San Francisco Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Creating & Improving Chart Monitoring/Chart Audit Plans (FY18-19)
Contracted Agencies

BACKGROUND

- **Many agencies use operational activities** (like clinical supervision and utilization review) as the primary vehicle to conduct monitoring and oversight of chart documentation
- **Many agencies use front-line staff** to conduct monitoring and oversight of chart documentation (e.g., peer review of charts)
- **Contracted agencies need feedback and guidance** from BHS to create a chart monitoring plan that can effectively detect and prevent problems
- **As part of a Plan of Correction to the DHCS Medi-Cal Triennial audit in 2017**, the San Francisco Mental Health Plan (SFMHP) is taking steps to improve the compliance and quality of chart documentation

EXISTING GUIDANCE TO PROVIDERS

Currently, there are three **different sources of guidance from BHS that could relate** to a chart monitoring/chart audit plan:

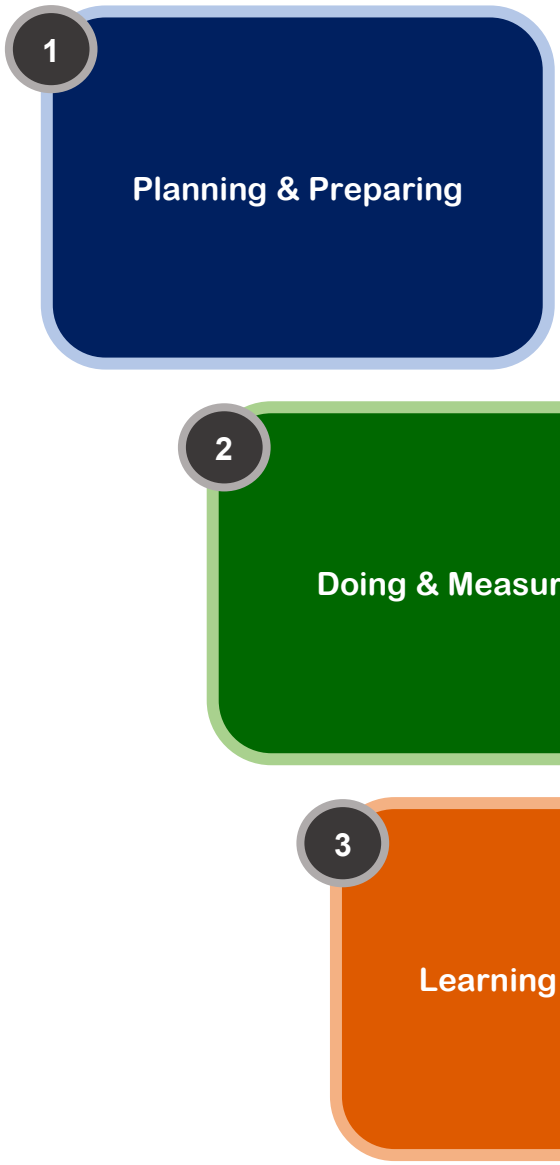
- P-600 Boilerplate Contract: "Contractor agrees to develop and implement a Quality Improvement Plan based on internal standards…[including]…staff evaluations…personnel policies and procedures…Board review of Quality Improvement Plan"
- Appendix A Template, CQI Prompt: "Describe your program's CQI activities…[including] quality of documentation, including a description of the frequency and scope of internal chart audits"
- Declaration of Contract Compliance: "each program must have within its Administrative Binder on site copies of the Board meeting minutes from the meeting at which the Board approved the agency's overall Quality Improvement Plan…[and]… have documentation of a program's most recent specific activities or projects of quality improvement"

Now, SFMHP is providing clarity and support to contracted providers to improve their chart monitoring/chart audit plan. **The goals of this initiative are**:

- Detect and prevent low-quality/low-value clinical documentation by creating and implementing an agency-level chart monitoring/chart audit plan
- To the extent possible (given agency size, funding and staffing), establish a process that is distinct from operational/clinical requirements, like utilization review and supervision)

A FRAMEWORK FOR CREATING CHART MONITORING/AUDITING PLANS

There are three broad steps involved in the process of creating a chart monitoring/chart auditing plan:



