SANTA BARBARA COUNTY DEPARTMENT OF Behavioral Wellness
A System of Care and Recovery

# Programmatic Policy and Procedure

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| **Section** | Psychiatric Health Facility (PHF) | **Effective:** | DRAFT |
| **Sub-section** | Administration | **Version:** | 1.0 |
| **Policy** | Peer Review Process | **Last Revised:** | DRAFT |

**Director's Approval** _____ **Date** _____
Alice Gleghorn, PhD

**PHF Medical Director's Approval** _____ **Date** _____
Ole Behrendtsen, MD

**Supersedes:** New policy

**Approvals:** PHF Medical Practice Committee: PHF Governing Board:



## 1. PURPOSE/SCOPE

1.1. To establish a formal peer review process for psychiatry services at the Santa Barbara County Psychiatric Health Facility (hereafter the "PHF") in accordance with state regulations and standards of professional practice.

## 2. DEFINITIONS

The following terms are limited to the purposes of this policy:

2.1. **Peer review** – an activity that involves patient records evaluation by an unbiased reviewer to measure, assess, and improve professional practice and the quality of patient care. The reviewer shall have expertise in the medical specialty and sufficient clinical experience in the role and responsibilities of the professional under review. Peer review within the context of this policy applies to psychiatrists assigned to work at the PHF only.

2.2. **Peer review body** – a medical or professional staff of the PHF who conducts peer review. [Business and Professions Code § 805(a)(1)(B)(i)]

## 3. POLICY

3.1. The PHF shall establish a formal peer review process focused on quality improvement of psychiatry services. Peer review shall include the evaluation of the adequacy, appropriateness, and effectiveness of the care and treatment planned for, or provided to, PHF patients. [22 CCR §77083(a)(1); 42 CFR §482.22(a)(1)]

3.2. Peer review will occur on a periodic basis as determined by the standing clinical members of the PHF Medical Practice Committee (MPC). The PHF MPC will determine the criteria and scope of the peer review process. [PHF Medical Staff Bylaws, Article VII, Section 2(a)]

3.3. The proceedings and records of the peer review body are typically exempt from discovery as evidence. [Cal. Evidence Code § 1157] Participants of the peer review process will restrict discussions of findings, recommendations and any other details as it pertains to the peer review to the PHF MPC.

## 4. PROCEDURES

4.1. A Quality Care Management (QCM) psychiatrist will conduct a review of PHF psychiatrist chart notes on a periodic basis as determined by the PHF MPC. A standardized peer review worksheet will be utilized by the reviewer to promote consistency in the review process. When applicable, the QCM psychiatrist will relay any findings and instructions for necessary corrective action to the PHF psychiatrist and the PHF Medical Director.

4.2. Based on the QCM psychiatrist's findings and recommendations, the PHF Medical Director may elect to take further action as indicated and appropriate, including, but not limited to, one or more of the following:

1. Collegial discussion with the PHF psychiatrist;
2. Focused education on clinical procedures through trainings and/or peer mentor arrangement;
3. Educational letter or Letter of Concern (LOC);
4. For locum tenens psychiatrists, notification to the locum tenens vendor; or
5. Temporary or permanent restriction or suspension of clinical privileges.

4.3. Peer review summary reports will be presented quarterly to the PHF MPC. Based on the summary report, the committee may recommend additional corrective action and quality improvement activities.

## REFERENCE

California Code of Regulations – Social Security
*Title 22, Section 77083*

California Business and Professions Code
*Section 805*

California Evidence Code
*Section 1157*

Federal Code of Regulations – Conditions of Participation for Hospitals
*Title 42, Section 482.22(b)*

PHF Medical Staff Bylaws
*Article VII, Section 2(a)*

## REVISION RECORD

| DATE | VERSION | REVISION DESCRIPTION |
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***Culturally and Linguistically Competent Policies***

*The Department of Behavioral Wellness is committed to the tenets of cultural competency and understands that culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse individuals. All policies and procedures are intended to reflect the integration of diversity and cultural literacy throughout the Department. To the fullest extent possible, information, services and treatments will be provided (in verbal and/or written form) in the individual's preferred language or mode of communication (i.e. assistive devices for blind/deaf).*