Guam Behavioral Health and Wellness Center		
TITLE: Peer Review Process	**POLICY NO.:** AD-MR-01	Page 1 of 3
RESPONSIBILITY: Clinical Programs		
APPROVED BY: Rey M. Vega **REY M. VEGA, DIRECTOR**	**EFFECTIVE DATE:** 4/19/17 **REVISED:**	

PURPOSE:

A. To define the process and describe the activities in the Peer Review as they relate to the improvement of health care quality, performance, effectiveness and efficiency of patient care by the mental healthcare providers.

B. The goal of the peer review process is to provide a review process that is educational, consistent, timely, balanced, fair, useful, and ongoing.

POLICY STATEMENT:

A. It is the policy of GBHWC to encourage and support peer review. The Medical staff and the Department heads of the different clinical disciplines or programs are responsible for conducting peer review and assess the performance of individual staff members.

B. Routine Peer Review of medical records shall be conducted and reported by each department on a quarterly basis.

C. Mandatory Peer Review shall only be conducted to critical incidents or fall out chart as necessary. The fall out chart that may trigger a peer review shall include but are not limited to the following;
   a. Sentinel Events or significant adverse outcome
   b. Critical incidents
   c. Adverse Drug Reaction
   d. Mortality
   e. Multiple readmission to crisis stabilization in a month
   f. Substance abuse relapse within 30 days of abstinence
   g. Persistent or repetitive violations of medical records standard or documentation issues.
   h. Complaints involving medical care or physician behavior
   i. Cases as identified by the Medical Director, Program Head or Supervisor where opportunities to improve may be addressed.

D. Peer review documentation is considered confidential and the results of such reviews will be communicated only with the appropriate individuals. Summary information shall be reported and provided on a quarterly basis to the Quality Performance Improvement Committee (QPIC) meeting.

C. Every attempt will be made to ensure that fair, equitable and non biased procedures are utilized in all peer review proceedings. Peer review will be included in the credentialing and privileging process of the medical staff practitioners and the performance evaluation of the mental health providers.

DEFINITIONS:

1. Mental Health Providers: Include Psychiatrist, Psychologist, Mental Health Nurse Practitioner/Psychiatric Nurse, Counselors and Clinical Social Workers.

2. Peer: "Peer" is an individual practicing in the same profession and who has expertise in the appropriate subject matter.

3. Peer Review: is the objective evaluation of an individual practitioner's professional performance and includes the identification of opportunities to improve care.

4. Case: An event during a consumer's stay in a Clinical Program that corresponds to approved criteria for peer review.

5. Fallout: A case meeting an indicator for peer review

6. Review Indicators: Identifies a significant event that would ordinarily require analysis by mental health provider peers to determine cause, effect and severity.

7. Committee: One or more members of the medical staff and other disciplines or an interdisciplinary body who review individual cases or aggregate practitioner data for the purpose of peer review under the auspices of a clinical program/section or Director.

PROCEDURE:

Each department, division, or committee will conduct regular patient care and medical chart reviews and studies of practice in conformity with the GBHWC general performance improvement plan.

A. Routine Peer Review
    1. Each Program shall have a discipline specific routine chart peer review every quarter. The *GBHWC Peer Review Form* (*reference attachments*) will be utilized for each peer review conducted.
    2. Ten (10) open charts (concurrent review) within the previous quarter and ten (10) charts closed within the year shall randomly be selected by the supervisor of the clinical discipline, or clinical administrator of the program and medical director for the medical staff for peer review.
    3. The supervisor, clinical administrator or Medical director shall keep the files of the peer review and will report the summary of the result in the quality improvement committee.
    4. Any deficiencies found in the chart peer review should be identified and corrected.

B. Mandatory Peer Review
    1. Cases are identified for review through referrals from medical staff, unusual occurrence reports or incident report, referrals from quality improvement committee meetings, team meetings, consumer or family complaints.
    2. Cases or fallout charts identified by the Quality Improvement Coordinator in the QPIC meetings shall be presented to the discipline or clinical program monthly meeting or team facilitators meeting for peer review.