Thinking through the process of chart monitoring

Specifying the workflow

Developing insights and making changes

A TEMPLATE FOR CREATING CHART MONITORING/AUDITING PLANS

Using the conceptual framework above, BHS created a tool (below) to assist in the development of a chart monitoring/chart auditing plan. Specifically, we have identified 14 possible elements of a plan:

- The core fundamental elements needed for success appear in *in red font*
- Higher-order elements are marked as *best practice considerations*

Creating a Chart Monitoring/Chart Auditing Plan: **14 Elements to Include in Planning, Doing & Learning**
1. Purpose/Goal: *What is the purpose of the plan? Does the agency implement the plan as intended? Examples could include "reduce errors," "identify low-quality documentation," maintain compliance," "maximize revenue," etc.*
2. Performance Benchmark *(fundamental element)*: *Is there a benchmark or metric* and a unit of analysis*? Comparison to external standard vs. past performance? Examples could include "for progress notes, the acceptable error rate 5% or below," "for each staff member, a 10% improvement from last audit," "for service cost, the acceptable error rate is ≤1% of program budget or below"*
3. Responsibility/Ownership: *Are the responsible departments, staff types, etc., identified? Do they have sufficient authority and ability to implement the plan? Examples could include "QA Director," "Under direction of the Chief Financial Officer"*
4. Sampling Scheme *(fundamental element)*: *Are there details about the unit of analysis (charts vs. claims), sample size (10% vs. 2 per staff member), selection criteria (random vs. criteria-based), timeframe (most recent three months of claims), frequency (annual), etc.?*
5. File Review Tool *(fundamental element)*: *What tool is being used for the review? Is the tool adequate for the purpose? Examples could include "BHS' tool," "DHCS' Annual Protocol," "self-designed tool," etc.*
6. Reviewer Selection *(fundamental element)*: *What type of staff conduct reviews? Do reviewers include Licensed Mental Health Professional staff? Is the staffing sufficient for the purpose? Examples could include "QA staff," "Program Director," "at least one LPHA staff"*
7. Reviewer Training: *How are reviewers trained? Is the training adequate for the task and for reliability? Is there standardized decision-making? Examples could include "staff are trained using BHS' documentation materials," "decision-making is based on standards in the BHS documentation manual"*
8. Pre-Review Preparation *(best practice consideration)*: *What processes are used to preparation for the review? Are staff notified in advance? Examples could include "clerks obtain the billing ledger in Avatar," "staff are notified 10 days in advance"*

Creating a Chart Monitoring/Chart Auditing Plan: **14 Elements to Include in Planning, Doing & Learning**
9. Review Process *(best practice consideration)*: *How does the reviewer implement the review tool? How do reviewers obtain consultation if they are unclear? Examples could include "both the current and prior TPOC are reviewed," "for progress notes, overall quality is described on a single form—if errors are observed, there is detail documented for each service," "questions are emailed to County staff for clarification"*
10. Maintaining Review Records: *How are the review records maintained and preserved? Examples could include "a binder system that is similar to PURQC," "EHR-specific functionality to track audit records," "excel files"*
11. Process for Review Appeal & Resolution *(best practice consideration)*: *What are the mechanisms for staff to dispute/appeal a review finding? Is there a written policy or direction for staff to appeal? Examples could include "a separate body determines the decision," "the Compliance Officer makes the final decision," etc.*
12. Reporting Review Findings *(fundamental element)*: *How are results and findings tabulated? What information is reported and to whom? Do agency executives receive and/or use the findings? Examples could include "reported as part of the Quality Improvement Committee," "for services that are 'backed-out,' the CFO is notified," "written reports are submitted to Program Director," etc.*
13. Post-Review Corrective Actions *(fundamental element)*: *What are the possible corrective actions for service-level problems? For staff-level problems? For agency-level problems? Examples could include "billing back-outs are completed by the billing clerk," "staff are required to complete training when error rates are above 25%," "ongoing non-compliance will result in Program-level action plans," etc.*
14. Plan/Program Evaluation *(best practice consideration)*: *Is the plan effective? Is the plan efficient? Is the plan updated? Does the plan lead to changes? Examples could include "the Compliance Committee reviews the plan annually," "the impact of the plan is determined at the time of cost settlement," "the agency's accreditation requires periodic updates of the plan"*
Notes: • Fundamental elements: item numbers 2, 4, 5, 6, 12 and 13 • *Best practice elements*: item numbers 8, 9, 11 and 14

