HealthWest
Muskegon's Behavioral Wellness Connection

Policy/Procedure Title: **Peer Chart Review**	Policy and Procedure #: 09-003	Review Dates	
Category: Quality Assurance Subject: HealthWest will develop and maintain a comprehensive, systematic peer chart review process that evaluates the quality, completeness, and accuracy of documentation and record keeping. The peer chart review process and its results will be used as a measure of quality, a mechanism for feedback, and a tool for improvement within the agency's overall Quality Assurance and Performance Improvement Program.	Prepared by: Name: Shawna Curran Title: Evaluation & Innovation Specialist Approved by: DocuSigned by: Rich Francisco AA7FBD48ABB04A3... Rich Francisco, Executive Director		
	Effective Date: 06/08/2000	Last Revised Date: 10/29/2025	

I. POLICY

HealthWest will have a peer chart review process that ensures the agency upholds best practices regarding the provision and documentation of services, and maintenance of consumer clinical records. The chart review process itself will also confirm with accreditation standards, enable adequate oversight, and provide a method for the agency to assess and maintain its adherence to all applicable regulation and requirements regarding clinical documentation.

II. APPLICATION

All consumer records and documentation regarding services provided by HealthWest staff and its network of contracted providers, including all medical (Physicians, Physician Assistants) providers.

III. DEFINITIONS

A. Peer: One who has equal standing with another, similar rank, similar job performance.

B. Peer Review Process: An evaluation by clinicians of the quality and efficiency of care performed by another practitioner/clinician. It is objective in nature and based on medical necessity, appropriateness, and efficiency of services.

IV. PROCEDURE

A. The Quality Assurance (QA) department will be responsible for coordinating and overseeing HealthWest's clinical chart review process while the medical chart review process is developed and supervised by licensed physicians.

B. The Quality Assurance department will implement the agency's chart review process, establishing and implementing the agency's chart review protocol including the content,

scope, sampling, frequency, and procedures for chart reviews. The Performance Improvement Committee in coordination with the Quality Assurance Department, will also assist with the review, compilation, distribution, and use of the results of chart reviews.

C. The Quality Assurance Department will determine the content of clinical chart review, evaluate the content of clinical chart review on an ongoing basis, and modify the content as needed. When determining content, input from a variety of sources will be considered including:

1. Current best clinical practices

2. Contractual requirements, which may be defined by the Centers for Medicaid and Medicare (CMS), the Michigan Department of Health and Human Services (MDHHS), the Lakeshore Reginal Entity (LRE) and other oversight bodies

3. All applicable behavioral healthcare standards and requirements contained in federal and state statutes and final rules, the Michigan mental Health Code (MHC) the Michigan Medicaid Provider manual, MDHHS Policies and Practice Guidelines, the CCBHC Demonstration handbook, Behavioral Health Code Charts and provider Qualifications, and pertinent site review tools.

4. Findings, observations, and areas needing improvement identified by external reviewers, surveyors, and auditors.

5. Improvement projects and elements of the HealthWest Quality Assurance and Performance Improvement program

6. Agency priorities and strategic plan objectives identified by HealthWest Leadership.

7. New processes, to ensure their efficiency and effectiveness.

8. Input from various stakeholders, including HealthWest Leadership Team; the Chief Clinical Officer and Clinical Operations Team; Clinical Supervisors, Managers, and Directors; members of the Performance Improvement and Corporate Compliance Committees; internal departments including Quality Assurance, Compliance and Provider Network Management and individuals receiving services.

D. The record review will minimally address whether:

1. The person served was actively involved in making informed choices regarding the services they received.

2. The assessments were thorough, complete, timely, and addressed all aspects of a person’s mental health.

3. Person-centered planning was utilized through pre-planning and development of the Individual Plan of Service (IPOS)

4. The goals and objectives on the Individual Plan of Service (IPOS) were based on the results of the assessments and on the input of the person served.

5. The services provided were related to the goals and objectives, and delivered in the amount, scope, duration, and frequency stated in the IPOS.