3. A medical staff or clinical staff peer reviewer shall be identified to review and close the chart if it is within the standards of care.
    i. The medical staff reviewer shall complete the review within 10 working days
4. If upon peer review the case was found not within the standards of care then it will be referred for Departmental Peer Review.
5. The assigned staff peer reviewer shall be responsible for case presentation during the departmental review.
6. The Lead Provider of the case to be presented for departmental peer review shall be notified a week prior to the scheduled meeting.
7. The Departmental Peer Review shall be completed within 45 days from the identification of the case and will determine areas or opportunities to improve care.

C. Outcome Categories (Routine & Fall out Chart). Level of Incident
    1. Upon review of the documentation, the peer reviewer, or committee will categorize the level of the incident as follows:
        i. Level 1 more than 85% compliant: Within standard of care, no further action needed.
        ii. Level 2 within 75-84% compliant; Mental Health Provider Self-identified Remediation
            a. Follow up at a specified interval to ensure that remediation is completed.
        iii. Level 3 less than 75% compliant; Care Inappropriate
            a. Corrective action will be taken as determined by the Medical Director and or Clinical Administrator or Departmental Supervisor with input from the peer review panel.

    2. The Director shall be notified by the Medical Director or Clinical Administrator or Department Heads of all level three (3) outcomes.

D. Documentation and Timeliness of Peer Review Process
    1. Routine peer review shall be conducted and reported by each discipline quarterly, and mandatory peer review of fall out cases shall be conducted as the need arise.
    2. The mandatory peer review shall be completed within 45 days after identification of the case.
    3. Documentation stemming from peer review recommendations shall be placed in departmental peer review minutes and, specific recommendations will be included in the mental health provider's performance evaluation.

ATTACHMENTS:
I. Medical Staff Peer Review Form
II. Psychiatric Nursing Peer Review Form
III. Routine Peer Review Form

SUPERSEDES: Peer Review of Medical Record Protocol; Effective date/signature date; July 31, 2012. Approved by Director Wilfred Aflague

Guam Behavioral Health and Wellness Center

Medical Staff Peer Review Form - Internal

Quarter: ◯ 1st ◯ 2nd ◯ 3rd ◯ 4th

Reviewed by: _____

Date of Review: _____

Consumer Initials: _____

Consumer Identification No: _____

Admission Date: _____

Date of Discharged: _____

Intake worker: _____

Psychiatrist: _____

Nurse: _____

Indicate an "X" under the appropriate field for "Y" if compliant and "N" if non-compliant. If section is not applicable, please indicate "N/A" in the corrective action box

INTAKE ASSESSMENT PROCESS					
#	Standard	Y	N	Reviewer Comments for Corrective Action	Corrective Actions Completed
Assessment:					
1	Is first contact/demographic form complete				
2	Is the presenting problem related to a mental illness				
3	Is the specific DSM 5 criteria present that support the diagnosis				
4	Was any suicidality, threat to others, medical problems, or withdraw issues appropriately addressed?				
5	Does the intake assessment adequately portray the documentation and need for treatment/services?				
6	Assessment is complete and contains information provided by participants				
7	Strength, Need, Abilities, & Preferences (SNAP) and Diagnosis are complete and documented				

	Interpretive Summary:				
1	Interpretive summary completed w/in 24 hours				
2	In a narrative format				
3	Identifies any co-occuring disabilities, co-morbidities, and/or disorders				
4	Addresses participant's central theme				
5	Includes clinician's clinical judgments				
6	Includes recommended treatment				
7	Is used in the development of the person centered plan				

