79.3%
Programmatic Integrity	87.8%	67.3%	81.7%
Documentation of Service	95%	100%	91.9%
Billing	96%	67.6%	77.4%
Overall	**92%**	**81%**	**86%**

Billing

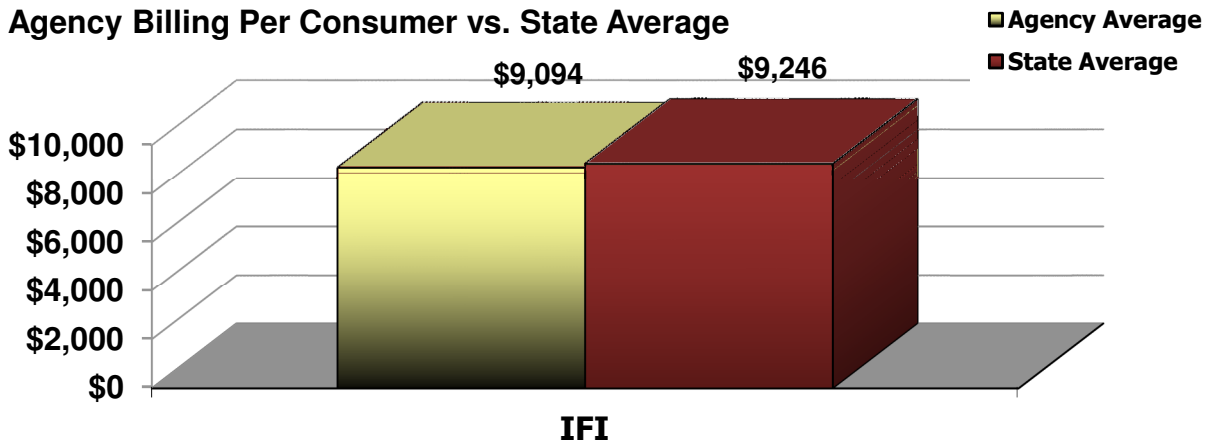
The Billing Score is the percentage of justified billed units vs. paid / billed units for the audited billed claims. Paid Dollars are calculated based on payer: Medicaid (MRO) is the sum of paid claims; Fee-for-Service (FFS) is the sum of paid encounters; State Contracted Services (SCS) is the estimated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

96%

Billing Sample: Justified vs. Unjustified



Total Billing Sample Reviewed: $18,596



Data for July 1, 2014 to March 31, 2015

Strengths and/or Improvements Since Previous Audit:

- Five staff members were reviewed and met DBHDD credentialing requirements.

The Billing Discrepancies were as follows:

Reason	Detail	Total
Qualitative	Progress note is missing	4
Quantitative	Progress note is missing	4

Eligibility:

- No issues noted.

Qualitative and Quantitative:

- Four progress notes were missing.

Assessment / Re-Assessment — 100%

Assessment Question	Answer	Total	
01. Consumer meets DBHDD Core Customer Criteria.	No	0	0%
	Yes	8	100%
02. Biopsychosocial assessment is present.	No	0	0%
	Yes	8	100%
03. Medical screening is present.	No	0	0%
	Yes	8	100%

04. Assessment includes individual's hopes, strengths, needs, abilities and preferences.	No	0	0%
	Yes	8	100%
05. Consumer was assessed for co-occurring disorders.	No	0	0%
	Yes	8	100%
06. Overall Assessment Score	*** Total: 40/40**	**40**	**100%**
** Total indicates total Yes answers / total possible Yes answers.*			

Strengths and/or Improvements Since Previous Audit:

- All records reviewed contained a biopsychosocial, medical screening, and co-occurring disorders assessment.
- All individuals served were assessed for their strengths, needs, abilities, and preferences.

Areas of Non-Compliance / Opportunities for Improvement:

- None noted.

Treatment Planning — 81%

Treatment Plan Question	Answer	Total	
01. Treatment plan includes goals that are specific and outcome based.	No	4	50.0%
	Yes	4	50.0%
02. Treatment plan objectives are Specific, Measurable, Achievable, Realistic, and Time-limited (SMART).	No	1	12.5%
	Yes	7	87.5%
03. Treatment plan is driven by the assessed needs and preferences of the consumer and is individualized.	No	0	0%
	Yes	8	100%
04. Discharge criteria is clearly defined (i.e. clinical benchmarks, step down service(s) and transition date are identified).	No	2	25.0%
	Yes	6	75.0%
05. For discharged consumers, there is a discharge summary that contains all of the required components.	N/A	7	
	No	0	0%
	Yes	1	100%
06. Consumer has signed the treatment plan.	No	0	0%
	Yes	8	100%
07. If applicable, co-occurring disorders are addressed on the treatment plan.	N/A	7	
	No	1	100%

	Yes	0	0%
08. Overall Treatment Plan Score	*** Total: 34/42**	**42**	**81.0%**
** Total indicates total Yes answers / total possible Yes answers.*			

Strengths and/or Improvements Since Previous Audit:

- All treatment plans reviewed were driven by the assessed needs of the individuals served and were individualized.
- All treatment plans were signed by the individual served and/or guardian, as appropriate.