6. Transition plans and discharge summaries were completed as required.

7. Services were documented in accordance with the agency's policies and practices regarding content and timeliness of documentation.

8. The individual plan was reviewed and updated according to the timeline agreed upon within the IPOS and in accordance with the agency's policies and procedures.

E. Selection of Cases for Clinical Chart Reviews

1. The QA Department will select cases for review by the first week of every quarter of the fiscal year. Selected cases will be sent to Clinical Supervisors, who will assign cases to team members. Clinical Supervisors will ensure completion.

2. To ensure representative sampling, cases for review will be selected from all clinical programs responsible for treatment planning and service delivery. The QA Department will review the sampling criteria before selecting cases each quarter, to ensure all necessary programs and supervisors are included in the review process.

3. Cases for review will be selected randomly from all cases which were open during the review period. Sample selection will be stratified by clinical program, as well as clinical supervisor, when multiple supervisors work within one program.

4. To ensure adequate sample size and equitable distribution of reviewing responsibilities, stratified sample selections will be proportional to the number of staff that work on each clinical team.

5. Oversampling will be used when selecting cases, to provide clinical supervisors with a small number of alternate cases to review in the event a selected case is not appropriate for review (e.g. has only been open a short time and does not have documentation available to review). However, cases must not be excluded from review simply because the results of the review would be negative.

6. Closed cases may still be reviewed. Inclusion of closed cases in clinical chart reviews provides an important opportunity to review transition planning and discharge processes.

F. Completion of Clinical Chart Reviews

1. Clinical Supervisors are responsible for assigning cases for review within their team and ensuring reviews are completed as assigned

2. Reviewers will utilize the current HealthWest Peer Chart Review form located on the Laserfiche database to complete their assigned clinical chart reviews.

Reviewers are expected to utilize all available documentation in the clinical record and to review all elements within the form.

3. Completed chart reviews are submitted via Laserfiche database from the reviewer to the clinical supervisor, who is responsible for reviewing all findings, sharing feedback with the appropriate case holder or clinical team member, and ensuring any corrections in the chart are completed as necessary.

4. For cases open more than one (1) year, reviewers should prioritize the most recent twelve-month period within the clinical record. For cases open less than one (1) year, the entire record will be reviewed.

G. Results of Chart Reviews

1. The Quality Assurance Department will review and analyze aggregated data and will make recommendations for follow-up as needed.

2. The Quality Assurance Department, in coordination with the Chief Clinical Officer, Medical Director and clinical supervisors, managers, and agency directors, will monitor follow-up activities intended to improve performance in their respective departments.

3. Supervisors will utilize the information from chart reviews for clinical staff training and development, annual performance evaluations, and as a basis for performance improvement initiatives.

4. Results of chart review process will be shared with the Performance Improvement Committee, Doctors Workgroup, and integrated into the agency's Quality Assurance and Performance Improvement Program (QAPIP).

5. The Quality Assurance Department, after analyzing results from previous quarters and from clinical audits, will update the Peer Chart Review document to reflect areas of improvement and to review for the next year to ensure process improvement and improvement within standards.

Protocol for Medical Peer Review Process

1. The peer review process will be supervised by licensed physicians.

2. The peer review process will occur as a chart review.
    a. The chart review criteria is developed by the physicians containing only objective evidence questions.
    b. The chart reviews will be documented on Form Q 036.

3. This is completed through random sampling and will include 8-10 charts. The peer review process is educational in nature and intended to educational in nature in an effort to enhance quality of care for physicians.

H. Additional Review Processes

1. Review protocols for other disciplines will be developed by the Clinical Supervisors and Managers of those services in consultation and coordination with the Performance Improvement Committee and QA Department.

2. Review protocols may also be developed as needed to meet focused or short-term interests. QA Department staff will provide technical assistance with process development, methodology, analysis, and reporting upon request.

I. Individuals' right to confidentiality will be maintained throughout the chart review process

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