Title	Peer Review Program			
Section	AD II-2	Issue Date 11/12/2020	Supersedes Date September 2008	Next Review Date 11/12/2021

References **Performance-Based Standards and Expected Practices for Adult Correctional Institutions, 5th Edition 5-ACI-6D-03 (M), North Carolina General Statutes (N.C.G.S.) 90-21.22A, 122C-191, 131E-95, 131E-107**

I. PURPOSE

(a) To ensure that all Health and Wellness clinical providers within the Division of Prisons (DOP) provide care to offenders that meets acceptable standards of care in accordance with DOP Health and Wellness policy and procedures, regulatory requirements of the applicable Discipline Governing Boards and other applicable agencies.

(b) To provide a confidential mechanism for giving feedback to clinical providers regarding their practice patterns.

(c) To provide a confidential program for identifying quality of care issues and a framework for performance improvement by clinical providers when it is determined that the care delivered does not meet or exceed acceptable standards of care.

II. POLICY

(a) The Health and Wellness Peer Review Program monitors the care provided by all health care practitioners/providers.

(b) The respective Section Directors are responsible for oversight of the Peer Review Program for clinical providers working in their sections.

(c) The Section Directors shall designate qualified peer reviewers who are equivalent in terms of discipline to perform documented clinical peer reviews.

(d) A documented external peer review will be conducted by a peer provider located at a different facility every two years and by occurrence, when indicated, to monitor the clinical practice provided by a provider.

(e) Materials used and produced are confidential and not considered public records (refer to

N.C.G.S. 90-21.22A, 122C-191, 131E-95, and/or 131E-107).

(f) Corrective action, determined by the Discipline Directors, will be addressed with clinical providers when quality of care concerns/problems are identified through the peer review process.

(g) The Peer Review Program should allow for open and honest discussion of topics pertaining to the clinical care provided to offenders by a particular provider.

III. DEFINITIONS

(a) **Provider:** DOP licensed clinician (to include contracted and locums) who delivers medical, psychiatric, dental or behavioral health **clinical** services. Providers include:

(1) Medical Doctors

(2) Psychiatrists

(3) Doctors of Osteopathy

(4) Physician Assistants

(5) Nurse Practitioners

(6) Dentists

(7) Psychologists

(8) Clinical Social Workers (LCSW/LCSWa)

(b) **Consultant:** a physician/provider outside of the DOP who provides consultation and makes recommendations to the attending provider related to specialty care of the patient.

IV. PROCEDURES

(a) All newly employed clinical providers who are State of North Carolina employees or who are on contract with the State of North Carolina shall have a minimum of five health records reviewed through the peer review process within the first six months of employment with DOP.

(b) All clinical providers who are State of North Carolina employees or who are on contract with the State of North Carolina shall have at least five health records reviewed through the peer review process every two years.

(c) Consultants who are not providing primary care under the direction of DOP Health and Wellness and are a member of a hospital medical staff are exempted from the peer review process within DOP.

(d) Peer Reviews also will occur:

(1) When there is an indication of questionable clinical practice.

(2) When Health and Wellness leadership (administration/section directors) are apprised of a potential quality of care concern/problem by a Health and Wellness professional, the Quality Assurance/Risk Management Section, the Utilization Review Section, DOP Commissioner, Assistant Commissioner, Director of Performance and Standards, Regional Directors, Wardens, NCDPS leadership and/or a DOP Committee.

(e) Peer Reviewer will:

(1) Randomly select a minimum of five health records for review, including active and, if applicable, inactive cases; and

(2) Complete a Discipline-Specific *Clinical Peer Review* form for each health record reviewed.

(A) If there are only “yes” responses on the *Clinical Peer Review* form, no further action is needed.

(B) If there are any “no” or “unclear” responses, an explanation detailed in the space provided in the comments section of the form will be required.

(f) Clinical Supervisor will:

(1) Discuss the "no" or "unclear" responses with the clinical provider. If, through such discussion, responses do not indicate a quality of care concern, no further action is needed.