Areas of Non-Compliance / Opportunities for Improvement:

- Half of treatment plans reviewed did not contain a majority of goals with specific outcomes. Examples include the following:
  - *"I want to have real friends"*
  - *"Cl will resolve conflict that underlies anger to eliminate defiance and disrespectful behaviors toward authority"*
  - *"I want to cope with my sexual assault so that I have better relationships with others"*

- Two of eight discharge plans reviewed did not contain clear clinical benchmarks. For example:
  - *"The client will be discharged when he is able to verbally identify at least 3 specific situations, thoughts, feelings, and past experiences that trigger cl anger and defiant behaviors within 90 days. Client will be discharged when he is able to explore and process feelings that cause defiant and oppositional behaviors and learn to manage reactions AEB cl complying with requests and rules and eliminate arguing with authority figures within the next 90 days. The client will be discharged when he is able to identify triggers to suicidal ideations or self-harm thoughts and within the next 90 days. The client will be discharged when he is able to learn and implement effective coping skills self-talk and communication skills"*
- An individual served with a co-occurring diagnosis of Marijuana Abuse did not have this issue addressed on his treatment plan.

Programmatic Integrity	87.8%

Service	Question	Answer	Total	
01. Intensive Family Intervention	01. The Team Leader is meeting with families at least 2x/month. (review authorization period)	No	0	0%
		Yes	8	100%
	02. Safety planning with the family and all parties involved evident in the record from the onset of services.	No	0	0%
		Yes	8	100%
	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	7	87.5%
		Yes	1	12.5%
	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	8	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	8	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	8	100%
	07. The Team leader is licensed/credentialed or CAC-II or equivalent.	No	0	0%
		Yes	8	100%
	08. Documentation reflects a tapering of services.	N/A	6	
		No	1	50.0%
		Yes	1	50.0%
	09. The team is making at least three contacts a week and at a frequency that is clinically appropriate. (review authorization period)	No	1	12.5%
		Yes	7	87.5%
	10. Services over 6 hours are related to a crisis and has supporting documentation signed by the Team Leader.	N/A	8	
		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	8	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	8	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	8	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	8	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	5	62.5%
		Yes	3	37.5%
	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	2	25.0%
		Yes	6	75.0%
02. Overall Service Score		*** Total: 65/74**	**74**	**87.8%**
	** Total indicates total Yes answers / total possible Yes answers.*			

Strengths and/or Improvements Since Previous Audit:

- All records contained evidence of the Team Leaders meeting with families two times per month, as required.
- Safety planning was evident in all records reviewed.
- A team approach containing a mix of services (individual and family counseling, skills training) was documented in 100% of records.

Areas of Non-Compliance / Opportunities for Improvement:

- Seven of eight records did not document transition planning with the individuals served, their family, and community stakeholders.
- One of two records lacked tapering of services, when appropriate.

Documentation of Service Provision — 95%

Question	Answer	Total	
1. Staff intervention related to plan	No	4	5.0%
	Yes	76	95.0%
2. Individual response is present	No	4	5.0%
	Yes	76	95.0%
3. Consumer progress is present	No	4	5.0%
	Yes	76	95.0%

4. Overall Documentation Of Service Provision Score	* Total: 228/240	240	95.0%
** Total indicates total Yes answers / total possible Yes answers.*			

Strengths & Improvements Since Previous Audit:

- All notes present in the records contained an intervention related to the treatment plan, the response of the individual served to the intervention, and a statement of progress toward individuals' goals and objectives.

Areas of Non-Compliance / Opportunities for Improvement:

- There were four missing notes.

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
01. 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).	Yes
	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. The IFI Organizational Plan is present and contains all required components.	Yes
	05. 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
	06. 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.	Yes
	07. The organization has procedures/protocols for emergency/crisis situations that describe methods for intervention when youths require psychiatric hospitalization.	Yes

Strengths & Improvements Since Previous Audit:

- All personnel records contained documentation of two hour training in the agency's chosen therapeutic model, Cognitive Behavioral Therapy.
- 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:

- Weekly individual supervision with the Team Leader is not occurring on Team One. The LAPC on the team is receiving individual supervision for licensure through another individual and the paraprofessional is not receiving any individual supervision.

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**

- Notes contain documentation of techniques/models which are not consistent with the identified model of the agency, Cognitive Behavioral Therapy. Gestalt and person-centered therapy were documented in the records.
- It was noted that an LAPC was referring to himself as a PP within the body of his progress notes making it difficult to discern his actual credential.
- Female individual served was referred to with a masculine pronoun.

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.

	Quantitative: Documentation is present and includes all components as required in the FY15 Provider Manual.

Treatment Planning Recommendations

Recurring:	Ensure the following:
	Goals are specific and outcome-based.
	Discharge plans contain clear clinical benchmarks to indicate readiness to transition to a less-intensive service or discharge from services.
✓	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: • Transition planning is evident in the record. • Records reflect a tapering of services, when approaching discharge.

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: • Individual supervision conducted by the Team Leader with the team members is held once a week.