TREATMENT PLANS

#	Standard	Y	N	Reviewer Comments for Corrective Action	Corrective Actions Completed
Treatment Plan					
1	a. Address isues identified during assessment intake				
2	b. Is person centered and in the words of person served				
3	Is completed with the person served within 30 days of admission into the outpatient program or within 24 hours in Crisis Stabilization Uniit				
4	d. Is based upon participant's strengths, needs, abilities, and preferences and is used within the treatment Plan				
5	e. Client was involved in creation of treatment plan, as evidences by signature of person served on treatment plan documentation document				
Treatment Goals					
1	a. Expressed in the words of the person served				
2	b. Includes short and long- term goals				

3	c. Achievable in a way that creates movement in treatment and allows individual to be successful				
Treatment Objectives		**Y**	**N**	**Reviewer Comments for Corrective Action**	**Corrective Actions Completed**
1	a. Measureable, achievable, time specific, and appropriate to the service/treatment setting				
2	b. Related to the identified/linked goal				
3	c. Reflective of the expectations of the participant and treatment team				
4	d. Reflective of person's age, development, and/or culture and ethnicity				
5	e. Identification of specific interventions, modalities, and or services to be used				

Treatment Plan Review					
#	**Standard**	**Y**	**N**	**Reviewer Comments for Corrective Action**	**Corrective Actions Completed**
1	Was the plan reviewed in the last six (6) months?				
2	Is progress towards goals documented?				
3	Does the review support continued treatment?				
4	Have targets dates been adjusted accordingly?				
5	Is there a steady improvement in the consumer's recovery? If not has it been properly documented?				
6	Treatment plan reviews are completed and documented in a timely manner every quarter				
7	Reflects the progress of participant's treatment in achieving each active items in the treatment plan(goals and Objectives)				
8	Reflect current issues relevant to person served				

PROGRESS NOTES					
#	Standard	Y	N	Reviewer Comments for Corrective Action	Corrective Actions Completed
1	Are the progress notes in the correct format				
2	Do progress notes focus on treatment of the identified mental illness				
3	Is there specific reference to the treatment plan goals/objectives?				
4	Do progress notes reflect current setbacks and improvements?				
5	Documents change in the level of care (LOC) and any significant events in consumer's life				
6	The delivery and outcome of specific interventions. Modalities, and/or services that support the person-centered plan				
7	Changes in frequency of services				

DISCHARGE SUMMARY					
#	Standard	Y	N	Reviewer Comments for Corrective Action	Corrective Actions Completed
1	Is a written discharge summary prepared for all persons leaving services				
2	Include date of admission				
3	Described services provided				
4	Identify presenting condition				
5	Describe the extent to which established goals and objectives were met				
6	Describe the reason for discharge				
7	Identify the status at last contact				
8	List recommendations for services or support				
9	Include the date of discharge				
10	Include information about medication(s) prescribed or administered				

MEDICATIONS/ REQUIRED FORMS					
#	Standard	Y	N	Reviewer Comments for Corrective Action	Corrective Actions Completed
1	Consent for treatment signed				
2	Medication consent				
3	Is the medication, dose, frequency, and continued use appropriate based on the diagnosis/progress?				

CRISIS STABILIZATION UNIT					
#	Standard				
1	Was admission appropriate				
2	Was discharge appropriate				

GENERAL OVERALL CHART REVIEW					
#	Standard	Y	N	Reviewer Comments for Corrective Action	Corrective Actions Completed
1	Is documentation timely and completed in its entirety				
2	Did the clinician follow through on all referrals				
3	Was the reason for intake appropriate and justified by the diagnosis				
4	Do Assessments justify the consumer's treatment/services?				
5	Is there justification for continued treatment?				
6	Are the services/treatment at the least restrictive level of care based on the consumer's current needs?				
7	Does the chart reflect an understanding of protocols and charting requirements?				