(2) Refer the case to the respective Discipline Director if the responses indicate a potential quality of care concern, to determine if performance improvement action is required.

(g) If the respective Discipline Director determines there is a quality of care concern which cannot be resolved by review and discussion with the provider, he/she shall take appropriate corrective action(s) to address the clinical performance.

(h) The confidential completed original *Clinical Peer Review* forms and all associated documentation will be kept on file in the Health and Wellness Central Office by the Directors of each discipline.

____ ____11/12/2020_

Todd E. Ishee — Date

Commissioner of Prisons

NORTH CAROLINA DEPARTMENT OF PUBLIC SAFETY
Health & Wellness Services
Dental Services Clinical Peer Review Form

Offender #: ________________________________ Date of Review: ______________________

Attending Clinician: _________________________ Discipline: **DENTAL SERVICES**

Setting: ☐ Inpatient ☐ Outpatient ☐ Residential ☐ Day Treatment

Reason for Review:

☐ New employee ☐ Utilization issues ☐ Mortality
☐ Annual review ☐ Appropriateness of care ☐ Drug usage
☐ Adverse drug reaction ☐ Patient complaint ☐ Random
☐ Professional concern ☐ Sentinel event ☐ Other: _______________

Answer all questions. Comment (back of page) is required for any response of "no" or "unclear."
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Does the documentation indicate:				
1. Assessment				
purpose of encounter clear?	Yes	No	N/A	Unclear
encounter within required timeframe?	Yes	No	N/A	Unclear
includes pertinent subjective and objective findings?	Yes	No	N/A	Unclear
2. Diagnosis				
specified?	Yes	No	N/A	Unclear
supported by radiograph and subjective/objective findings?	Yes	No	N/A	Unclear
3. Treatment				
consistent with diagnosis?	Yes	No	N/A	Unclear
consent form?	Yes	No	N/A	Unclear
dental lab Rx?	Yes	No	N/A	Unclear
4. Request for consult/UR?	Yes	No	N/A	Unclear
completed in a timely manner?	Yes	No	N/A	Unclear
5. Frequency of contact is consistent with diagnosis and treatment?	Yes	No	N/A	Unclear
6. Medication				
justified by diagnosis and symptoms?	Yes	No	N/A	Unclear
consistent with peers?	Yes	No	N/A	Unclear
applicable protocols followed?	Yes	No	N/A	Unclear
7. Patient Education				
documented?	Yes	No	N/A	Unclear
post-operative instructions provided?	Yes	No	N/A	Unclear

_______________________________ _______________________________ _______________
Reviewer's Printed Name & Title Reviewer's Signature Review Date

NORTH CAROLINA DEPARTMENT OF PUBLIC SAFETY
Health & Wellness Services
Dental Services Clinical Peer Review Form

COMMENTS ____

Reviewer's Printed Name & Title

Reviewer's Signature

Review Date

NORTH CAROLINA DIVISION OF PRISONS
Health & Wellness Services

Behavioral Health Clinical Peer Review Form

Offender #: ______________________________ **Attending Clinician:** _______________________

Attending Clinician Discipline: ☐ Psychology ☐ Clinical Social Work

Setting: ☐ Inpatient ☐ Outpatient ☐ Residential ☐ Day Treatment ☐ TDU

Reason: ☐ New Employee ☐ Patient complaint ☐ Sentinel event
☐ Bi-Annual Review ☐ Professional concern ☐ Other: _______________