AN EXAMPLE CHART MONITORING/AUDITING PLAN

Possible Elements & Examples for a Chart Review/Quality Assurance Plan…	SFMHP County-Operated Clinics and System of Care (SOC) Program Managers
1. Purpose/Goal: *What is the purpose of the plan? Does the agency implement the plan as intended? Examples could include "reduce errors," "maintain compliance," "maximize revenue," etc.*	Goals: • Maintain an acceptable error rate • Identify needs for improvement (staff, clinic and age system levels) • Monitor clinical progress and service quality
2. *Performance Benchmark: *Is there a benchmark or metric* and a unit of analysis*? Comparison to external standard vs. past performance? Examples could include "for progress notes, the acceptable error rate 5% or below," "10% improvement from last audit finding," "for service cost*, the acceptable error rate is 1% of program budget or below"	Metrics: • Metric #1 (Progress Note Error Rate): Maintain an acceptable error rate (for review of 3 months of progress notes, ≤5% of notes)
3. Responsibility/Ownership: *Are the responsible departments, staff types, etc., identified? Do they have sufficient authority and ability to implement the plan? Examples could include "QA Director," "Under direction of the Chief Financial Officer"*	Responsibility: • At the *clinic-level*, the Program Director holds accountability for implementing the chart monitoring/audit plan • At the *System of Care (SOC) level*, the SOC Director holds accountability for implementing their own and their clinics' chart monitoring/audit plans

Possible Elements & Examples for a Chart Review/Quality Assurance Plan…	SFMHP County-Operated Clinics and System of Care (SOC) Program Managers

4. *Sampling Scheme: *Are there details about the unit of analysis (charts vs. claims), sample size (10% vs. 2 per staff member), selection criteria (random vs. criteria-based), timeframe (most recent three months of claims), frequency (annual), etc.?*	Levels:
	• *Clinics*: 2 charts per staff member every 6 months (4 annually).
	  ○ In the pilot year, staff can identify the charts for review. Subsequently, clinics will randomly select charts or propose a sampling plan based on a review of audit findings
	• *SOC Program Managers*: 50 charts every 6 months (100 annually, divided evenly between)
	  ○ Charts should be randomly selected and stratified based on size of the clinic (annually, Small clinic = 8 charts; Medium clinic = 17 charts; Large clinic = 25 charts)

5. *File Review Tool: *What tool is being used for the review? Is the tool adequate for the purpose? Examples could include "BHS' tool," "DHCS' Annual Protocol," "self-designed tool," etc.*	All staff will use the most current version of the BHS' Compliance Office audit tool
6. *Reviewer Selection: *What type of staff conduct reviews? Do reviewers include Licensed Mental Health Professional staff? Is the staffing sufficient for the purpose? Examples could include "QA staff," "Program Director," "at least one LPHA staff"*	Levels: • *Clinics*: the review must be conducted by a Program Director, Supervisor, or another staff member with authority to direct/evaluate the work of other staff • *SOC Program Managers*: the review is conducted by Program Managers and/or a contracted expert

Possible Elements & Examples for a Chart Review/Quality Assurance Plan…	SFMHP County-Operated Clinics and System of Care (SOC) Program Managers
7. Reviewer Training: *How are reviewers trained? Is the training adequate for the task and for reliability? Is there standardized decision-making? Examples could include "staff are trained using BHS' documentation materials," "decision-making is based on standards in the BHS documentation manual"*	Training: • *Clinic and SOC Program Managers* received an initial training by Quality Management (QM) and Compliance in Quarters 2 and 3 of FY18-19 • Annual training and "booster training" will be conducted by QM and Compliance
8. Pre-Review Preparation *(best practice consideration)*: *What processes are used to preparation for the review? Are staff notified in advance? Examples could include "clerks obtain the billing ledger in Avatar," "staff are notified 10 days in advance"*	***IN PROCESS***: • BHS is exploring various strategies (e.g., unannounced audits) • One consideration is having a staff member and the Program Director conduct independent reviews so the Program Director can gauge staff insight into documentation standards
9. Review Process *(best practice consideration)*: *How does the reviewer implement the review tool? How do reviewers obtain consultation if they are unclear? Examples could include "both the current and prior TPOC are reviewed," "for progress notes, overall quality is described on a single form—if errors are observed, there is detail documented for each service," "questions are emailed to County staff for clarification"*	***IN PROCESS***: • BHS is exploring strategies (e.g., one SOC staff as point-person for clinics) • BHS plans on developing a "decision-support tool" to help determine if documentation meets the standard