Corrective Action Status

[ ] Level 1 > 85% compliacnt No corrections are needed/Within Standards of Care

[ ] Level 2 within 75-84% compliant corrections are needed (see above)

- **[ ] Provider Self Identified Remediation**
- **[ ] Education was provided and accepted**
- **[ ] Corrective actions taken and completed**

[ ] Level 3 < 75% Compliant ,Care Inappropriate, corrective action will be taken as determined by the Medical Director

Reviewer Signature: _____ **Date** _____

Guam Behavioral Health and Wellness Center

Psychiatric Nurses Peer Review Form

Quarter: ◯ 1st ◯ 2nd ◯ 3rd ◯ 4th

Reviewed by: _____

Date of Review: _____

Consumer Initials: _____

Consumer Identification No: _____

Admission Date: _____

Date of Discharged: _____

Admitting Nurse: _____

Attending Psychiatrist: _____

Social Worker: _____

Indicate an "X" under the appropriate field for "Y" if compliant and "N" if non-compliant. If section is not applicable, please indicate "N/A" in the corrective action box

ADMISSION ORIENTATION PROCESS					
#	Standard	Y	N	Reviewer Comments for Corrective Action	Corrective Actions Completed
Assessment:					
1	Consumer provided with an appropriate orientation to the unit and admission process				
2	Informed Consent obtained for medications				
3	Consent obtained for notifications (visitations/phone)				
4	Consumer was actively involved in making informed choices regarding the services they received.				
3	RN Assessment is complete and contains information provided by participants				
4	Strength, Need, Abilities, & Preferences (SNAP) and Diagnosis are complete				
5	Suicide/Homicide Risk Assessment completed				
6	Fall/Assault/Elopement/Nutrition assessment completed				
7	Advanced Crisis Planning completed				
	c. Identifies any co-occuring disabilities, co-morbidities, and/or disorders (including diagnosis)				
	d. Addresses participant's central theme				
	g. Is used in the development of the person centered plan				

#	Standard	Y	N	Reviewer Comments for Corrective Action	Corrective Actions Completed
PROGRESS NOTES					
33	Admission note completed (includes reason for admission)				
34	Progress, or lack thereof, in achieving treatment plan goals are evident in progress notes				
35	The delivery and outcome of specific interventions. Modalities, and/or services that support the person-centered plan				

TREATMENT PLANS					
#	Standard	Y	N	Reviewer Comments for Corrective Action	Corrective Actions Completed
Initial Treatment Plan					
12	a. Address isues identified during assessment intake				
13	b. Is person centered and in the words of person served				
14	c. Initial Plan Is completed with the person served within 24 hours of admission into the inpatient program				
15	d. Is based upon participant's strengths, needs, abilities, and preferences and is used within the treatment Plan				
16	e. Client was involved in creation of treatment plan, as evidences by signature ofperson served on tretament plan documentation document				
Treatment Goals					
17	a. Expressed in the words of the person served				
18	b. Includes short and long- term goals				
19	c. Achievable in a way that creates movement in treatment and allows individual to be successful				
Treatment Objectives					
20	a. Measureable, achievable, time specific, and appropriate to the service/treatment setting				
21	b. Related to the identified/linked goal				

22	c. Reflective of the expectations of the participant and treatment team				
23	d. Reflective of person's age, development, and/or culture and ethnicity				
24	e. Identification of specific interventions, modalities, and or services to be used				

DISCHARGE SUMMARY					
#	Standard	Y	N	Reviewer Comments for Corrective Action	Corrective Actions Completed
38	a. Include date of admission				
39	b. Described services provided				
40	c. Identify presenting condition				
41	d. Describe the extent to which established goals and objectives were met				
42	e. Describe the reason for discharge				
43	f. Identify the status at last contact				
44	g. List recommendations for services or support				
45	h. Include the date of discharge				
46	i. Include information about medication(s) prescribed or administered				
47	Client and/or family provided an After Care Plan				

GENERAL OVERALL CHART REVIEW					
#	Standard	Y	N	Reviewer Comments for Corrective Action	Corrective Actions Completed
1	Is documentation timely and completed in its entirety				
2	Did the clinician follow through on all referrals				
3	Was the reason for intake appropriate and justified by the diagnosis				
4	Do Assessments justify the consumer's treatment/services?				
5	Is there justification for continued treatment?				
6	Are the services/treatment at the least restrictive level of care based on the consumer's current needs?				
7	Does the chart reflect an understanding of protocols and charting requirements?				