Answer all questions. Comment (back of page) is required for any response of "no" or "unclear."
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Does the documentation Indicate:				
1. Discipline specific assessment				
includes thorough review of psycho-social history?	Yes	No	N/A	Unclear
is completed within required timeframe?	Yes	No	N/A	Unclear
includes current observations and recent behavior changes?	Yes	No	N/A	Unclear
2. Diagnosis is justified by history and current assessment?	Yes	No	N/A	Unclear
3. Treatment plan				
is consistent with diagnosis?	Yes	No	N/A	Unclear
is completed within required timeframe?	Yes	No	N/A	Unclear
includes measurable goals?	Yes	No	N/A	Unclear
4. Progress notes				
relate to the identified problems per treatment plan?	Yes	No	N/A	Unclear
are completed within required time frames?	Yes	No	N/A	Unclear
show changes in patient condition/behavior/mental status?	Yes	No	N/A	Unclear
5. Frequency of contact is consistent with diagnosis and severity of symptoms?	Yes	No	N/A	Unclear
6. Documentation of medication monitoring (reported side effects, medication adherence) if prescribed psychotropics?	Yes	No	N/A	Unclear
7. Are clinical alerts (suicide, homicide, escape) adequately addressed?	Yes	No	N/A	Unclear
8. Documentation does not have confusing or inappropriate language or terms. Documentation is absence of language conveying personal opinions against the patient.	Yes	No	N/A	Unclear
9. Documentation is patient-specific? If text-strings or templates are used, patient-specific information is evident?	Yes	No	N/A	Unclear

_____________________________ _____________________________ _______________
Reviewer's Printed Name & Title **Reviewer's Signature** **Review Date**

 Form Date: 5/07/2020

Behavioral Health Clinical Peer Review Form Comments:

Offender #: ______________________________ **Attending Clinician:** _________________________

Reviewer's Printed Name & Title **Reviewer's Signature** **Review Date**

 Form Date: 5/07/2020

NORTH CAROLINA DEPARTMENT OF PUBLIC SAFETY
Health and Wellness Services
Medical and Mental Health Clinical Peer Review Form

Offender #: ______________________________ Attending Clinician: _______________________

Setting: ☐ Inpatient ☐ Outpatient

Reason:
☐ New Employee ☐ Utilization Issues ☐ Mortality
☐ Annual Review ☐ Appropriateness of care ☐ Drug usage
☐ Adverse drug reaction ☐ Patient complaint ☐ Random
☐ Professional concern ☐ Sentinel event ☐ Other: _______________

Answer all questions. Comment (back of page) is required for any response of "no" or "unclear".
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Does the Chart Review Indicate:				
1. Appropriate Documentation				
Was completed in appropriate time frame following visit?	Yes	No	N/A	Unclear
Includes clear chief complaint?	Yes	No	N/A	Unclear
Includes at least one pertinent positive and negative?	Yes	No	N/A	Unclear
Incudes vitals and pertinent physical exam?	Yes	No	N/A	Unclear
Documentation is in SOAPE format?	Yes	No	N/A	Unclear
2. Appropriate Diagnosis				
Includes evidence of a differential diagnosis considered?	Yes	No	N/A	Unclear
Includes justification of diagnosis by history and assessment?	Yes	No	N/A	Unclear
3. Appropriate Treatment Plan				
Consults/labs/ treatments are appropriate for diagnosis?	Yes	No	N/A	Unclear
Medications are justified by diagnosis and severity of symptoms?	Yes	No	N/A	Unclear
Prescribing practices are consistent with peers, i.e., provider stays within the Health and Wellness formulary when prescribing ?	Yes	No	N/A	Unclear
Applicable Health and Wellness protocols are followed - Policies and Procedures (Hep C, HIV, TB, etc.)?	Yes	No	N/A	Unclear
Includes documentation of patient education?	Yes	No	N/A	Unclear
4. Appropriate Treatment Monitoring				
Includes documentation of medication monitoring (reported side effects, medication adherence)?	Yes	No	N/A	Unclear
Consults/lab testing/special treatments are reviewed in a timely manner ?	Yes	No	N/A	Unclear
Follow up plan is made and consistent with diagnosis and severity of symptoms?	Yes	No	N/A	Unclear
Includes aftercare/discharge planning?	Yes	No	N/A	Unclear

_______________________ _______________________ _______________
Reviewer's Printed Name Reviewer's Signature Date

NORTH CAROLINA DEPARTMENT OF PUBLIC SAFETY
Health and Wellness Services
Medical and Mental Health Clinical Peer Review Form

Offender #: ____________ Attending Provider: __________________________

______________________________ ______________________________ ________________
Reviewer's Printed Name Reviewer's Signature Date

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