Possible Elements & Examples for a Chart Review/Quality Assurance Plan…	SFMHP County-Operated Clinics and System of Care (SOC) Program Managers

10. Maintaining Review Records: *How are the review records maintained and preserved? Examples could include "a binder system that is similar to PURQC," "EHR-specific functionality to track audit records," "excel files"*	Levels:
	• *Clinics*: in the pilot phase, all review tools are sent to Program Managers at 1380 Howard St.
	  ○ Subsequently, the review tools are to be maintained securely, in a similar fashion to PURQC materials (i.e., organized by time period, by staff) at the clinic site
	  ○ These records must be available for inspection, review, etc. by SFMHP administrators
	• *SOC Program Managers*: review tools are to be maintained securely, in a similar fashion to PURQC materials (i.e., organized by time period, by staff) at the clinic site

11. Process for Review Appeal & Resolution *(best practice consideration)*: *What are the mechanisms for staff to dispute/appeal a review finding? Is there a written policy or direction for staff to appeal? Examples could include "a separate body determines the decision," "the Compliance Officer makes the final decision," etc.*	***IN PROCESS***: • BHS is exploring various strategies (e.g., a specific form and/or a tracking system) • One consideration is drawing from Utilization Management procedures
12. *Reporting Review Findings: *How are results and findings tabulated? What information is reported and to whom? Do agency executives receive and/or use the findings? Examples could include "reported as part of the Quality Improvement Committee," "for services that are 'backed-out,' the CFO is notified," "written reports are submitted to Program Director," etc.*	Levels: • *Clinics*: each clinic reports quantitative and qualitative data to their respective System of Care Director. Then, the SOC Director will compile and summarize all clinic data • *SOC Program Managers*: Program Managers use the same reporting format to submit quantitative and qualitative data to the SOC Director • *SOC Directors*: the SOC Directors will aggregate their age-specific information and submit this report to the BHS Director every 6 months

Possible Elements & Examples for a Chart Review/Quality Assurance Plan…	SFMHP County-Operated Clinics and System of Care (SOC) Program Managers
13. *Post-Review Corrective Actions: *What are the possible corrective actions for service-level problems? For staff-level problems? For agency-level problems? Examples could include "billing back-outs are completed by the billing clerk," "staff are required to complete training when error rates are above 25%," "ongoing non-compliance will result in Program-level action plans," etc.*	Actions: • Billing back-outs (if a service has already been billed) and/or change to "non-billable service" (if the service is "open") will be confirmed by Program Directors (for clinic-level) and by Program Managers (for SOC-level reviews). Evidence for this activity will be the Client Ledger reports and back-out forms • Performance appraisals will include information on the staff members' chart documentation performance (for front-line staff)
14. Plan/Program Evaluation *(best practice consideration)*: *Is the plan effective? Is the plan efficient? Is the plan updated? Does the plan lead to changes? Examples could include "the Compliance Committee reviews the plan annually," "the impact of the plan is determined at the time of cost settlement," "the agency's accreditation requires periodic updates of the plan"*	***IN PROCESS***: • BHS is exploring various strategies (e.g., exploring if the "effectiveness" of the plan varies by clinic size, staff patterns, service types, etc.) • One consideration is using DHCS' model for an MHP Quality Improvement Plan, which requires an annual evaluation of the goals/objectives drawing from Utilization Management procedures
***** = *fundamental element of a chart monitoring/auditing plan*	