Corrective Action Status

[ ] level 1 > 85% compliant No corrections are needed/Within Standards of Care

[ ] Level 2 within 75%-84% Complaint Corrections are needed (see above)

- **[ ] Provider Self Identified Remediation**
- **[ ] Education was provided and accepted**
- **[ ] Corrective actions taken and completed**

[ ] Level 3 < 75% Complainat Care Inappropriate, corrective action will be taken as determined by the Medical Director or Clinical Administrator

Reviewer: _____ **Date:** _____

Guam Behavioral Health and Wellness Center

Routine Chart Peer Review Form Outpatient

Quarter: ◯ 1st ◯ 2nd ◯ 3rd ◯ 4th

Reviewed by: _____

Date of Review: _____

Consumer Initials: _____

Consumer Identification No: _____

Admission Date: _____

Date of Discharged: _____

Intake worker: _____

Lead provider: _____

Counselor: _____

Psychiatrist: _____

Psychologist: _____

Indicate an "X" under the appropriate field for "Y" if compliant and "N" if non-compliant. If section is not applicable, please indicate "N/A" in the corrective action box

SCREENING ORIENTATION PROCESS					
#	Standard	Y	N	Reviewer Comments for Corrective Action	Corrective Actions Completed
Assessment:					
1	Consumer provided with an appropriate orientation				
2	Consumer was actively involved in making informed choices regarding the services they received.				

INTAKE ASSSESSMENT PROCESS					
#	Standard	Y	N	Reviewer Comments for Corrective Action	Corrective Actions Completed
Assessment:					
3	Assessment is complete and contains information provided by participants				
4	Strength, Need, Abilities, & Preferences (SNAP) and Diagnosis are complete				

Interpretive Summary:					
5	a. Interpretive summary completed w/in 24 hours				
6	b. In a narrative format				
7	c. Identifies any co-occuring disabilities, co-morbidities, and/or disorders				
8	d. Addresses participant's central theme				
9	e. Includes clinician's clinical judgments				
10	f. Includes recommended treatment				
11	g. Is used in the development of the person centered plan				

TREATMENT PLANS

#	Standard	Y	N	Reviewer Comments for Corrective Action	Corrective Actions Completed
Treatment Plan					
12	a. Address isues identified during assessment intake				
13	b. Is person centered and in the words of person served				
14	Is completed with the person served within 30 days of admission into the outpatient program				
15	d. Is based upon participant's strengths, needs, abilities, and preferences and is used within the treatment Plan				
16	e. Client was involved in creation of treatment plan, as evidences by signature ofperson served on tretament plan documentation document				
Treatment Goals					
17	a. Expressed in the words of the person served				

18	b. Includes short and long- term goals				
19	c. Achievable in a way that creates movement in treatment and allows individual to be successful				
Treatment Objectives					
20	a. Measureable, achievable, time specific, and appropriate to the service/treatment setting				
21	b. Related to the identified/linked goal				
22	c. Reflective of the expectations of the participant and treatment team				
23	d. Reflective of person's age, development, and/or culture and ethnicity				
24	e. Identification of specific interventions, modalities, and or services to be used				

Counselor Interventions					
#	**Standard**	**Y**	**N**	**Reviewer Comments for Corrective Action**	**Corrective Actions Completed**
25	a. Are measurable and time- limited				
26	b. Are therapeutic and counselor-driven				
27	c. Indicates frequency of intervention				
28	d. Referrals for outside services are documented as part of the participant's treatment plan				
29	e. Treatment Plan is completed within 30 days of admission into treatment				
30	f. Treatment plan reviews are completed and documented in a timely manner every quarter				
31	g. Reflects the progress of participant's tretament in achieving each active items in the treatment plan(goals and Objectives)				
32	h. Reflect current issues relevant to person served				

