**GHS Quality Management Plan FY’23**

Genesee Health System (GHS) has established a Quality Management (QM) department with primary responsibilities for implementation of quality management and improvement duties. This document provides a description of the GHS QM program and the annual implementation plan associated with GHS Policy 01-400-93 and R10 Policy #01-04-01, Quality Assessment & Performance Improvement Program, and R10 QM Committee Plan. GHS QM is committed to furthering the mission of Genesee Health System, which is “supporting recovery, prevention, health and wellness or the body, the mind, and the community”.

**Quality Management connection to GHS overall mission, vision and values:**

Genesee Health System Quality Management is dedicated to supporting the mission, vision and values of Genesee Health System by supporting quality programs and initiatives focused on assisting clinical providers in meeting both the treatment and documentation standards and expectations of GHS, Region 10, and MDHHS. GHS QM also interfaces with the Customer Services and Utilization Management departments to monitor interventions and feedback related to regional and state growth initiatives. With special focus on the experience of persons served, QM encourages timely, responsive care; and increased integration and coordination between physical and behavioral health teams for a truly holistic experience. We also focus on providing good stewardship of public health resources by ensuring that treatment is high quality, well documented, based in medical necessity and provided by trained and credentialed providers.

**Overview of Quality Management Processes:**

Annual provider audits

Genesee Health System Quality Management conducts internal audits of the clinical programs providing care for those we serve. This includes primary GHS internal programs as well as contracted provider agency clinical service programs. In addition, due to the specific clinical background inherent in Behavior Treatment Waiver (Applied Behavior Analysis) programs, those programs are also reviewed on an annual basis by QM, despite being an ancillary service.

The QM audit tool is comprised of 165 indicators specifically related to requirements outlined in the Michigan Medicaid Provider Manual, the Michigan Mental Health code, MDHHS and Region 10 initiatives, and standard of care for treatment modalities. This audit tool is a living document and is adjusted to meet evolving guidelines as needed between fiscal year audit cycles.

A schedule of annual audits is developed by fiscal year, with most clinical program audits occurring internally within a two week window, while autism program audits occur within a one week window. At that time, QM is reviewing clinical chart information, as well as Credentialing and Privileging documentation and policies. Site reviews have also been standard; however, at this time as the bodies that govern CMHSP are conducting virtual/desk audits in the wake of the COVID-19 pandemic and ongoing effects, GHS QM will align with this standard. For provider networks, 30 cases are selected and both QM coordinators and provider network staff engage in auditing those records. QM coordinators audit a sample of selected cases and conduct the C&P review also at that time. For GHS providers, QM will audit a total of 30 cases, and no self-auditing is required.

Providers are alerted to the upcoming audit process by letter two weeks ahead of the scheduled audit. At that time they are asked for their staff list to give them time to prepare all C&P documentation to provide. All clinical records are electronic as a part of the CHIP EMR; C&P documentation is largely provided electronically as well, although providers can request QM complete review of paper files on site.

During the audit period, QM coordinators will review all aspects of the EMR, noting areas of excellence, expectations met, need for growth or improvement, and any barriers to proper care, treatment, integrated services delivery, less than ideal satisfaction, and increased risk and liability. Though infrequent, coordinators may seek consult from Corporate Compliance or Recipient Rights if the need arises. Once the audit cycle is completed, coordinators will summarize audit findings and request a Corrective Action Plan for any fields resulting in a rating less than 95%. Providers are required to review the findings, complete root-cause analysis as to why the indicator(s) did not meet expectations, and a plan to improve this aspect of service provision. Once providers develop their CAP and this is accepted by QM, they will have a three month period to demonstrate improvement, with self-audits and spot audits occurring at the 3 month mark. Following the discussion of findings, providers have the option to request QM provide additional education to assist teams in understanding requirements and developing ways to improve performance. Also following discussion of findings, providers are requested to complete a satisfaction survey related to their experience of the audit process, in accordance with quality management department’s own internal performance improvement process.

In addition to regular annual audits, the quality management team also participates in clinical review of quarterly children’s ICCS services. In conjunction with the utilization management department, QM will review cases on a quarterly basis where there is over or underutilization to determine any quality concerns or supports needed. Focus audits can also be requested to address specific concerns in programs.

Throughout the audit process, the coordinators work diligently with program leaders to seek additional evidence or verification for items not easily available within the record. This assists providers in maintaining their records prior to external audits, reviews, or compliance questions. It is the overall goal of the QM department to provide collaborative quality improvement reviews, focused on supporting providers in providing and documenting quality care for the individuals we serve, in accordance with Genesee Health System, Region 10 PIHP, and MDHHS standards and guidelines.

**Audit Process and Plan:**

1. Each provider to audit 30 cases selected by GHS according to the GHS audit tool
2. GHS QM pulls 28 random open and 2 random closed records, via web-based report
3. GHS auditors to also audit 10 of those 30
	1. Audit results will be compared for validity
	2. GHS may clarify audit indicators and ask provider to re-audit if results are vastly different
4. If provider scores below 95% a CAP will be requested with self-audits due every quarter
	1. Auditors may continue to audit a number of cases each quarter to ensure validity of responses
	2. If audit scores on specific indicators and overall do not improve in subsequent audits consequences will evolve further

The review consists of three distinct parts:

* Site Visit with Credentialing and Privileging Review
* Quality of Care Audit
1. Provider to self-audit 30 records designated by GHS utilizing the provided QOC MH Audit Tool. Review is to be completed by clinical staff within the program.

**Please note:** Only dates from one year previous to the date of this letter will be accepted in the audit. Any records added electronically or scanned after that date will not be considered in the review.

1. GHS Auditor to audit sample of provider records utilizing the same tool
* Optional formal exit consultation

TIMELINE OF AUDIT PROCESS:

* Providers will be notified of upcoming audit two weeks in advance of audit. Providers will be asked to compile and provide a list of staff providing services to GHS individuals at that time.

* Providers will be given a list of 30 selected cases for self-audit review, on or before the start of audit, either by email or in person from the auditors.
* The process allows 30 days to complete the review, meanwhile GHS auditors are also completing a chart review.
* Audit results from the provider and GHS will be compared for reliability.
* Provider audit results will be communicated within 30 days of the conclusion of audit.
* Providers are encouraged to participate in optional exit review and/or follow-up education with auditors, which can take place at any time determined mutually convenient.
* Extensions may be provided upon request.
* Focus Audits- Trends that require further investigation will result in focus audits throughout the year
* Planned focus audit- Trend/risk discovery for high risk or high utilization cases

 Audit will focus on:

* Goals pertinent to issues consumer states and assessments
* Progress notes moving toward goal progress (before and after hospitalizations)
* Goals changing as issues arise
* Contact following crisis or hospitalization and increase in frequency of contact
* Meaningful changes to relapse prevention or IPOS post hospitalization
* IPOS reviews showing progress towards goals and changes if goals need to adapt
* Frequency of medication reviews
* Medication; frequency of changes, number of medications
* Medication compliance
* Number of case managers in the past year
* Waiver consumers (HSW, CWP, and SEDW) have specific scope, amount, frequency and duration identified in IPOS without ranges.