PROGRESS NOTES					
#	Standard	Y	N	Reviewer Comments for Corrective Action	Corrective Actions Completed
33	a. Progress, or lack thereof, in achieviing treatment plan goals are evident in progress notes				
34	b. Reflective of the participant's progress, or lack thereof, toward achievement of identified objectives				
35	c. Documents change in the level of care (LOC) and any significant events in consumer's life				
36	d. The delivery and outcome of specific interventions. Modalities, and/or services that support the person-centered plan				
37	e. Changes in frequency of services				

DISCHARGE SUMMARY					
#	Standard	Y	N	Reviewer Comments for Corrective Action	Corrective Actions Completed
38	Is a written discharge summary prepared for all persons leaving services				
39	a. Include date of admission				
40	b. Described services provided				
41	c. Identify presenting condition				
42	d. Describe the extent to which established goals and objectives were met				
43	e. Describe the reason for discharge				
44	f. Identify the status at last contact				
45	g. List recommendations for services or support				
46	h. Include the date of discharge				
47	i. Include information about medication(s) prescribed or administered				

GENERAL OVERALL CHART REVIEW					
#	Standard	Y	N	Reviewer Comments for Corrective Action	Corrective Actions Completed
1	Is documentation timely and completed in its entirety				
2	Did the clinician follow through on all referrals				
3	Was the reason for intake appropriate and justified by the diagnosis				

4	Do Assessments justify the consumer's treatment/services?				
5	Is there justification for continued treatment?				
6	Are the services/treatment at the least restrictive level of care based on the consumer's current needs?				
7	Does the chart reflect an understanding of protocols and charting requirements?				

Corrective Action Status

[ ] Level 1 > 85% compliant No corrections are needed/Within Standards of Care

[ ] Level 2 within 75-84% compliant corrections are needed (see above)

- **[ ] Provider Self Identified Remediation**
- **[ ] Education was provided and accepted**
- **[ ] Corrective actions taken and completed**

[ ] Level 3 < 75% Compliant ,Care Inappropriate, corrective action will be taken as determined by the Medical Director

Reviewer Signature: _____ **Date** _____

GUAM BEHAVIORAL HEALTH AND WELLNESS CENTER
REVIEW AND ENDORSEMENT CERTIFICATION

The signatories on this document acknowledge that they have reviewed and approved the following:

[x] Policies and Procedure
[x] Program plan
[ ] Protocol/Form

Submitted by: Cydsel Toledo

Policy No: AD-MR-01

Title: Peer Review Process

Reviewed/Endorsed	**Date**	**Signature**
	4/14/17	Reina R. Sanchez
Title	Reina Sanchez Supervisor Community Support Services	
Reviewed/Endorsed	**Date**	**Signature**
	4/18/17	
Title	Dr. Ariel Ismael Medical Director	
Reviewed/Endorsed	**Date**	**Signature**
	4/19/17	
Title	Jeremy Lloyd RN Acting Nurse Administrator	
Reviewed/Endorsed	**Date**	**Signature**
	4/17/17	
Title	*Shermalin Pineda* *Manager Residential Recovery Program*	
Reviewed/Endorsed	**Date**	**Signature**
	4/17/17	
Title	*Sylvia Quinata* *Adult Counseling Supervisor*	
Reviewed/Endorsed	**Date**	**Signature**
	4.17.17	
Title	Annie Unpingco Administrator CASD	

GUAM BEHAVIORAL HEALTH AND WELLNESS CENTER
REVIEW AND ENDORSEMENT CERTIFICATION

Reviewed/Endorsed	**Date**	**Signature**
Title	Athena Duenas Supervisor Drug and Alcohol Program	
Reviewed/Endorsed	**Date**	**Signature**
	04/19/2017	
Title	Maria Teresa Aguon Program Manager Healing Hearts	
Reviewed/Endorsed	**Date**	**Signature**
	4/17/2017	
Title	*Cydsel Victoria Toledo* *Quality Improvement Coordinator*	
Reviewed/Endorsed	**Date**	**Signature**
	4/19/17	
Title	*Rey M. Vega* *Director*	